water storage that moves California ahead and supplies farms, cities, and environmental needs.

We have this opportunity in a project that has long awaited our authorization, the Sites Reservoir in the western part of Colusa and Glenn Counties, a district that I used to represent in the State legislature and which my colleague, JOHN GARAMENDI, now represents in Congress.

We will soon be introducing a piece of legislation to move forward on the Sites Reservoir with an authorization for the funds needed to complete the studies and get started.

Some may say: Well, it will take 7 or 10 years to get this done.

Had we started 7 or 10 years ago, we would be right near completion; so we need to start today, and the people will thank us 7 or 10 years from now when we get this done. This will be introduced, hopefully, soon.

□ 0915

## MILITARY TRANSITION SUPPORT PROJECT

(Mr. PETERS of California asked and was given permission to address the House for 1 minute.)

Mr. PETERS of California. Mr. Speaker, I rise today to highlight the Military Transition Support Project, an innovative program to ease the transition for recently discharged veterans as they return to civilian life, which I helped launch last month.

Each year, over 15,000 servicemembers are discharged in San Diego, and around half will choose to stay there. Over the past year, we have worked with our local veteran leadership, our Navy and Marine commanders, and the San Diego philanthropic community to create a central system to help servicemembers navigate through their transition process.

This unique effort will improve the quality of life for servicemembers across San Diego. The program will begin in the last year of service and will give these dedicated men and women access to resources and continuous support throughout the transition process, beginning while they are still in uniform, by providing a central portal for benefits, employment, and housing.

This program has the potential to serve as a model for military communities around the country. It represents a groundbreaking, collaborative effort where the military, nonprofits, and private sector stakeholders can come together in the cooperative spirit that is a hallmark of San Diego to get our veterans to work.

## SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION ACT OF 2014

Mr. PITTS. Mr. Speaker, pursuant to House Resolution 515, I call up the bill (H.R. 4015) to amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and improve Medicare payments for physicians and other professionals, and for other purposes to amend section 530D of title 28, United States Code, and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 515, the amendment printed in part B of House Report 113–379 is adopted and the bill, as amended, is considered read.

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

H.R. 4015

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''SGR Repeal and Medicare Provider Payment Modernization Act of 2014''.

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



**SEC. 2. REPEALING THE SUSTAINABLE GROWTH RATE (SGR) AND IMPROVING MEDICARE PAYMENT FOR PHYSICIANS' SERVICES.**

(a) STABILIZING FEE UPDATES.—

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

(A) in subsection (d)—

(i) in paragraph (1)(A), by inserting ''or a subsequent paragraph'' after ''paragraph (4)''; and

(ii) in paragraph (4)—

(I) in the heading, by inserting ''AND ENDING WITH 2013'' after ''YEARS BEGINNING WITH 2001''; and

(II) in subparagraph (A), by inserting ''and ending with 2013'' after ''a year beginning with 2001''; and

(B) in subsection (f)—

(i) in paragraph (1)(B), by inserting ''through 2013'' after ''of each succeeding year''; and

(ii) in paragraph (2), in the matter preceding subparagraph (A), by inserting ''and ending with 2013'' after ''beginning with 2000''.

(2) UPDATE OF RATES FOR APRIL THROUGH DECEMBER OF 2014, 2015, AND SUBSEQUENT YEARS.—Subsection (d) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by striking paragraph (15) and inserting the following new paragraphs:

''(15) UPDATE FOR 2014 THROUGH 2018.—The update to the single conversion factor established in paragraph (1)(C) for 2014 and each subsequent year through 2018 shall be 0.5 percent.

''(16) UPDATE FOR 2019 THROUGH 2023.—The update to the single conversion factor established in paragraph (1)(C) for 2019 and each subsequent year through 2023 shall be zero percent.

''(17) UPDATE FOR 2024 AND SUBSEQUENT YEARS.—The update to the single conversion factor established in paragraph (1)(C) for 2024 and each subsequent year shall be—

''(A) for items and services furnished by a qualifying APM participant (as defined in section 1833(z)(2)) for such year, 1.0 percent; and

''(B) for other items and services, 0.5 percent.''.

(3) MEDPAC REPORTS.—

(A) INITIAL REPORT.—Not later than July 1, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship between—

(i) physician and other health professional utilization and expenditures (and the rate of increase of such utilization and expenditures) of items and services for which payment is made under section 1848 of the Social Security Act (42 U.S.C. 1395w–4); and

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

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

(B) FINAL REPORT.—Not later than July 1, 2020, the Medicare Payment Advisory Commission shall submit to Congress a report on the relationship described in subparagraph (A), including the results determined from applying the methodology included in the report submitted under such subparagraph.

(C) REPORT ON UPDATE TO PHYSICIANS' SERVICES UNDER MEDICARE.—Not later than July 1, 2018, the Medicare Payment Advisory Commission shall submit to Congress a report on—

(i) the payment update for professional services applied under the Medicare program under title XVIII of the Social Security Act for the period of years 2014 through 2018;

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

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

(iv) recommendations for any future payment updates for professional services under such program to ensure adequate access to care is maintained for Medicare beneficiaries.

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

(1) EHR MEANINGFUL USE INCENTIVE PROGRAM.—

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

(i) in clause (i), by striking ''or any subsequent payment year'' and inserting ''or 2017'';

(ii) in clause (ii)—

(I) in the matter preceding subclause (I), by striking ''Subject to clause (iii), for'' and inserting ''For'';

(II) in subclause (I), by adding at the end ''and'';

(III) in subclause (II), by striking ''; and'' and inserting a period; and

(IV) by striking subclause (III); and

(iii) by striking clause (iii).

(B) CONTINUATION OF MEANINGFUL USE DETERMINATIONS FOR MIPS.—Section 1848(o)(2) of

the Social Security Act (42 U.S.C. 1395w–4(o)(2)) is amended—

(i) in subparagraph (A), in the matter preceding clause (i)—

(I) by striking ''For purposes of paragraph (1), an'' and inserting ''An''; and

(II) by inserting '', or pursuant to subparagraph (D) for purposes of subsection (q), for a performance period under such subsection for a year'' after ''under such subsection for a year''; and

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

''(D) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—With respect to 2018 and each subsequent payment year, the Secretary shall, for purposes of subsection (q) and in accordance with paragraph (1)(F) of such subsection, determine whether an eligible professional who is a MIPS eligible professional (as defined in subsection (q)(1)(C)) for such year is a meaningful EHR user under this paragraph for the performance period under subsection (q) for such year.''.

(2) QUALITY REPORTING.—

(A) SUNSETTING SEPARATE QUALITY REPORTING INCENTIVES.—Section 1848(a)(8)(A) of the Social Security Act (42 U.S.C. 1395w–4(a)(8)(A)) is amended—

(i) in clause (i), by striking ''or any subsequent year'' and inserting ''or 2017''; and

(ii) in clause (ii)(II), by striking ''and each subsequent year''.

(B) CONTINUATION OF QUALITY MEASURES AND PROCESSES FOR MIPS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(i) in subsection (k), by adding at the end the following new paragraph:

''(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the provisions of this subsection—

''(A) for purposes of subsection (q); and

''(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.''; and

(ii) in subsection (m)—

(I) by redesignating paragraph (7) added by section 10327(a) of Public Law 111–148 as paragraph (8); and

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

''(9) CONTINUED APPLICATION FOR PURPOSES OF MIPS AND FOR CERTAIN PROFESSIONALS VOLUNTEERING TO REPORT.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out the processes under this subsection—

''(A) for purposes of subsection (q); and

''(B) for eligible professionals who are not MIPS eligible professionals (as defined in subsection (q)(1)(C)) for the year involved.''.

(3) VALUE-BASED PAYMENTS.—

(A) SUNSETTING SEPARATE VALUE-BASED PAYMENTS.—Clause (iii) of section 1848(p)(4)(B) of the Social Security Act (42 U.S.C. 1395w–4(p)(4)(B)) is amended to read as follows:

''(iii) APPLICATION.—The Secretary shall apply the payment modifier established under this subsection for items and services furnished on or after January 1, 2015, but before January 1, 2018, with respect to specific physicians and groups of physicians the Secretary determines appropriate. Such payment modifier shall not be applied for items and services furnished on or after January 1, 2018.''.

(B) CONTINUATION OF VALUE-BASED PAYMENT MODIFIER MEASURES FOR MIPS.—Section 1848(p) of the Social Security Act (42 U.S.C. 1395w–4(p)) is amended—

(i) in paragraph (2), by adding at the end the following new subparagraph:

''(C) CONTINUED APPLICATION FOR PURPOSES OF MIPS.—The Secretary shall, in accordance with subsection (q)(1)(F), carry out subparagraph (B) for purposes of subsection (q).''; and

(ii) in paragraph (3), by adding at the end the following: ''With respect to 2018 and each subsequent year, the Secretary shall, in accordance with subsection (q)(1)(F), carry out this paragraph for purposes of subsection (q).''.

(c) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

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

''(q) MERIT-BASED INCENTIVE PAYMENT SYSTEM.—

''(1) ESTABLISHMENT.—

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

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

''(ii) using such methodology, provide for a composite performance score in accordance with paragraph (5) for each such professional for each performance period; and

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

''(B) PROGRAM IMPLEMENTATION.—The MIPS shall apply to payments for items and services furnished on or after January 1, 2018.

''(C) MIPS ELIGIBLE PROFESSIONAL DEFINED.—

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

''(I) for the first and second years for which the MIPS applies to payments (and for the performance period for such first and second year), a physician (as defined in section 1861(r)), a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)) and a group that includes such professionals; and

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

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

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

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

''(III) for the performance period with respect to such year, does not exceed the low-volume threshold measurement selected under clause (iv).

''(iii) PARTIAL QUALIFYING APM PARTICIPANT.—For purposes of this subparagraph, the term 'partial qualifying APM participant' means, with respect to a year, an eligible professional for whom the Secretary determines the minimum payment percentage (or percentages), as applicable, described in paragraph (2) of section 1833(z) for such year have not been satisfied, but who would be considered a qualifying APM participant (as defined in such paragraph) for such year if—

''(I) with respect to 2018 and 2019, the reference in subparagraph (A) of such paragraph to 25 percent was instead a reference to 20 percent;

''(II) with respect to 2020 and 2021—

''(aa) the reference in subparagraph (B)(i) of such paragraph to 50 percent was instead a reference to 40 percent; and

''(bb) the references in subparagraph (B)(ii) of such paragraph to 50 percent and 25 percent of such paragraph were instead references to 40 percent and 20 percent, respectively; and

''(III) with respect to 2022 and subsequent years—

''(aa) the reference in subparagraph (C)(i) of such paragraph to 75 percent was instead a reference to 50 percent; and

''(bb) the references in subparagraph (C)(ii) of such paragraph to 75 percent and 25 percent of such paragraph were instead references to 50 percent and 20 percent, respectively.

''(iv) SELECTION OF LOW-VOLUME THRESHOLD MEASUREMENT.—The Secretary shall select a low-volume threshold to apply for purposes of clause (ii)(III), which may include one or more or a combination of the following:

''(I) The minimum number (as determined by the Secretary) of individuals enrolled under this part who are treated by the eligible professional for the performance period involved.

''(II) The minimum number (as determined by the Secretary) of items and services furnished to individuals enrolled under this part by such professional for such performance period.

''(III) The minimum amount (as determined by the Secretary) of allowed charges billed by such professional under this part for such performance period.

''(v) TREATMENT OF NEW MEDICARE ENROLLED ELIGIBLE PROFESSIONALS.—In the case of a professional who first becomes a Medicare enrolled eligible professional during the performance period for a year (and had not previously submitted claims under this title such as a person, an entity, or a part of a physician group or under a different billing number or tax identifier), such professional shall not be treated under this subsection as a MIPS eligible professional until the subsequent year and performance period for such subsequent year.

''(vi) CLARIFICATION.—In the case of items and services furnished during a year by an individual who is not a MIPS eligible professional (including pursuant to clauses (ii) and (v)) with respect to a year, in no case shall a MIPS adjustment factor (or additional MIPS adjustment factor) under paragraph (6) apply to such individual for such year.

''(vii) PARTIAL QUALIFYING APM PARTICIPANT CLARIFICATIONS.—

''(I) TREATMENT AS MIPS ELIGIBLE PROFESSIONAL.—In the case of an eligible professional who is a partial qualifying APM participant, with respect to a year, and who for the performance period for such year reports on applicable measures and activities described in paragraph (2)(B) that are required to be reported by such a professional under

the MIPS, such eligible professional is considered to be a MIPS eligible professional with respect to such year.

''(II) NOT ELIGIBLE FOR QUALIFYING APM PARTICIPANT PAYMENTS.—In no case shall an eligible professional who is a partial qualifying APM participant, with respect to a year, be considered a qualifying APM participant (as defined in paragraph (2) of section 1833(z)) for such year or be eligible for the additional payment under paragraph (1) of such section for such year.

''(D) APPLICATION TO GROUP PRACTICES.—

''(i) IN GENERAL.—Under the MIPS:

''(I) QUALITY PERFORMANCE CATEGORY.—The Secretary shall establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing performance of such group with respect to the performance category described in clause (i) of paragraph (2)(A).

''(II) OTHER PERFORMANCE CATEGORIES.—The Secretary may establish and apply a process that includes features of the provisions of subsection (m)(3)(C) for MIPS eligible professionals in a group practice with respect to assessing the performance of such group with respect to the performance categories described in clauses (ii) through (iv) of such paragraph.

''(ii) ENSURING COMPREHENSIVENESS OF GROUP PRACTICE ASSESSMENT.—The process established under clause (i) shall to the extent practicable reflect the range of items and services furnished by the MIPS eligible professionals in the group practice involved.

''(iii) CLARIFICATION.—MIPS eligible professionals electing to be a virtual group under paragraph (5)(I) shall not be considered MIPS eligible professionals in a group practice for purposes of applying this subparagraph.

''(E) USE OF REGISTRIES.—Under the MIPS, the Secretary shall encourage the use of qualified clinical data registries pursuant to subsection (m)(3)(E) in carrying out this subsection.

''(F) APPLICATION OF CERTAIN PROVISIONS.—In applying a provision of subsection (k), (m), (o), or (p) for purposes of this subsection, the Secretary shall—

''(i) adjust the application of such provision to ensure the provision is consistent with the provisions of this subsection; and

''(ii) not apply such provision to the extent that the provision is duplicative with a provision of this subsection.

''(G) ACCOUNTING FOR RISK FACTORS.—

''(i) RISK FACTORS.—Taking into account the relevant studies conducted and recommendations made in reports under section 2(f)(1) of the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, the Secretary, on an ongoing basis, shall estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into the MIPS.

''(ii) ACCOUNTING FOR OTHER FACTORS IN PAYMENT ADJUSTMENTS.—Taking into account the studies conducted and recommendations made in reports under section 2(f)(1) of the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 and other information as appropriate, the Secretary shall account for identified factors with an effect on quality and resource use outcome measures when determining payment adjustments, composite performance scores, scores for performance categories, or scores for measures or activities under the MIPS.

''(2) MEASURES AND ACTIVITIES UNDER PERFORMANCE CATEGORIES.—

''(A) PERFORMANCE CATEGORIES.—Under the MIPS, the Secretary shall use the following performance categories (each of which is referred to in this subsection as a performance category) in determining the composite performance score under paragraph (5):

''(i) Quality.

''(ii) Resource use.

''(iii) Clinical practice improvement activities.

''(iv) Meaningful use of certified EHR technology.

''(B) MEASURES AND ACTIVITIES SPECIFIED FOR EACH CATEGORY.—For purposes of paragraph (3)(A) and subject to subparagraph (C), measures and activities specified for a performance period (as established under paragraph (4)) for a year are as follows:

''(i) QUALITY.—For the performance category described in subparagraph (A)(i), the quality measures included in the final measures list published under subparagraph (D)(i) for such year and the list of quality measures described in subparagraph (D)(vi) used by qualified clinical data registries under subsection (m)(3)(E).

''(ii) RESOURCE USE.—For the performance category described in subparagraph (A)(ii), the measurement of resource use for such period under subsection (p)(3), using the methodology under subsection (r) as appropriate, and, as feasible and applicable, accounting for the cost of drugs under part D.

''(iii) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—For the performance category described in subparagraph (A)(iii), clinical practice improvement activities (as defined in subparagraph (C)(v)(III)) under subcategories specified by the Secretary for such period, which shall include at least the following:

''(I) The subcategory of expanded practice access, which shall include activities such as same day appointments for urgent needs and after hours access to clinician advice.

''(II) The subcategory of population management, which shall include activities such as monitoring health conditions of individuals to provide timely health care interventions or participation in a qualified clinical data registry.

''(III) The subcategory of care coordination, which shall include activities such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth.

''(IV) The subcategory of beneficiary engagement, which shall include activities such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms.

''(V) The subcategory of patient safety and practice assessment, such as through use of clinical or surgical checklists and practice assessments related to maintaining certification.

''(VI) The subcategory of participation in an alternative payment model (as defined in section 1833(z)(3)(C)).

In establishing activities under this clause, the Secretary shall give consideration to the circumstances of small practices (consisting of 15 or fewer professionals) and practices located in rural areas and in health professional shortage areas (as designated under section 332(a)(1)(A) of the Public Health Service Act).

''(iv) MEANINGFUL EHR USE.—For the performance category described in subparagraph (A)(iv), the requirements established for such period under subsection (o)(2) for determining whether an eligible professional is a meaningful EHR user.

''(C) ADDITIONAL PROVISIONS.—

''(i) EMPHASIZING OUTCOME MEASURES UNDER THE QUALITY PERFORMANCE CATEGORY.—In applying subparagraph (B)(i), the Secretary shall, as feasible, emphasize the application of outcome measures.

''(ii) APPLICATION OF ADDITIONAL SYSTEM MEASURES.—The Secretary may use measures used for a payment system other than for physicians, such as measures for inpatient hospitals, for purposes of the performance categories described in clauses (i) and (ii) of subparagraph (A). For purposes of the previous sentence, the Secretary may not use measures for hospital outpatient departments, except in the case of emergency physicians.

''(iii) GLOBAL AND POPULATION-BASED MEASURES.—The Secretary may use global measures, such as global outcome measures, and population-based measures for purposes of the performance category described in subparagraph (A)(i).

''(iv) APPLICATION OF MEASURES AND ACTIVITIES TO NON-PATIENT-FACING PROFESSIONALS.—In carrying out this paragraph, with respect to measures and activities specified in subparagraph (B) for performance categories described in subparagraph (A), the Secretary—

''(I) shall give consideration to the circumstances of professional types (or subcategories of those types determined by practice characteristics) who typically furnish services that do not involve face-to-face interaction with a patient; and

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

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

''(v) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES.—

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

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

''(aa) identifying activities described in subparagraph (B)(iii);

''(bb) specifying criteria for such activities; and

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

''(III) CLINICAL PRACTICE IMPROVEMENT ACTIVITIES DEFINED.—For purposes of this subsection, the term 'clinical practice improvement activity' means an activity that relevant eligible professional organizations and other relevant stakeholders identify as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, is likely to result in improved outcomes.

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

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

''(I) not later than November 1 of the year prior to the first day of the first performance period under the MIPS, establish and publish in the Federal Register a final list of quality measures; and

''(II) not later than November 1 of the year prior to the first day of each subsequent performance period, update the final list of quality measures from the previous year (and publish such updated final list in the Federal Register), by—

''(aa) removing from such list, as appropriate, quality measures, which may include the removal of measures that are no longer meaningful (such as measures that are topped out);

''(bb) adding to such list, as appropriate, new quality measures; and

''(cc) determining whether or not quality measures on such list that have undergone substantive changes should be included in the updated list.

''(ii) CALL FOR QUALITY MEASURES.—

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

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

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

''(I) provide that, to the extent practicable, all quality domains (as defined in subsection (s)(1)(B)) are addressed by such measures; and

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

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

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

''(I) measures endorsed by a consensus-based entity;

''(II) measures developed under subsection (s); and

''(III) measures submitted under clause (ii)(I).

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

''(vi) EXCEPTION FOR QUALIFIED CLINICAL DATA REGISTRY MEASURES.—Measures used by a qualified clinical data registry under subsection (m)(3)(E) shall not be subject to the requirements under clauses (i), (iv), and (v). The Secretary shall publish the list of measures used by such qualified clinical data registries on the Internet website of the Centers for Medicare & Medicaid Services.

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

''(I) shall not be subject to the requirements under clause (i) (except under items (aa) and (cc) of subclause (II) of such clause) or to the requirement under clause (iv); and

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

''(viii) CONSULTATION WITH RELEVANT ELIGIBLE PROFESSIONAL ORGANIZATIONS AND OTHER RELEVANT STAKEHOLDERS.—Relevant eligible professional organizations and other relevant stakeholders, including State and national medical societies, shall be consulted in carrying out this subparagraph.

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

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—Under the MIPS, the Secretary shall establish performance standards with respect to measures and activities specified under paragraph (2)(B) for a performance period (as established under paragraph (4)) for a year.

''(B) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing such performance standards with respect to measures and activities specified under paragraph (2)(B), the Secretary shall consider the following:

''(i) Historical performance standards.

''(ii) Improvement.

''(iii) The opportunity for continued improvement.

''(4) PERFORMANCE PERIOD.—The Secretary shall establish a performance period (or periods) for a year (beginning with the year described in paragraph (1)(B)). Such performance period (or periods) shall begin and end prior to the beginning of such year and be as close as possible to such year. In this subsection, such performance period (or periods) for a year shall be referred to as the performance period for the year.

''(5) COMPOSITE PERFORMANCE SCORE.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph and taking into account, as available and applicable, paragraph (1)(G), the Secretary shall develop a methodology for assessing the total performance of each MIPS eligible professional according to performance standards under paragraph (3) with respect to applicable measures and activities specified in paragraph (2)(B) with respect to each performance category applicable to such professional for a performance period (as established under paragraph (4)) for a year. Using such methodology, the Secretary shall provide for a composite assessment (using a scoring scale of 0 to 100) for each such professional for the performance period for such year. In this subsection such a composite assessment for such a professional with respect to a performance period shall be referred to as the 'composite performance score' for such professional for such performance period.

''(B) INCENTIVE TO REPORT; ENCOURAGING USE OF CERTIFIED EHR TECHNOLOGY FOR REPORTING QUALITY MEASURES.—

''(i) INCENTIVE TO REPORT.—Under the methodology established under subparagraph (A), the Secretary shall provide that in the case of a MIPS eligible professional who fails to report on an applicable measure or activity that is required to be reported by the professional, the professional shall be treated as achieving the lowest potential score applicable to such measure or activity.

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

''(I) encourage MIPS eligible professionals to report on applicable measures with respect to the performance category described in paragraph (2)(A)(i) through the use of certified EHR technology and qualified clinical data registries; and

''(II) with respect to a performance period, with respect to a year, for which a MIPS eligible professional reports such measures through the use of such EHR technology, treat such professional as satisfying the clinical quality measures reporting requirement described in subsection (o)(2)(A)(iii) for such year.

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

''(i) RULE FOR ACCREDITATION.—A MIPS eligible professional who is in a practice that is certified as a patient-centered medical home or comparable specialty practice pursuant to subsection (b)(8)(B)(i) with respect to a performance period shall be given the highest potential score for the performance category described in paragraph (2)(A)(iii) for such period.

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

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

''(D) ACHIEVEMENT AND IMPROVEMENT.—

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

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

''(II) in the case of performance scores for other performance categories, may take into account the improvement of the professional.

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

''(E) WEIGHTS FOR THE PERFORMANCE CATEGORIES.—

''(i) IN GENERAL.—Under the methodology developed under subparagraph (A), subject to subparagraph (F)(i) and clauses (ii) and (iii), the composite performance score shall be determined as follows:

''(I) QUALITY.—

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

applying the previous sentence, the Secretary shall, as feasible, encourage the application of outcome measures within such category.

''(bb) FIRST 2 YEARS.—For the first and second years for which the MIPS applies to payments, the percentage applicable under item (aa) shall be increased in a manner such that the total percentage points of the increase under this item for the respective year equals the total number of percentage points by which the percentage applied under subclause (II)(bb) for the respective year is less than 30 percent.

''(II) RESOURCE USE.—

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

''(bb) FIRST 2 YEARS.—For the first year for which the MIPS applies to payments, not more than 10 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A). For the second year for which the MIPS applies to payments, not more than 15 percent of such score shall be based on performance with respect to the category described in clause (ii) of paragraph (2)(A).

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

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

''(ii) AUTHORITY TO ADJUST PERCENTAGES IN CASE OF HIGH EHR MEANINGFUL USE ADOPTION.—In any year in which the Secretary estimates that the proportion of eligible professionals (as defined in subsection (o)(5)) who are meaningful EHR users (as determined under subsection (o)(2)) is 75 percent or greater, the Secretary may reduce the percent applicable under clause (i)(IV), but not below 15 percent. If the Secretary makes such reduction for a year, subject to subclauses (I)(bb) and (II)(bb) of clause (i), the percentages applicable under one or more of subclauses (I), (II), and (III) of clause (i) for such year shall be increased in a manner such that the total percentage points of the increase under this clause for such year equals the total number of percentage points reduced under the preceding sentence for such year.

''(F) CERTAIN FLEXIBILITY FOR WEIGHTING PERFORMANCE CATEGORIES, MEASURES, AND ACTIVITIES.—Under the methodology under subparagraph (A), if there are not sufficient measures and clinical practice improvement activities applicable and available to each type of eligible professional involved, the Secretary shall assign different scoring weights (including a weight of 0)—

''(i) which may vary from the scoring weights specified in subparagraph (E), for each performance category based on the extent to which the category is applicable to the type of eligible professional involved; and

''(ii) for each measure and activity specified under paragraph (2)(B) with respect to each such category based on the extent to which the measure or activity is applicable and available to the type of eligible professional involved.

''(G) RESOURCE USE.—Analysis of the performance category described in paragraph (2)(A)(ii) shall include results from the methodology described in subsection (r)(5), as appropriate.

''(H) INCLUSION OF QUALITY MEASURE DATA FROM OTHER PAYERS.—In applying subsections (k), (m), and (p) with respect to measures described in paragraph (2)(B)(i), analysis of the performance category described in paragraph (2)(A)(i) may include data submitted by MIPS eligible professionals with respect to items and services furnished to individuals who are not individuals entitled to benefits under part A or enrolled under part B.

''(I) USE OF VOLUNTARY VIRTUAL GROUPS FOR CERTAIN ASSESSMENT PURPOSES.—

''(i) IN GENERAL.—In the case of MIPS eligible professionals electing to be a virtual group under clause (ii) with respect to a performance period for a year, for purposes of applying the methodology under subparagraph (A)—

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

''(II) the composite score provided under this paragraph for such performance period with respect to each such performance category for each such MIPS eligible professional in such virtual group shall be based on the assessment of the combined performance under subclause (I) for the performance category and performance period.

''(ii) ELECTION OF PRACTICES TO BE A VIRTUAL GROUP.—The Secretary shall, in accordance with clause (iii), establish and have in place a process to allow an individual MIPS eligible professional or a group practice consisting of not more than 10 MIPS eligible professionals to elect, with respect to a performance period for a year, for such individual MIPS eligible professional or all such MIPS eligible professionals in such group practice, respectively, to be a virtual group under this subparagraph with at least one other such individual MIPS eligible professional or group practice making such an election. Such a virtual group may be based on geographic areas or on provider specialties defined by nationally recognized multispecialty boards of certification or equivalent certification boards and such other eligible professional groupings in order to capture classifications of providers across eligible professional organizations and other practice areas or categories.

''(iii) REQUIREMENTS.—The process under clause (ii)—

''(I) shall provide that an election under such clause, with respect to a performance period, shall be made before or during the beginning of such performance period and may not be changed during such performance period;

''(II) shall provide that a practice described in such clause, and each MIPS eligible professional in such practice, may elect to be in no more than one virtual group for a performance period; and

''(III) may provide that a virtual group may be combined at the tax identification number level.

''(6) MIPS PAYMENTS.—

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

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

''(ii) in a manner such that the adjustment factors specified under this subparagraph for a year result in differential payments under this paragraph reflecting that—

''(I) MIPS eligible professionals with composite performance scores for such year at or above such performance threshold for such year receive zero or positive incentive payment adjustment factors for such year in accordance with clause (iii), with such professionals having higher composite performance scores receiving higher adjustment factors; and

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

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

''(iv) in a manner such that—

''(I) subject to subclause (II), MIPS eligible professionals with composite performance scores described in clause (ii)(II) for such year receive a negative payment adjustment factor on a linear sliding scale such that an adjustment factor of 0 percent is assigned for a score at the performance threshold and an adjustment factor of the negative of the applicable percent specified in subparagraph (B) is assigned for a score of 0; and

''(II) MIPS eligible professionals with composite performance scores that are equal to or greater than 0, but not greater than ¼ of the performance threshold specified under subparagraph (D)(i) for such year, receive a negative payment adjustment factor that is equal to the negative of the applicable percent specified in subparagraph (B) for such year.

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

''(i) for 2018, 4 percent;

''(ii) for 2019, 5 percent;

''(iii) for 2020, 7 percent; and

''(iv) for 2021 and subsequent years, 9 percent.

''(C) ADDITIONAL MIPS ADJUSTMENT FACTORS FOR EXCEPTIONAL PERFORMANCE.—

''(i) IN GENERAL.—In the case of a MIPS eligible professional with a composite performance score for a year at or above the additional performance threshold under subparagraph (D)(ii) for such year, in addition to the MIPS adjustment factor under subparagraph (A) for the eligible professional for such year, subject to the availability of funds under clause (ii), the Secretary shall specify an additional positive MIPS adjustment factor for such professional and year. Such additional MIPS adjustment factors shall be determined by the Secretary in a manner such that professionals having higher composite performance scores above the additional performance threshold receive higher additional MIPS adjustment factors.

''(ii) ADDITIONAL FUNDING POOL.—For 2018 and each subsequent year through 2023, there is appropriated from the Federal Supplementary Medical Insurance Trust Fund $500,000,000 for MIPS payments under this paragraph resulting from the application of the additional MIPS adjustment factors under clause (i).

''(D) ESTABLISHMENT OF PERFORMANCE THRESHOLDS.—

''(i) PERFORMANCE THRESHOLD.—For each year of the MIPS, the Secretary shall compute a performance threshold with respect to which the composite performance score of MIPS eligible professionals shall be compared for purposes of determining adjustment factors under subparagraph (A) that are positive, negative, and zero. Such performance threshold for a year shall be the mean or median (as selected by the Secretary) of the composite performance scores for all MIPS eligible professionals with respect to a prior period specified by the Secretary. The Secretary may reassess the selection under the previous sentence every 3 years.

''(ii) ADDITIONAL PERFORMANCE THRESHOLD FOR EXCEPTIONAL PERFORMANCE.—In addition to the performance threshold under clause (i), for each year of the MIPS, the Secretary shall compute an additional performance threshold for purposes of determining the additional MIPS adjustment factors under subparagraph (C)(i). For each such year, the Secretary shall apply either of the following methods for computing such additional performance threshold for such a year:

''(I) The threshold shall be the score that is equal to the 25th percentile of the range of possible composite performance scores above the performance threshold with respect to the prior period described in clause (i).

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

''(iii) SPECIAL RULE FOR INITIAL 2 YEARS.—With respect to each of the first two years to which the MIPS applies, the Secretary shall, prior to the performance period for such years, establish a performance threshold for purposes of determining MIPS adjustment factors under subparagraph (A) and a threshold for purposes of determining additional MIPS adjustment factors under subparagraph (C)(i). Each such performance threshold shall—

''(I) be based on a period prior to such performance periods; and

''(II) take into account—

''(aa) data available with respect to performance on measures and activities that may be used under the performance categories under subparagraph (2)(B); and

''(bb) other factors determined appropriate by the Secretary.

''(E) APPLICATION OF MIPS ADJUSTMENT FACTORS.—In the case of items and services furnished by a MIPS eligible professional during a year (beginning with 2018), the amount otherwise paid under this part with respect to such items and services and MIPS eligible professional for such year, shall be multiplied by—

''(i) 1, plus

''(ii) the sum of—

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

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

''(F) AGGREGATE APPLICATION OF MIPS ADJUSTMENT FACTORS.—

''(i) APPLICATION OF SCALING FACTOR.—

''(I) IN GENERAL.—With respect to positive MIPS adjustment factors under subparagraph (A)(ii)(I) for eligible professionals whose composite performance score is above the performance threshold under subparagraph (D)(i) for such year, subject to subclause (II), the Secretary shall increase or decrease such adjustment factors by a scaling factor in order to ensure that the budget neutrality requirement of clause (ii) is met.

''(II) SCALING FACTOR LIMIT.—In no case may be the scaling factor applied under this clause exceed 3.0.

''(ii) BUDGET NEUTRALITY REQUIREMENT.—

''(I) IN GENERAL.—Subject to clause (iii), the Secretary shall ensure that the estimated amount described in subclause (II) for a year is equal to the estimated amount described in subclause (III) for such year.

''(II) AGGREGATE INCREASES.—The amount described in this subclause is the estimated increase in the aggregate allowed charges resulting from the application of positive MIPS adjustment factors under subparagraph (A) (after application of the scaling factor described in clause (i)) to MIPS eligible professionals whose composite performance score for a year is above the performance threshold under subparagraph (D)(i) for such year.

''(III) AGGREGATE DECREASES.—The amount described in this subclause is the estimated decrease in the aggregate allowed charges resulting from the application of negative MIPS adjustment factors under subparagraph (A) to MIPS eligible professionals whose composite performance score for a year is below the performance threshold under subparagraph (D)(i) for such year.

''(iii) EXCEPTIONS.—

''(I) In the case that all MIPS eligible professionals receive composite performance scores for a year that are below the performance threshold under subparagraph (D)(i) for such year, the negative MIPS adjustment factors under subparagraph (A) shall apply with respect to such MIPS eligible professionals and the budget neutrality requirement of clause (ii) shall not apply for such year.

''(II) In the case that, with respect to a year, the application of clause (i) results in a scaling factor equal to the maximum scaling factor specified in clause (i)(II), such scaling factor shall apply and the budget neutrality requirement of clause (ii) shall not apply for such year.

''(iv) ADDITIONAL INCENTIVE PAYMENT ADJUSTMENTS.—In specifying the MIPS additional adjustment factors under subparagraph (C)(i) for each applicable MIPS eligible professional for a year, the Secretary shall ensure that the estimated increase in payments under this part resulting from the application of such additional adjustment factors for MIPS eligible professionals in a year shall be equal (as estimated by the Secretary) to the additional funding pool amount for such year under subparagraph (C)(ii).

''(7) ANNOUNCEMENT OF RESULT OF ADJUSTMENTS.—Under the MIPS, the Secretary shall, not later than 30 days prior to January 1 of the year involved, make available to MIPS eligible professionals the MIPS adjustment factor (and, as applicable, the additional MIPS adjustment factor) under paragraph (6) applicable to the eligible professional for items and services furnished by the professional for such year. The Secretary may include such information in the confidential feedback under paragraph (12).

''(8) NO EFFECT IN SUBSEQUENT YEARS.—The MIPS adjustment factors and additional MIPS adjustment factors under paragraph (6) shall apply only with respect to the year involved, and the Secretary shall not take into account such adjustment factors in making payments to a MIPS eligible professional under this part in a subsequent year.

''(9) PUBLIC REPORTING.—

''(A) IN GENERAL.—The Secretary shall, in an easily understandable format, make available on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services the following:

''(i) Information regarding the performance of MIPS eligible professionals under the MIPS, which—

''(I) shall include the composite score for each such MIPS eligible professional and the performance of each such MIPS eligible professional with respect to each performance category; and

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

''(ii) The names of eligible professionals in eligible alternative payment models (as defined in section 1833(z)(3)(D)) and, to the extent feasible, the names of such eligible alternative payment models and performance of such models.

''(B) DISCLOSURE.—The information made available under this paragraph shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

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

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

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

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

''(A) IN GENERAL.—The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to—

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

''(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C).

''(B) FUNDING FOR IMPLEMENTATION.—

''(i) IN GENERAL.—For purposes of implementing subparagraph (A), the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 to the Centers for Medicare & Medicaid Services Program Management Account of $40,000,000 for each of fiscal years 2015 through 2019.

Amounts transferred under this subparagraph for a fiscal year shall be available until expended.

''(ii) TECHNICAL ASSISTANCE.—Of the amounts transferred pursuant to clause (i) for each of fiscal years 2015 through 2019, not less than $10,000,000 shall be made available for each such year for technical assistance to small practices in health professional shortage areas (as so designated) and medically underserved areas.

''(12) FEEDBACK AND INFORMATION TO IMPROVE PERFORMANCE.—

''(A) PERFORMANCE FEEDBACK.—

''(i) IN GENERAL.—Beginning July 1, 2016, the Secretary—

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

''(II) may make available confidential feedback to each such professional on the performance of such professional with respect to the performance categories under clauses (iii) and (iv) of such paragraph.

''(ii) MECHANISMS.—The Secretary may use one or more mechanisms to make feedback available under clause (i), which may include use of a web-based portal or other mechanisms determined appropriate by the Secretary. With respect to the performance category described in paragraph (2)(A)(i), feedback under this subparagraph shall, to the extent an eligible professional chooses to participate in a data registry for purposes of this subsection (including registries under subsections (k) and (m)), be provided based on performance on quality measures reported through the use of such registries. With respect to any other performance category described in paragraph (2)(A), the Secretary shall encourage provision of feedback through qualified clinical data registries as described in subsection (m)(3)(E)).

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

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

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

''(B) ADDITIONAL INFORMATION.—

''(i) IN GENERAL.—Beginning July 1, 2017, the Secretary shall make available to each MIPS eligible professional information, with respect to individuals who are patients of such MIPS eligible professional, about items and services for which payment is made under this title that are furnished to such individuals by other suppliers and providers of services, which may include information described in clause (ii). Such information may be made available under the previous sentence to such MIPS eligible professionals by mechanisms determined appropriate by the Secretary, which may include use of a web-based portal. Such information may be made available in accordance with the same or similar terms as data are made available to accountable care organizations participating in the shared savings program under section 1899, including a beneficiary opt-out.

''(ii) TYPE OF INFORMATION.—For purposes of clause (i), the information described in this clause, is the following:

''(I) With respect to selected items and services (as determined appropriate by the Secretary) for which payment is made under this title and that are furnished to individuals, who are patients of a MIPS eligible professional, by another supplier or provider of services during the most recent period for which data are available (such as the most recent three-month period), such as the name of such providers furnishing such items and services to such patients during such period, the types of such items and services so furnished, and the dates such items and services were so furnished.

''(II) Historical data, such as averages and other measures of the distribution if appropriate, of the total, and components of, allowed charges (and other figures as determined appropriate by the Secretary).

''(13) REVIEW.—

''(A) TARGETED REVIEW.—The Secretary shall establish a process under which a MIPS eligible professional may seek an informal review of the calculation of the MIPS adjustment factor applicable to such eligible professional under this subsection for a year. The results of a review conducted pursuant to the previous sentence shall not be taken into account for purposes of paragraph (6) with respect to a year (other than with respect to the calculation of such eligible professional's MIPS adjustment factor for such year or additional MIPS adjustment factor for such year) after the factors determined in subparagraph (A) and subparagraph (C) of such paragraph have been determined for such year.

''(B) LIMITATION.—Except as provided for in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(i) The methodology used to determine the amount of the MIPS adjustment factor under paragraph (6)(A) and the amount of the additional MIPS adjustment factor under paragraph (6)(C)(i) and the determination of such amounts.

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

''(iii) The identification of measures and activities specified under paragraph (2)(B) and information made public or posted on the Physician Compare Internet website of the Centers for Medicare & Medicaid Services under paragraph (9).

''(iv) The methodology developed under paragraph (5) that is used to calculate performance scores and the calculation of such scores, including the weighting of measures and activities under such methodology.''.

(2) GAO REPORTS.—

(A) EVALUATION OF ELIGIBLE PROFESSIONAL MIPS.—Not later than October 1, 2019, and October 1, 2022, the Comptroller General of the United States shall submit to Congress a report evaluating the eligible professional Merit-based Incentive Payment System under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1). Such report shall—

(i) examine the distribution of the composite performance scores and MIPS adjustment factors (and additional MIPS adjustment factors) for MIPS eligible professionals (as defined in subsection (q)(1)(c) of such section) under such program, and patterns relating to such scores and adjustment factors, including based on type of provider, practice size, geographic location, and patient mix;

(ii) provide recommendations for improving such program;

(iii) evaluate the impact of technical assistance funding under section 1848(q)(11) of the Social Security Act, as added by paragraph (1), on the ability of professionals to improve within such program or successfully transition to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)), with priority for such evaluation given to practices located in rural areas, health professional shortage areas (as designated in section 332(a)(1)(a) of the Public Health Service Act), and medically underserved areas; and

(iv) provide recommendations for optimizing the use of such technical assistance funds.

(B) STUDY TO EXAMINE ALIGNMENT OF QUALITY MEASURES USED IN PUBLIC AND PRIVATE PROGRAMS.—

(i) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that—

(I) compares the similarities and differences in the use of quality measures under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare Advantage program under part C of such title, selected State Medicaid programs under title XIX of such Act, and private payer arrangements; and

(II) makes recommendations on how to reduce the administrative burden involved in applying such quality measures.

(ii) REQUIREMENTS.—The report under clause (i) shall—

(I) consider those measures applicable to individuals entitled to, or enrolled for, benefits under such part A, or enrolled under such part B and individuals under the age of 65; and

(II) focus on those measures that comprise the most significant component of the quality performance category of the eligible professional MIPS incentive program under subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as added by paragraph (1).

(C) STUDY ON ROLE OF INDEPENDENT RISK MANAGERS.—Not later than January 1, 2016, the Comptroller General of the United States shall submit to Congress a report examining whether entities that pool financial risk for physician practices, such as independent risk managers, can play a role in supporting physician practices, particularly small physician practices, in assuming financial risk for the treatment of patients. Such report shall examine barriers that small physician practices currently face in assuming financial risk for treating patients, the types of risk management entities that could assist physician practices in participating in two-sided risk payment models, and how such entities could assist with risk management and with quality improvement activities. Such report shall also include an analysis of any existing legal barriers to such arrangements.

(D) STUDY TO EXAMINE RURAL AND HEALTH PROFESSIONAL SHORTAGE AREA ALTERNATIVE PAYMENT MODELS.—Not later than October 1, 2020, and October 1, 2022, the Comptroller General of the United States shall submit to Congress a report that examines the transition of professionals in rural areas, health professional shortage areas (as designated in section 332(a)(1)(A) of the Public Health Service Act), or medically underserved areas to an alternative payment model (as defined in section 1833(z)(3) of the Social Security Act, as added by subsection (e)). Such report shall make recommendations for removing administrative barriers to practices, including small practices consisting of 15 or fewer professionals, in rural areas, health professional shortage areas, and medically underserved areas to participation in such models.

(3) FUNDING FOR IMPLEMENTATION.—For purposes of implementing the provisions of and the amendments made by this section, the Secretary of Health and Human Services shall provide for the transfer of $80,000,000 from the Supplementary Medical Insurance Trust Fund established under section 1841 of

the Social Security Act (42 U.S.C. 1395t) to the Centers for Medicare & Medicaid Program Management Account for each of the fiscal years 2014 through 2018. Amounts transferred under this paragraph shall be available until expended.

(d) IMPROVING QUALITY REPORTING FOR COMPOSITE SCORES.—

(1) CHANGES FOR GROUP REPORTING OPTION.—

(A) IN GENERAL.—Section 1848(m)(3)(C)(ii)) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(C)(ii)) is amended by inserting ''and, for 2015 and subsequent years, may provide'' after ''shall provide''.

(B) CLARIFICATION OF QUALIFIED CLINICAL DATA REGISTRY REPORTING TO GROUP PRACTICES.—Section 1848(m)(3)(D) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(D)) is amended by inserting ''and, for 2015 and subsequent years, subparagraph (A) or (C)'' after ''subparagraph (A)''.

(2) CHANGES FOR MULTIPLE REPORTING PERIODS AND ALTERNATIVE CRITERIA FOR SATISFACTORY REPORTING.—Section 1848(m)(5)(F) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)(F)) is amended—

(A) by striking ''and subsequent years'' and inserting ''through reporting periods occurring in 2014''; and

(B) by inserting ''and, for reporting periods occurring in 2015 and subsequent years, the Secretary may establish'' following ''shall establish''.

(3) PHYSICIAN FEEDBACK PROGRAM REPORTS SUCCEEDED BY REPORTS UNDER MIPS.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended by adding at the end the following new paragraph:

''(11) REPORTS ENDING WITH 2016.—Reports under the Program shall not be provided after December 31, 2016. See subsection (q)(12) for reports under the eligible professionals Merit-based Incentive Payment System.''.

(4) COORDINATION WITH SATISFYING MEANINGFUL EHR USE CLINICAL QUALITY MEASURE REPORTING REQUIREMENT.—Section 1848(o)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(iii)) is amended by inserting ''and subsection (q)(5)(B)(ii)(II)'' after ''Subject to subparagraph (B)(ii)''.

(e) PROMOTING ALTERNATIVE PAYMENT MODELS.—

(1) INCREASING TRANSPARENCY OF PHYSICIAN FOCUSED PAYMENT MODELS.—Section 1868 of the Social Security Act (42 U.S.C. 1395ee) is amended by adding at the end the following new subsection:

''(c) PHYSICIAN FOCUSED PAYMENT MODELS.—

''(1) TECHNICAL ADVISORY COMMITTEE.—

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

''(B) MEMBERSHIP.—

''(i) NUMBER AND APPOINTMENT.—The Committee shall be composed of 11 members appointed by the Comptroller General of the United States.

''(ii) QUALIFICATIONS.—The membership of the Committee shall include individuals with national recognition for their expertise in payment models and related delivery of care. No more than 5 members of the Committee shall be providers of services or suppliers, or representatives of providers of services or suppliers.

''(iii) PROHIBITION ON FEDERAL EMPLOYMENT.—A member of the Committee shall not be an employee of the Federal Government.

''(iv) ETHICS DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Committee of financial and other potential conflicts of interest relating to such members. Members of the Committee shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(v) DATE OF INITIAL APPOINTMENTS.—The initial appointments of members of the Committee shall be made by not later than 180 days after the date of enactment of this subsection.

''(C) TERM; VACANCIES.—

''(i) TERM.—The terms of members of the Committee shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(ii) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Committee shall be filled in the manner in which the original appointment was made.

''(D) DUTIES.—The Committee shall meet, as needed, to provide comments and recommendations to the Secretary, as described in paragraph (2)(C), on physician-focused payment models.

''(E) COMPENSATION OF MEMBERS.—

''(i) IN GENERAL.—Except as provided in clause (ii), a member of the Committee shall serve without compensation.

''(ii) TRAVEL EXPENSES.—A member of the Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for an employee of an agency under subchapter I of chapter 57 of title 5, United States Code, while away from the home or regular place of business of the member in the performance of the duties of the Committee.

''(F) OPERATIONAL AND TECHNICAL SUPPORT.—

''(i) IN GENERAL.—The Assistant Secretary for Planning and Evaluation shall provide technical and operational support for the Committee, which may be by use of a contractor. The Office of the Actuary of the Centers for Medicare & Medicaid Services shall provide to the Committee actuarial assistance as needed.

''(ii) FUNDING.—The Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, such amounts as are necessary to carry out clause (i) (not to exceed $5,000,000) for fiscal year 2014 and each subsequent fiscal year. Any amounts transferred under the preceding sentence for a fiscal year shall remain available until expended.

''(G) APPLICATION.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(2) CRITERIA AND PROCESS FOR SUBMISSION AND REVIEW OF PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(A) CRITERIA FOR ASSESSING PHYSICIAN-FOCUSED PAYMENT MODELS.—

''(i) RULEMAKING.—Not later than November 1, 2015, the Secretary shall, through notice and comment rulemaking, following a request for information, establish criteria for physician-focused payment models, including models for specialist physicians, that could be used by the Committee for making comments and recommendations pursuant to paragraph (1)(D).

''(ii) MEDPAC SUBMISSION OF COMMENTS.—During the comment period for the proposed rule described in clause (i), the Medicare Payment Advisory Commission may submit comments to the Secretary on the proposed criteria under such clause.

''(iii) UPDATING.—The Secretary may update the criteria established under this subparagraph through rulemaking.

''(B) STAKEHOLDER SUBMISSION OF PHYSICIAN FOCUSED PAYMENT MODELS.—On an ongoing basis, individuals and stakeholder entities may submit to the Committee proposals for physician-focused payment models that such individuals and entities believe meet the criteria described in subparagraph (A).

''(C) TAC REVIEW OF MODELS SUBMITTED.—The Committee shall, on a periodic basis, review models submitted under subparagraph (B), prepare comments and recommendations regarding whether such models meet the criteria described in subparagraph (A), and submit such comments and recommendations to the Secretary.

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

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

(2) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(z) INCENTIVE PAYMENTS FOR PARTICIPATION IN ELIGIBLE ALTERNATIVE PAYMENT MODELS.—

''(1) PAYMENT INCENTIVE.—

''(A) IN GENERAL.—In the case of covered professional services furnished by an eligible professional during a year that is in the period beginning with 2018 and ending with 2023 and for which the professional is a qualifying APM participant, in addition to the amount of payment that would otherwise be made for such covered professional services under this part for such year, there also shall be paid to such professional an amount equal to 5 percent of the payment amount for the covered professional services under this part for the preceding year. For purposes of the previous sentence, the payment amount for the preceding year may be an estimation for the full preceding year based on a period of such preceding year that is less than the full year. The Secretary shall establish policies to implement this subparagraph in cases where payment for covered professional services furnished by a qualifying APM participant in an alternative payment model is made to an entity participating in the alternative payment model rather than directly to the qualifying APM participant.

''(B) FORM OF PAYMENT.—Payments under this subsection shall be made in a lump sum, on an annual basis, as soon as practicable.

''(C) TREATMENT OF PAYMENT INCENTIVE.—Payments under this subsection shall not be taken into account for purposes of determining actual expenditures under an alternative payment model and for purposes of determining or rebasing any benchmarks used under the alternative payment model.

''(D) COORDINATION.—The amount of the additional payment for an item or service under this subsection or subsection (m) shall be determined without regard to any additional payment for the item or service under subsection (m) and this subsection, respectively. The amount of the additional payment for an item or service under this subsection or subsection (x) shall be determined without regard to any additional payment for the item or service under subsection (x) and this subsection, respectively. The amount of the additional payment for an

item or service under this subsection or subsection (y) shall be determined without regard to any additional payment for the item or service under subsection (y) and this subsection, respectively.

''(2) QUALIFYING APM PARTICIPANT.—For purposes of this subsection, the term 'qualifying APM participant' means the following:

''(A) 2018 AND 2019.—With respect to 2018 and 2019, an eligible professional for whom the Secretary determines that at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

''(B) 2020 AND 2021.—With respect to 2020 and 2021, an eligible professional described in either of the following clauses:

''(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 50 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

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

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 50 percent of the sum of—

''(aa) payments described in clause (i); and

''(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law, and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

''(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

''(bb) certified EHR technology is used; and

''(cc) the eligible professional (AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or (BB) is a medical home (with respect to beneficiaries under title XIX) that meets criteria comparable to medical homes expanded under section 1115A(c).

''(C) BEGINNING IN 2022.—With respect to 2022 and each subsequent year, an eligible professional described in either of the following clauses:

''(i) MEDICARE REVENUE THRESHOLD OPTION.—An eligible professional for whom the Secretary determines that at least 75 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services.

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

''(I) for whom the Secretary determines, with respect to items and services furnished by such professional during the most recent period for which data are available (which may be less than a year), that at least 75 percent of the sum of—

''(aa) payments described in clause (i); and

''(bb) all other payments, regardless of payer (other than payments made by the Secretary of Defense or the Secretary of Veterans Affairs under chapter 55 of title 10, United States Code, or title 38, United States Code, or any other provision of law, and other than payments made under title XIX in a State in which no medical home or alternative payment model is available under the State program under that title),

meet the requirement described in clause (iii)(I) with respect to payments described in item (aa) and meet the requirement described in clause (iii)(II) with respect to payments described in item (bb);

''(II) for whom the Secretary determines at least 25 percent of payments under this part for covered professional services furnished by such professional during the most recent period for which data are available (which may be less than a year) were attributable to such services furnished under this part through an entity that participates in an eligible alternative payment model with respect to such services; and

''(III) who provides to the Secretary such information as is necessary for the Secretary to make a determination under subclause (I), with respect to such professional.

''(iii) REQUIREMENT.—For purposes of clause (ii)(I)—

''(I) the requirement described in this subclause, with respect to payments described in item (aa) of such clause, is that such payments are made under an eligible alternative payment model; and

''(II) the requirement described in this subclause, with respect to payments described in item (bb) of such clause, is that such payments are made under an arrangement in which—

''(aa) quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i) apply;

''(bb) certified EHR technology is used; and

''(cc) the eligible professional (AA) bears more than nominal financial risk if actual aggregate expenditures exceeds expected aggregate expenditures; or (BB) is a medical home (with respect to beneficiaries under title XIX) that meets criteria comparable to medical homes expanded under section 1115A(c).

''(3) ADDITIONAL DEFINITIONS.—In this subsection:

''(A) COVERED PROFESSIONAL SERVICES.—The term 'covered professional services' has the meaning given that term in section 1848(k)(3)(A).

''(B) ELIGIBLE PROFESSIONAL.—The term 'eligible professional' has the meaning given that term in section 1848(k)(3)(B).

''(C) ALTERNATIVE PAYMENT MODEL (APM).—The term 'alternative payment model' means any of the following:

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

''(ii) The shared savings program under section 1899.

''(iii) A demonstration under section 1866C.

''(iv) A demonstration required by Federal law.

''(D) ELIGIBLE ALTERNATIVE PAYMENT MODEL (APM).—

''(i) IN GENERAL.—The term 'eligible alternative payment model' means, with respect to a year, an alternative payment model—

''(I) that requires use of certified EHR technology (as defined in subsection (o)(4));

''(II) that provides for payment for covered professional services based on quality measures comparable to measures under the performance category described in section 1848(q)(2)(B)(i); and

''(III) that satisfies the requirement described in clause (ii).

''(ii) ADDITIONAL REQUIREMENT.—For purposes of clause (i)(III), the requirement described in this clause, with respect to a year and an alternative payment model, is that the alternative payment model—

''(I) is one in which one or more entities bear financial risk for monetary losses under such model that are in excess of a nominal amount; or

''(II) is a medical home expanded under section 1115A(c).

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

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

''(B) The determination of the amount of the 5 percent payment incentive under paragraph (1)(A), including any estimation as part of such determination.''.

(3) COORDINATION CONFORMING AMENDMENTS.—Section 1833 of the Social Security Act (42 U.S.C. 13951) is further amended—

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

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

(4) ENCOURAGING DEVELOPMENT AND TESTING OF CERTAIN MODELS.—Section 1115A(b)(2) of the Social Security Act (42 U.S.C. 1315a(b)(2)) is amended—

(A) in subparagraph (B), by adding at the end the following new clauses:

''(xxi) Focusing primarily on physicians' services (as defined in section 1848(j)(3)) furnished by physicians who are not primary care practitioners.

''(xxii) Focusing on practices of 15 or fewer professionals.

''(xxiii) Focusing on risk-based models for small physician practices which may involve two-sided risk and prospective patient assignment, and which examine risk-adjusted decreases in mortality rates, hospital readmissions rates, and other relevant and appropriate clinical measures.

''(xxiv) Focusing primarily on title XIX, working in conjunction with the Center for Medicaid and CHIP Services.''; and

(B) in subparagraph (C)(viii), by striking ''other public sector or private sector payers'' and inserting ''other public sector payers, private sector payers, or Statewide payment models''.

(5) CONSTRUCTION REGARDING TELEHEALTH SERVICES.—Nothing in the provisions of, or amendments made by, this Act shall be construed as precluding an alternative payment model or a qualifying APM participant (as those terms are defined in section 1833(z) of the Social Security Act, as added by paragraph (1)) from furnishing a telehealth service for which payment is not made under section 1834(m) of the Social Security Act (42 U.S.C. 1395m(m)).

(6) INTEGRATING MEDICARE ADVANTAGE ALTERNATIVE PAYMENT MODELS.—Not later than July 1, 2015, the Secretary of Health and Human Services shall submit to Congress a study that examines the feasibility of integrating alternative payment models in the Medicare Advantage payment system. The study shall include the feasibility of including a value-based modifier and whether such modifier should be budget neutral.

(7) STUDY AND REPORT ON FRAUD RELATED TO ALTERNATIVE PAYMENT MODELS UNDER THE MEDICARE PROGRAM.—

(A) STUDY.—The Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a study that—

(i) examines the applicability of the Federal fraud prevention laws to items and services furnished under title XVIII of the Social Security Act for which payment is made under an alternative payment model (as defined in section 1833(z)(3)(C) of such Act (42 U.S.C. 1395l(z)(3)(C)));

(ii) identifies aspects of such alternative payment models that are vulnerable to fraudulent activity; and

(iii) examines the implications of waivers to such laws granted in support of such alternative payment models, including under any potential expansion of such models.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subparagraph (A). Such report shall include recommendations for actions to be taken to reduce the vulnerability of such alternative payment models to fraudulent activity. Such report also shall include, as appropriate, recommendations of the Inspector General for changes in Federal fraud prevention laws to reduce such vulnerability.

(f) IMPROVING PAYMENT ACCURACY.—

(1) STUDIES AND REPORTS OF EFFECT OF CERTAIN INFORMATION ON QUALITY AND RESOURCE USE.—

(A) STUDY USING EXISTING MEDICARE DATA.—

(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study that examines the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

(ii) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

(B) STUDY USING OTHER DATA.—

(i) STUDY.—The Secretary shall conduct a study that examines the impact of risk factors, such as those described in section 1848(p)(3) of the Social Security Act (42 U.S.C. 1395w–4(p)(3)), race, health literacy, limited English proficiency (LEP), and patient activation, on quality and resource use outcome measures under the Medicare program (such as to recognize that less healthy individuals may require more intensive interventions). In conducting such study the Secretary may use existing Federal data and collect such additional data as may be necessary to complete the study.

(ii) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under clause (i).

(C) EXAMINATION OF DATA IN CONDUCTING STUDIES.—In conducting the studies under subparagraphs (A) and (B), the Secretary shall examine what non-Medicare data sets, such as data from the American Community Survey (ACS), can be useful in conducting the types of studies under such paragraphs and how such data sets that are identified as useful can be coordinated with Medicare administrative data in order to improve the overall data set available to do such studies and for the administration of the Medicare program.

(D) RECOMMENDATIONS TO ACCOUNT FOR INFORMATION IN PAYMENT ADJUSTMENT MECHANISMS.—If the studies conducted under subparagraphs (A) and (B) find a relationship between the factors examined in the studies and quality and resource use outcome measures, then the Secretary shall also provide recommendations for how the Centers for Medicare & Medicaid Services should—

(i) obtain access to the necessary data (if such data is not already being collected) on such factors, including recommendations on how to address barriers to the Centers in accessing such data; and

(ii) account for such factors in determining payment adjustments based on quality and resource use outcome measures under the eligible professional Merit-based Incentive Payment System under section 1848(q) of the Social Security Act (42 U.S.C. 1395w–4(q)) and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(E) FUNDING.—There are hereby appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act to the Secretary to carry out this paragraph $6,000,000, to remain available until expended.

(2) CMS ACTIVITIES.—

(A) HIERARCHAL CONDITION CATEGORY (HCC) IMPROVEMENT.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1), the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate, estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, shall incorporate information from quality and resource use outcome measurement (including care episode and patient condition groups) into provisions of title XVIII of the Social Security Act that are similar to the eligible professional Merit-based Incentive Payment System under section 1848(q) of such Act.

(B) ACCOUNTING FOR OTHER FACTORS IN PAYMENT ADJUSTMENT MECHANISMS.—

(i) IN GENERAL.—Taking into account the studies conducted and recommendations made in reports under paragraph (1) and other information as appropriate, the Secretary shall, as the Secretary determines appropriate, account for identified factors with an effect on quality and resource use outcome measures when determining payment adjustment mechanisms under provisions of title XVIII of the Social Security Act that are similar to the eligible professional Merit-based Incentive Payment System under section 1848(q) of such Act.

(ii) ACCESSING DATA.—The Secretary shall collect or otherwise obtain access to the data necessary to carry out this paragraph through existing and new data sources.

(iii) PERIODIC ANALYSES.—The Secretary shall carry out periodic analyses, at least every 3 years, based on the factors referred to in clause (i) so as to monitor changes in possible relationships.

(C) FUNDING.—There are hereby appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act to the Secretary to carry out this paragraph and the application of this paragraph to the Merit-based Incentive Payment System under section 1848(q) of such Act $10,000,000, to remain available until expended.

(3) STRATEGIC PLAN FOR ACCESSING RACE AND ETHNICITY DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of carrying out the eligible professional Merit-based Incentive Payment System under section 1848(q) of the Social Security Act and, as the Secretary determines appropriate, other similar provisions of title XVIII of such Act.

(g) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsection (c), is further amended by adding at the end the following new subsection:

''(r) COLLABORATING WITH THE PHYSICIAN, PRACTITIONER, AND OTHER STAKEHOLDER COMMUNITIES TO IMPROVE RESOURCE USE MEASUREMENT.—

''(1) IN GENERAL.—In order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement, including for purposes of the value-based performance incentive program under subsection (q) and alternative payment models under section 1833(z), the Secretary shall undertake the steps described in the succeeding provisions of this subsection.

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

''(A) IN GENERAL.—In order to classify similar patients into care episode groups and patient condition groups, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

''(B) PUBLIC AVAILABILITY OF EXISTING EFFORTS TO DESIGN AN EPISODE GROUPER.—Not later than 120 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a list of the episode groups developed pursuant to

subsection (n)(9)(A) and related descriptive information.

''(C) STAKEHOLDER INPUT.—The Secretary shall accept, through the date that is 60 days after the day the Secretary posts the list pursuant to subparagraph (B), suggestions from physician specialty societies, applicable practitioner organizations, and other stakeholders for episode groups in addition to those posted pursuant to such subparagraph, and specific clinical criteria and patient characteristics to classify patients into—

''(i) care episode groups; and

''(ii) patient condition groups.

''(D) DEVELOPMENT OF PROPOSED CLASSIFICATION CODES.—

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

''(I) establish care episode groups and patient condition groups, which account for a target of an estimated ⅔ of expenditures under parts A and B; and

''(II) assign codes to such groups.

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

''(I) the patient's clinical problems at the time items and services are furnished during an episode of care, such as the clinical conditions or diagnoses, whether or not inpatient hospitalization is anticipated or occurs, and the principal procedures or services planned or furnished; and

''(II) other factors determined appropriate by the Secretary.

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

''(I) the patient's clinical history at the time of each medical visit, such as the patient's combination of chronic conditions, current health status, and recent significant history (such as hospitalization and major surgery during a previous period, such as 3 months); and

''(II) other factors determined appropriate by the Secretary, such as eligibility status under this title (including eligibility under section 226(a), 226(b), or 226A, and dual eligibility under this title and title XIX).

''(E) DRAFT CARE EPISODE AND PATIENT CONDITION GROUPS AND CLASSIFICATION CODES.—Not later than 180 days after the end of the comment period described in subparagraph (C), the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the care episode and patient condition codes established under subparagraph (D) (and the criteria and characteristics assigned to such code).

''(F) SOLICITATION OF INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (E), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the care episode and patient condition groups (and codes) posted under subparagraph (E). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include use of open door forums, town hall meetings, or other appropriate mechanisms.

''(G) OPERATIONAL LIST OF CARE EPISODE AND PATIENT CONDITION GROUPS AND CODES.—Not later than 180 days after the end of the comment period described in subparagraph (F), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of care episode and patient condition codes (and the criteria and characteristics assigned to such code).

''(H) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2017), the Secretary shall, through rulemaking, make revisions to the operational lists of care episode and patient condition codes as the Secretary determines may be appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(3) ATTRIBUTION OF PATIENTS TO PHYSICIANS OR PRACTITIONERS.—

''(A) IN GENERAL.—In order to facilitate the attribution of patients and episodes (in whole or in part) to one or more physicians or applicable practitioners furnishing items and services, the Secretary shall undertake the steps described in the succeeding provisions of this paragraph.

''(B) DEVELOPMENT OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—The Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient at the time of furnishing an item or service. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

''(i) considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;

''(ii) considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;

''(iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;

''(iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or

''(v) furnishes items and services only as ordered by another physician or practitioner.

''(C) DRAFT LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 270 days after the date of the enactment of this subsection, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a draft list of the patient relationship categories and codes developed under subparagraph (B).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek, through the date that is 60 days after the Secretary posts the list pursuant to subparagraph (C), comments from physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the patient relationship categories and codes posted under subparagraph (C). In seeking such comments, the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

''(E) OPERATIONAL LIST OF PATIENT RELATIONSHIP CATEGORIES AND CODES.—Not later than 180 days after the end of the comment period described in subparagraph (D), taking into account the comments received under such subparagraph, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services an operational list of patient relationship categories and codes.

''(F) SUBSEQUENT REVISIONS.—Not later than November 1 of each year (beginning with 2017), the Secretary shall, through rulemaking, make revisions to the operational list of patient relationship categories and codes as the Secretary determines appropriate. Such revisions may be based on experience, new information developed pursuant to subsection (n)(9)(A), and input from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part.

''(4) REPORTING OF INFORMATION FOR RESOURCE USE MEASUREMENT.—Claims submitted for items and services furnished by a physician or applicable practitioner on or after January 1, 2017, shall, as determined appropriate by the Secretary, include—

''(A) applicable codes established under paragraphs (2) and (3); and

''(B) the national provider identifier of the ordering physician or applicable practitioner (if different from the billing physician or applicable practitioner).

''(5) METHODOLOGY FOR RESOURCE USE ANALYSIS.—

''(A) IN GENERAL.—In order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall—

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

''(ii) use the care episode and patient condition codes reported on claims pursuant to paragraph (4) as a basis to compare similar patients and care episodes and patient condition groups; and

''(iii) conduct an analysis of resource use (with respect to care episodes and patient condition groups of such patients), as the Secretary determines appropriate.

''(B) ANALYSIS OF PATIENTS OF PHYSICIANS AND PRACTITIONERS.—In conducting the analysis described in subparagraph (A)(iii) with respect to patients attributed to physicians and applicable practitioners, the Secretary shall, as feasible—

''(i) use the claims data experience of such patients by patient condition codes during a common period, such as 12 months; and

''(ii) use the claims data experience of such patients by care episode codes—

''(I) in the case of episodes without a hospitalization, during periods of time (such as the number of days) determined appropriate by the Secretary; and

''(II) in the case of episodes with a hospitalization, during periods of time (such as the number of days) before, during, and after the hospitalization.

''(C) MEASUREMENT OF RESOURCE USE.—In measuring such resource use, the Secretary—

''(i) shall use per patient total allowed charges for all services under part A and this part (and, if the Secretary determines appropriate, part D) for the analysis of patient resource use, by care episode codes and by patient condition codes; and

''(ii) may, as determined appropriate, use other measures of allowed charges (such as subtotals for categories of items and services) and measures of utilization of items and services (such as frequency of specific items and services and the ratio of specific items and services among attributed patients or episodes).

''(D) STAKEHOLDER INPUT.—The Secretary shall seek comments from the physician specialty societies, applicable practitioner organizations, and other stakeholders, including representatives of individuals entitled to benefits under part A or enrolled under this part, regarding the resource use methodology established pursuant to this paragraph. In seeking comments the Secretary shall use one or more mechanisms (other than notice and comment rulemaking) that may include open door forums, town hall meetings, or other appropriate mechanisms.

''(6) IMPLEMENTATION.—To the extent that the Secretary contracts with an entity to carry out any part of the provisions of this subsection, the Secretary may not contract with an entity or an entity with a subcontract if the entity or subcontracting entity currently makes recommendations to the Secretary on relative values for services under the fee schedule for physicians' services under this section.

''(7) LIMITATION.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) care episode and patient condition groups and codes established under paragraph (2);

''(B) patient relationship categories and codes established under paragraph (3); and

''(C) measurement of, and analyses of resource use with respect to, care episode and patient condition codes and patient relationship codes pursuant to paragraph (5).

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

''(9) DEFINITIONS.—In this section:

''(A) PHYSICIAN.—The term 'physician' has the meaning given such term in section 1861(r)(1).

''(B) APPLICABLE PRACTITIONER.—The term 'applicable practitioner' means—

''(i) a physician assistant, nurse practitioner, and clinical nurse specialist (as such terms are defined in section 1861(aa)(5)), and a certified registered nurse anesthetist (as defined in section 1861(bb)(2)); and

''(ii) beginning January 1, 2018, such other eligible professionals (as defined in subsection (k)(3)(B)) as specified by the Secretary.

''(10) CLARIFICATION.—The provisions of sections 1890(b)(7) and 1890A shall not apply to this subsection.''.

**SEC. 3. PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.**

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4), as amended by subsections (c) and (g) of section 2, is further amended by inserting at the end the following new subsection:

''(s) PRIORITIES AND FUNDING FOR MEASURE DEVELOPMENT.—

''(1) PLAN IDENTIFYING MEASURE DEVELOPMENT PRIORITIES AND TIMELINES.—

''(A) DRAFT MEASURE DEVELOPMENT PLAN.—Not later than January 1, 2015, the Secretary shall develop, and post on the Internet website of the Centers for Medicare & Medicaid Services, a draft plan for the development of quality measures for application under the applicable provisions (as defined in paragraph (5)). Under such plan the Secretary shall—

''(i) address how measures used by private payers and integrated delivery systems could be incorporated under title XVIII;

''(ii) describe how coordination, to the extent possible, will occur across organizations developing such measures; and

''(iii) take into account how clinical best practices and clinical practice guidelines should be used in the development of quality measures.

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

''(i) Clinical care.

''(ii) Safety.

''(iii) Care coordination.

''(iv) Patient and caregiver experience.

''(v) Population health and prevention.

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

''(i) gap analyses conducted by the entity with a contract under section 1890(a) or other contractors or entities;

''(ii) whether measures are applicable across health care settings;

''(iii) clinical practice improvement activities submitted under subsection (q)(2)(C)(iv) for identifying possible areas for future measure development and identifying existing gaps with respect to such measures; and

''(iv) the quality domains applied under this subsection.

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

''(i) Outcome measures, including patient reported outcome and functional status measures.

''(ii) Patient experience measures.

''(iii) Care coordination measures.

''(iv) Measures of appropriate use of services, including measures of over use.

''(E) STAKEHOLDER INPUT.—The Secretary shall accept through March 1, 2015, comments on the draft plan posted under paragraph (1)(A) from the public, including health care providers, payers, consumers, and other stakeholders.

''(F) FINAL MEASURE DEVELOPMENT PLAN.—Not later than May 1, 2015, taking into account the comments received under this subparagraph, the Secretary shall finalize the plan and post on the Internet website of the Centers for Medicare & Medicaid Services an operational plan for the development of quality measures for use under the applicable provisions. Such plan shall be updated as appropriate.

''(2) CONTRACTS AND OTHER ARRANGEMENTS FOR QUALITY MEASURE DEVELOPMENT.—

''(A) IN GENERAL.—The Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions. Such entities shall include organizations with quality measure development expertise.

''(B) PRIORITIZATION.—

''(i) IN GENERAL.—In entering into contracts or other arrangements under subparagraph (A), the Secretary shall give priority to the development of the types of measures described in paragraph (1)(D).

''(ii) CONSIDERATION.—In selecting measures for development under this subsection, the Secretary shall consider—

''(I) whether such measures would be electronically specified; and

''(II) clinical practice guidelines to the extent that such guidelines exist.

''(3) ANNUAL REPORT BY THE SECRETARY.—

''(A) IN GENERAL.—Not later than May 1, 2016, and annually thereafter, the Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services a report on the progress made in developing quality measures for application under the applicable provisions.

''(B) REQUIREMENTS.—Each report submitted pursuant to subparagraph (A) shall include the following:

''(i) A description of the Secretary's efforts to implement this paragraph.

''(ii) With respect to the measures developed during the previous year—

''(I) a description of the total number of quality measures developed and the types of such measures, such as an outcome or patient experience measure;

''(II) the name of each measure developed;

''(III) the name of the developer and steward of each measure;

''(IV) with respect to each type of measure, an estimate of the total amount expended under this title to develop all measures of such type; and

''(V) whether the measure would be electronically specified.

''(iii) With respect to measures in development at the time of the report—

''(I) the information described in clause (ii), if available; and

''(II) a timeline for completion of the development of such measures.

''(iv) A description of any updates to the plan under paragraph (1) (including newly identified gaps and the status of previously identified gaps) and the inventory of measures applicable under the applicable provisions.

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

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

''(A) the identification of gaps where no quality measures exist, particularly with respect to the types of measures described in paragraph (1)(D);

''(B) prioritizing quality measure development to address such gaps; and

''(C) other areas related to quality measure development determined appropriate by the Secretary.

''(5) DEFINITION OF APPLICABLE PROVISIONS.—In this subsection, the term 'applicable provisions' means the following provisions:

''(A) Subsection (q)(2)(B)(i).

''(B) Section 1833(z)(2)(C).

''(6) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2014 through 2018. Amounts transferred under this paragraph shall remain available through the end of fiscal year 2021.''.

**SEC. 4. ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.**

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

''(8) ENCOURAGING CARE MANAGEMENT FOR INDIVIDUALS WITH CHRONIC CARE NEEDS.—

''(A) IN GENERAL.—In order to encourage the management of care by an applicable provider (as defined in subparagraph (B)) for individuals with chronic care needs the Secretary shall—

''(i) establish one or more HCPCS codes for chronic care management services for such individuals; and

''(ii) subject to subparagraph (D), make payment (as the Secretary determines to be appropriate) under this section for such management services furnished on or after January 1, 2015, by an applicable provider.

''(B) APPLICABLE PROVIDER DEFINED.—For purposes of this paragraph, the term 'applicable provider' means a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), or clinical nurse specialist (as defined in section 1861(aa)(5)(B)) who furnishes services as part of a patient-centered

medical home or a comparable specialty practice that—

''(i) is recognized as such a medical home or comparable specialty practice by an organization that is recognized by the Secretary for purposes of such recognition as such a medical home or practice; or

''(ii) meets such other comparable qualifications as the Secretary determines to be appropriate.

''(C) BUDGET NEUTRALITY.—The budget neutrality provision under subsection (c)(2)(B)(ii)(II) shall apply in establishing the payment under subparagraph (A)(ii).

''(D) POLICIES RELATING TO PAYMENT.—In carrying out this paragraph, with respect to chronic care management services, the Secretary shall—

''(i) make payment to only one applicable provider for such services furnished to an individual during a period;

''(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services (such as in the case of hospice care or home health services); and

''(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section 1861(ww)) be furnished as a condition of payment for such management services.''.

(b) EDUCATION AND OUTREACH.—

(1) CAMPAIGN.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct an education and outreach campaign to inform professionals who furnish items and services under part B of title XVIII of the Social Security Act and individuals enrolled under such part of the benefits of chronic care management services described in section 1848(b)(8) of the Social Security Act, as added by subsection (a), and encourage such individuals with chronic care needs to receive such services.

(B) REQUIREMENTS.—Such campaign shall—

(i) be directed by the Office of Rural Health Policy of the Department of Health and Human Services and the Office of Minority Health of the Centers for Medicare & Medicaid Services; and

(ii) focus on encouraging participation by underserved rural populations and racial and ethnic minority populations.

(2) REPORT.—

(A) IN GENERAL.—Not later than December 31, 2017, the Secretary shall submit to Congress a report on the use of chronic care management services described in such section 1848(b)(8) by individuals living in rural areas and by racial and ethnic minority populations. Such report shall—

(i) identify barriers to receiving chronic care management services; and

(ii) make recommendations for increasing the appropriate use of chronic care management services.

**SEC. 5. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE PHYSICIAN FEE SCHEDULE.**

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

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

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

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

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

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

''(I) Time involved in furnishing services.

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

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

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

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

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

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

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

''(III) Electronic health records.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(XV) Codes with high cost supplies.

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

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

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

''(O) TARGET FOR RELATIVE VALUE ADJUSTMENTS FOR MISVALUED SERVICES.—With respect to fee schedules established for each of 2015 through 2018, the following shall apply:

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

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

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

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

''(iii) EXEMPTION FROM BUDGET NEUTRALITY IF TARGET NOT MET.—If the estimated net reduction in expenditures determined under clause (i) for the year is less than the target for the year, reduced expenditures in an amount equal to the target recapture amount shall not be taken into account in applying subparagraph (B)(ii)(II) with respect to fee schedules beginning with 2015.

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

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

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

''(v) TARGET.—For purposes of this subparagraph, with respect to a year, the target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule under this section for the year.''.

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

''(VIII) REDUCTIONS FOR MISVALUED SERVICES IF TARGET NOT MET.—Effective for fee schedules beginning with 2015, reduced expenditures attributable to the application of the target recapture amount described in subparagraph (O)(iii).''.

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

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

''(7) PHASE-IN OF SIGNIFICANT RELATIVE VALUE UNIT (RVU) REDUCTIONS.—Effective for fee schedules established beginning with 2015, if the total relative value units for a service for a year would otherwise be decreased by an estimated amount equal to or greater than 20 percent as compared to the total relative value units for the previous year, the applicable adjustments in work, practice expense, and malpractice relative value units shall be phased-in over a 2-year period.''.

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

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

(B) in subparagraph (K)(iii)(VI)—

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

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

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

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

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

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

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

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

(h) ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(ii) Payment locality 3.

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

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

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

**SEC. 6. PROMOTING EVIDENCE-BASED CARE.**

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

''(p) RECOGNIZING APPROPRIATE USE CRITERIA FOR CERTAIN IMAGING SERVICES.—

''(1) PROGRAM ESTABLISHED.—

''(A) IN GENERAL.—The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

''(B) APPROPRIATE USE CRITERIA DEFINED.—In this subsection, the term 'appropriate use criteria' means criteria, only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical condition. To the extent feasible, such criteria shall be evidence-based.

''(C) APPLICABLE IMAGING SERVICE DEFINED.—In this subsection, the term 'applicable imaging service' means an advanced diagnostic imaging service (as defined in subsection (e)(1)(B)) for which the Secretary determines—

''(i) one or more applicable appropriate use criteria specified under paragraph (2) apply;

''(ii) there are one or more qualified clinical decision support mechanisms listed under paragraph (3)(C); and

''(iii) one or more of such mechanisms is available free of charge.

''(D) APPLICABLE SETTING DEFINED.—In this subsection, the term 'applicable setting' means a physician's office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and any other provider-led outpatient setting determined appropriate by the Secretary.

''(E) ORDERING PROFESSIONAL DEFINED.—In this subsection, the term 'ordering professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who orders an applicable imaging service for an individual.

''(F) FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term 'furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service for an individual.

''(2) ESTABLISHMENT OF APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) IN GENERAL.—Not later than November 15, 2015, the Secretary shall through rulemaking, and in consultation with physicians, practitioners, and other stakeholders, specify applicable appropriate use criteria for applicable imaging services only from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other provider-led entities.

''(B) CONSIDERATIONS.—In specifying applicable appropriate use criteria under subparagraph (A), the Secretary shall take into account whether the criteria—

''(i) have stakeholder consensus;

''(ii) are scientifically valid and evidence based; and

''(iii) are based on studies that are published and reviewable by stakeholders.

''(C) REVISIONS.—The Secretary shall review, on an annual basis, the specified applicable appropriate use criteria to determine if there is a need to update or revise (as appropriate) such specification of applicable appropriate use criteria and make such updates or revisions through rulemaking.

''(D) TREATMENT OF MULTIPLE APPLICABLE APPROPRIATE USE CRITERIA.—In the case where the Secretary determines that more than one appropriate use criteria applies with respect to an applicable imaging service, the Secretary shall permit one or more applicable appropriate use criteria under this paragraph for the service.

''(3) MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) IDENTIFICATION OF MECHANISMS TO CONSULT WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(i) IN GENERAL.—The Secretary shall specify qualified clinical decision support mechanisms that could be used by ordering professionals to consult with applicable appropriate use criteria for applicable imaging services.

''(ii) CONSULTATION.—The Secretary shall consult with physicians, practitioners, health care technology experts, and other stakeholders in specifying mechanisms under this paragraph.

''(iii) INCLUSION OF CERTAIN MECHANISMS.—Mechanisms specified under this paragraph may include any or all of the following that meet the requirements described in subparagraph (B)(ii):

''(I) Use of clinical decision support modules in certified EHR technology (as defined in section 1848(o)(4)).

''(II) Use of private sector clinical decision support mechanisms that are independent from certified EHR technology, which may include use of clinical decision support mechanisms available from medical specialty organizations.

''(III) Use of a clinical decision support mechanism established by the Secretary.

''(B) QUALIFIED CLINICAL DECISION SUPPORT MECHANISMS.—

''(i) IN GENERAL.—For purposes of this subsection, a qualified clinical decision support mechanism is a mechanism that the Secretary determines meets the requirements described in clause (ii).

''(ii) REQUIREMENTS.—The requirements described in this clause are the following:

''(I) The mechanism makes available to the ordering professional applicable appropriate use criteria specified under paragraph (2) and the supporting documentation for the applicable imaging service ordered.

''(II) In the case where there are more than one applicable appropriate use criteria specified under such paragraph for an applicable imaging service, the mechanism indicates the criteria that it uses for the service.

''(III) The mechanism determines the extent to which an applicable imaging service ordered is consistent with the applicable appropriate use criteria so specified.

''(IV) The mechanism generates and provides to the ordering professional a certification or documentation that documents that the qualified clinical decision support mechanism was consulted by the ordering professional.

''(V) The mechanism is updated on a timely basis to reflect revisions to the specification of applicable appropriate use criteria under such paragraph.

''(VI) The mechanism meets privacy and security standards under applicable provisions of law.

''(VII) The mechanism performs such other functions as specified by the Secretary, which may include a requirement to provide aggregate feedback to the ordering professional.

''(C) LIST OF MECHANISMS FOR CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(i) INITIAL LIST.—Not later than April 1, 2016, the Secretary shall publish a list of mechanisms specified under this paragraph.

''(ii) PERIODIC UPDATING OF LIST.—The Secretary shall identify on an annual basis the list of qualified clinical decision support mechanisms specified under this paragraph.

''(4) CONSULTATION WITH APPLICABLE APPROPRIATE USE CRITERIA.—

''(A) CONSULTATION BY ORDERING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), an ordering professional shall—

''(i) consult with a qualified decision support mechanism listed under paragraph (3)(C); and

''(ii) provide to the furnishing professional the information described in clauses (i) through (iii) of subparagraph (B).

''(B) REPORTING BY FURNISHING PROFESSIONAL.—Beginning with January 1, 2017, subject to subparagraph (C), with respect to an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (as defined in subparagraph (D)), payment for such service may only be made if the claim for the service includes the following:

''(i) Information about which qualified clinical decision support mechanism was consulted by the ordering professional for the service.

''(ii) Information regarding—

''(I) whether the service ordered would adhere to the applicable appropriate use criteria specified under paragraph (2);

''(II) whether the service ordered would not adhere to such criteria; or

''(III) whether such criteria was not applicable to the service ordered.

''(iii) The national provider identifier of the ordering professional (if different from the furnishing professional).

''(C) EXCEPTIONS.—The provisions of subparagraphs (A) and (B) and paragraph (6)(A) shall not apply to the following:

''(i) EMERGENCY SERVICES.—An applicable imaging service ordered for an individual with an emergency medical condition (as defined in section 1867(e)(1)).

''(ii) INPATIENT SERVICES.—An applicable imaging service ordered for an inpatient and for which payment is made under part A.

''(iii) ALTERNATIVE PAYMENT MODELS.—An applicable imaging service ordered by an ordering professional with respect to an individual attributed to an alternative payment model (as defined in section 1833(z)(3)(C)).

''(iv) SIGNIFICANT HARDSHIP.—An applicable imaging service ordered by an ordering professional who the Secretary may, on a case-by-case basis, exempt from the application of such provisions if the Secretary determines, subject to annual renewal, that consultation with applicable appropriate use criteria would result in a significant hardship, such as in the case of a professional who practices in a rural area without sufficient Internet access.

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

''(i) The physician fee schedule established under section 1848(b).

''(ii) The prospective payment system for hospital outpatient department services under section 1833(t).

''(iii) The ambulatory surgical center payment systems under section 1833(i).

''(5) IDENTIFICATION OF OUTLIER ORDERING PROFESSIONALS.—

''(A) IN GENERAL.—With respect to applicable imaging services furnished beginning with 2017, the Secretary shall determine, on an annual basis, no more than five percent of the total number of ordering professionals who are outlier ordering professionals.

''(B) OUTLIER ORDERING PROFESSIONALS.—The determination of an outlier ordering professional shall—

''(i) be based on low adherence to applicable appropriate use criteria specified under paragraph (2), which may be based on comparison to other ordering professionals; and

''(ii) include data for ordering professionals for whom prior authorization under paragraph (6)(A) applies.

''(C) USE OF TWO YEARS OF DATA.—The Secretary shall use two years of data to identify outlier ordering professionals under this paragraph.

''(D) PROCESS.—The Secretary shall establish a process for determining when an outlier ordering professional is no longer an outlier ordering professional.

''(E) CONSULTATION WITH STAKEHOLDERS.—The Secretary shall consult with physicians, practitioners and other stakeholders in developing methods to identify outlier ordering professionals under this paragraph.

''(6) PRIOR AUTHORIZATION FOR ORDERING PROFESSIONALS WHO ARE OUTLIERS.—

''(A) IN GENERAL.—Beginning January 1, 2020, subject to paragraph (4)(C), with respect to services furnished during a year, the Secretary shall, for a period determined appropriate by the Secretary, apply prior authorization for applicable imaging services that

are ordered by an outlier ordering professional identified under paragraph (5).

''(B) APPROPRIATE USE CRITERIA IN PRIOR AUTHORIZATION.—In applying prior authorization under subparagraph (A), the Secretary shall utilize only the applicable appropriate use criteria specified under this subsection.

''(C) FUNDING.—For purposes of carrying out this paragraph, the Secretary shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2019 through 2021. Amounts transferred under the preceding sentence shall remain available until expended.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as granting the Secretary the authority to develop or initiate the development of clinical practice guidelines or appropriate use criteria.''.

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

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

(c) REPORT ON EXPERIENCE OF IMAGING APPROPRIATE USE CRITERIA PROGRAM.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), such as radiation therapy and clinical diagnostic laboratory services.

**SEC. 7. EMPOWERING BENEFICIARY CHOICES THROUGH ACCESS TO INFORMATION ON PHYSICIANS' SERVICES.**

(a) IN GENERAL.—The Secretary shall make publicly available on Physician Compare the information described in subsection (b) with respect to eligible professionals.

(b) INFORMATION DESCRIBED.—The following information, with respect to an eligible professional, is described in this subsection:

(1) Information on the number of services furnished by the eligible professional under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), which may include information on the most frequent services furnished or groupings of services.

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

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

(c) SEARCHABILITY.—The information made available under this section shall be searchable by at least the following:

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

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

(3) The location of the eligible professional.

(d) DISCLOSURE.—The information made available under this section shall indicate, where appropriate, that publicized information may not be representative of the eligible professional's entire patient population, the variety of services furnished by the eligible professional, or the health conditions of individuals treated.

(e) IMPLEMENTATION.—

(1) INITIAL IMPLEMENTATION.—Physician Compare shall include the information described in subsection (b)—

(A) with respect to physicians, by not later than July 1, 2015; and

(B) with respect to other eligible professionals, by not later than July 1, 2016.

(2) ANNUAL UPDATING.—The information made available under this section shall be updated on Physician Compare not less frequently than on an annual basis.

(f) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall provide for an opportunity for an eligible professional to review, and submit corrections for, the information to be made public with respect to the eligible professional under this section prior to such information being made public.

(g) DEFINITIONS.—In this section:

(1) ELIGIBLE PROFESSIONAL; PHYSICIAN; SECRETARY.—The terms ''eligible professional'', ''physician'', and ''Secretary'' have the meaning given such terms in section 10331(i) of Public Law 111–148.

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

**SEC. 8. EXPANDING AVAILABILITY OF MEDICARE DATA.**

(a) EXPANDING USES OF MEDICARE DATA BY QUALIFIED ENTITIES.—

(1) ADDITIONAL ANALYSES.—

(A) IN GENERAL.—Subject to subparagraph (B), to the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2015, a qualified entity may use the combined data described in paragraph (4)(B)(iii) of such section received by such entity under such section, and information derived from the evaluation described in such paragraph (4)(D), to conduct additional non-public analyses (as determined appropriate by the Secretary) and provide or sell such analyses to authorized users for non-public use (including for the purposes of assisting providers of services and suppliers to develop and participate in quality and patient care improvement activities, including developing new models of care).

(B) LIMITATIONS WITH RESPECT TO ANALYSES.—

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

(ii) HEALTH INSURANCE ISSUERS.—A qualified entity may not provide or sell an analysis to a health insurance issuer described in paragraph (9)(A)(iv) unless the issuer is providing the qualified entity with data under section 1874(e)(4)(B)(iii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(B)(iii)).

(2) ACCESS TO CERTAIN DATA.—

(A) ACCESS.—To the extent consistent with applicable information, privacy, security, and disclosure laws (including paragraph (3)), notwithstanding paragraph (4)(B) of section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) and the second sentence of paragraph (4)(D) of such section, beginning July 1, 2015, a qualified entity may—

(i) provide or sell the combined data described in paragraph (4)(B)(iii) of such section to authorized users described in clauses (i), (ii), and (v) of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B); or

(ii) subject to subparagraph (C), provide Medicare claims data to authorized users described in clauses (i), (ii), and (v), of paragraph (9)(A) for non-public use, including for the purposes described in subparagraph (B).

(B) PURPOSES DESCRIBED.—The purposes described in this subparagraph are assisting providers of services and suppliers in developing and participating in quality and patient care improvement activities, including developing new models of care.

(C) MEDICARE CLAIMS DATA MUST BE PROVIDED AT NO COST.—A qualified entity may not charge a fee for providing the data under subparagraph (A)(ii).

(3) PROTECTION OF INFORMATION.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an analysis or data that is provided or sold under paragraph (1) or (2) shall not contain information that individually identifies a patient.

(B) INFORMATION ON PATIENTS OF THE PROVIDER OF SERVICES OR SUPPLIER.—To the extent consistent with applicable information, privacy, security, and disclosure laws, an analysis or data that is provided or sold to a provider of services or supplier under paragraph (1) or (2) may contain information that individually identifies a patient of such provider or supplier, including with respect to items and services furnished to the patient by other providers of services or suppliers.

(C) PROHIBITION ON USING ANALYSES OR DATA FOR MARKETING PURPOSES.—An authorized user shall not use an analysis or data provided or sold under paragraph (1) or (2) for marketing purposes.

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

(5) NO REDISCLOSURE OF ANALYSES OR DATA.—

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

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

(6) OPPORTUNITY FOR PROVIDERS OF SERVICES AND SUPPLIERS TO REVIEW.—Prior to a qualified entity providing or selling an analysis to an authorized user under paragraph (1), to the extent that such analysis would individually identify a provider of services or supplier who is not being provided or sold such analysis, such qualified entity shall provide such provider or supplier with the opportunity to appeal and correct errors in the manner described in section 1874(e)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(C)(ii)).

(7) ASSESSMENT FOR A BREACH.—

(A) IN GENERAL.—In the case of a breach of a data use agreement under this section or section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)), the Secretary shall impose

an assessment on the qualified entity both in the case of—

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

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

(B) ASSESSMENT.—The assessment under subparagraph (A) shall be an amount up to $100 for each individual entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title—

(i) in the case of an agreement described in subparagraph (A)(i), for whom the Secretary provided data on to the qualified entity under paragraph (2); and

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

(C) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to this paragraph shall be deposited in Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

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

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

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

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

(D) other information determined appropriate by the Secretary.

(9) DEFINITIONS.—In this subsection and subsection (b):

(A) AUTHORIZED USER.—The term ''authorized user'' means the following:

(i) A provider of services.

(ii) A supplier.

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

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

(v) A medical society or hospital association.

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

(B) PROVIDER OF SERVICES.—The term ''provider of services'' has the meaning given such term in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)).

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

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

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

(b) ACCESS TO MEDICARE DATA BY QUALIFIED CLINICAL DATA REGISTRIES TO FACILITATE QUALITY IMPROVEMENT.—

(1) ACCESS.—

(A) IN GENERAL.—To the extent consistent with applicable information, privacy, security, and disclosure laws, beginning July 1, 2015, the Secretary shall, at the request of a qualified clinical data registry under section 1848(m)(3)(E) of the Social Security Act (42 U.S.C. 1395w–4(m)(3)(E)), provide the data described in subparagraph (B) (in a form and manner determined to be appropriate) to such qualified clinical data registry for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety, provided that any public reporting of such analyses or research that identifies a provider of services or supplier shall only be conducted with the opportunity of such provider or supplier to appeal and correct errors in the manner described in subsection (a)(6).

(B) DATA DESCRIBED.—The data described in this subparagraph is—

(i) claims data under the Medicare program under title XVIII of the Social Security Act; and

(ii) if the Secretary determines appropriate, claims data under the Medicaid program under title XIX of such Act and the State Children's Health Insurance Program under title XXI of such Act.

(2) FEE.—Data described in paragraph (1)(B) shall be provided to a qualified clinical data registry under paragraph (1) at a fee equal to the cost of providing such data. Any fee collected pursuant to the preceding sentence shall be deposited in the Centers for Medicare & Medicaid Services Program Management Account.

(c) EXPANSION OF DATA AVAILABLE TO QUALIFIED ENTITIES.—Section 1874(e) of the Social Security Act (42 U.S.C. 1395kk(e)) is amended—

(1) in the subsection heading, by striking ''MEDICARE''; and

(2) in paragraph (3)—

(A) by inserting after the first sentence the following new sentence: ''Beginning July 1, 2015, if the Secretary determines appropriate, the data described in this paragraph may also include standardized extracts (as determined by the Secretary) of claims data under titles XIX and XXI for assistance provided under such titles for one or more specified geographic areas and time periods requested by a qualified entity.''; and

(B) in the last sentence, by inserting ''or under titles XIX or XXI'' before the period at the end.

(d) REVISION OF PLACEMENT OF FEES.—Section 1874(e)(4)(A) of the Social Security Act (42 U.S.C. 1395kk(e)(4)(A)) is amended, in the second sentence—

(1) by inserting '', for periods prior to July 1, 2015,'' after ''deposited''; and

(2) by inserting the following before the period at the end: '', and, beginning July 1, 2015, into the Centers for Medicare & Medicaid Services Program Management Account''.

**SEC. 9. REDUCING ADMINISTRATIVE BURDEN AND OTHER PROVISIONS.**

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

(1) INDEFINITE, CONTINUING AUTOMATIC EXTENSION OF OPT OUT ELECTION.—

(A) IN GENERAL.—Section 1802(b)(3) of the Social Security Act (42 U.S.C. 1395a(b)(3)) is amended—

(i) in subparagraph (B)(ii), by striking ''during the 2-year period beginning on the date the affidavit is signed'' and inserting ''during the applicable 2-year period (as defined in subparagraph (D))'';

(ii) in subparagraph (C), by striking ''during the 2-year period described in subparagraph (B)(ii)'' and inserting ''during the applicable 2-year period''; and

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

''(D) APPLICABLE 2-YEAR PERIODS FOR EFFECTIVENESS OF AFFIDAVITS.—In this subsection, the term 'applicable 2-year period' means, with respect to an affidavit of a physician or practitioner under subparagraph (B), the 2-year period beginning on the date the affidavit is signed and includes each subsequent 2-year period unless the physician or practitioner involved provides notice to the Secretary (in a form and manner specified by the Secretary), not later than 30 days before the end of the previous 2-year period, that the physician or practitioner does not want to extend the application of the affidavit for such subsequent 2-year period.''.

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

(2) PUBLIC AVAILABILITY OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—Section 1802(b) of the Social Security Act (42 U.S.C. 1395a(b)) is amended—

(A) in paragraph (5), by adding at the end the following new subparagraph:

''(D) OPT-OUT PHYSICIAN OR PRACTITIONER.—The term 'opt-out physician or practitioner' means a physician or practitioner who has in effect an affidavit under paragraph (3)(B).'';

(B) by redesignating paragraph (5) as paragraph (6); and

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

''(5) POSTING OF INFORMATION ON OPT-OUT PHYSICIANS AND PRACTITIONERS.—

''(A) IN GENERAL.—Beginning not later than February 1, 2015, the Secretary shall make publicly available through an appropriate publicly accessible website of the Department of Health and Human Services information on the number and characteristics of opt-out physicians and practitioners and shall update such information on such website not less often than annually.

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

''(i) Their number.

''(ii) Their physician or professional specialty or other designation.

''(iii) Their geographic distribution.

''(iv) The timing of their becoming opt-out physicians and practitioners, relative to when they first entered practice and with respect to applicable 2-year periods.

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

(b) GAINSHARING STUDY AND REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with the Inspector General of the Department of Health and Human Services, shall submit to Congress a report with legislative recommendations to amend existing fraud and abuse laws, through exceptions, safe harbors, or other narrowly targeted provisions, to permit gainsharing or similar arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency. The report shall—

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

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

(3) consider whether a portion of any savings generated by such arrangements should accrue to the Medicare program under title XVIII of the Social Security Act.

(c) PROMOTING INTEROPERABILITY OF ELECTRONIC HEALTH RECORD SYSTEMS.—

(1) RECOMMENDATIONS FOR ACHIEVING WIDESPREAD EHR INTEROPERABILITY.—

(A) OBJECTIVE.—As a consequence of a significant Federal investment in the implementation of health information technology through the Medicare and Medicaid EHR incentive programs, Congress declares it a national objective to achieve widespread exchange of health information through interoperable certified EHR technology nationwide by December 31, 2017.

(B) DEFINITIONS.—In this paragraph:

(i) WIDESPREAD INTEROPERABILITY.—The term ''widespread interoperability'' means interoperability between certified EHR technology systems employed by meaningful EHR users under the Medicare and Medicaid EHR incentive programs and other clinicians and health care providers on a nationwide basis.

(ii) INTEROPERABILITY.—The term ''interoperability'' means the ability of two or more health information systems or components to exchange clinical and other information and to use the information that has been exchanged using common standards as to provide access to longitudinal information for health care providers in order to facilitate coordinated care and improved patient outcomes.

(C) ESTABLISHMENT OF METRICS.—Not later than July 1, 2015, and in consultation with stakeholders, the Secretary shall establish metrics to be used to determine if and to the extent that the objective described in subparagraph (A) has been achieved.

(D) RECOMMENDATIONS IF OBJECTIVE NOT ACHIEVED.—If the Secretary of Health and Human Services determines that the objective described in subparagraph (A) has not been achieved by December 31, 2017, then the Secretary shall submit to Congress a report, by not later than December 31, 2018, that identifies barriers to such objective and recommends actions that the Federal Government can take to achieve such objective. Such recommended actions may include recommendations—

(i) to adjust payments for not being meaningful EHR users under the Medicare EHR incentive programs; and

(ii) for criteria for decertifying certified EHR technology products.

(2) PREVENTING BLOCKING THE SHARING OF INFORMATION.—

(A) FOR MEANINGFUL EHR PROFESSIONALS.—Section 1848(o)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(o)(2)(A)(ii)) is amended by inserting before the period at the end the following: '', and the professional demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the professional has not knowingly and willfully taken any action to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(B) FOR MEANINGFUL EHR HOSPITALS.—Section 1886(n)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395ww(n)(3)(A)(ii)) is amended by inserting before the period at the end the following: '', and the hospital demonstrates (through a process specified by the Secretary, such as the use of an attestation) that the hospital has not knowingly and willfully taken any action to limit or restrict the compatibility or interoperability of the certified EHR technology''.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to meaningful EHR users as of the date that is one year after the date of the enactment of this Act.

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

(A) STUDY.—The Secretary shall conduct a study to examine the feasibility of establishing mechanisms that includes aggregated results of surveys of meaningful EHR users on the functionality of certified EHR technology products to enable such users to directly compare the functionality and other features of such products. Such information may be made available through contracts with physician, hospital, or other organizations that maintain such comparative information.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the website. The report shall include information on the benefits of, and resources needed to develop and maintain, such a website.

(4) DEFINITIONS.—In this subsection:

(A) The term ''certified EHR technology'' has the meaning given such term in section 1848(o)(4) of the Social Security Act (42 U.S.C. 1395w–4(o)(4)).

(B) The term ''meaningful EHR user'' has the meaning given such term under the Medicare EHR incentive programs.

(C) The term ''Medicare and Medicaid EHR incentive programs'' means—

(i) in the case of the Medicare program under title XVIII of the Social Security Act, the incentive programs under section 1814(l)(3), section 1848(o), subsections (l) and (m) of section 1853, and section 1886(n) of the Social Security Act (42 U.S.C. 1395f(l)(3), 1395w–4(o), 1395w–23, 1395ww(n)); and

(ii) in the case of the Medicaid program under title XIX of such Act, the incentive program under subsections (a)(3)(F) and (t) of section 1903 of such Act (42 U.S.C. 1396b).

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

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

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

(A) How the definition of telehealth across various Federal programs and Federal efforts can inform the use of telehealth in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

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

(C) Potential implications of greater use of telehealth with respect to payment and delivery system transformations under the Medicare program under such title XVIII and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(D) How the Centers for Medicare & Medicaid Services conducts oversight of payments made under the Medicare program under such title XVIII to providers for telehealth services.

(2) STUDY ON REMOTE PATIENT MONITORING SERVICES.—

(A) IN GENERAL.—The Comptroller General of the United States shall conduct a study—

(i) of the dissemination of remote patient monitoring technology in the private health insurance market;

(ii) of the financial incentives in the private health insurance market relating to adoption of such technology;

(iii) of the barriers to adoption of such services under the Medicare program under title XVIII of the Social Security Act;

(iv) that evaluates the patients, conditions, and clinical circumstances that could most benefit from remote patient monitoring services; and

(v) that evaluates the challenges related to establishing appropriate valuation for remote patient monitoring services under the Medicare physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) in order to accurately reflect the resources involved in furnishing such services.

(B) DEFINITIONS.—For purposes of this paragraph:

(i) REMOTE PATIENT MONITORING SERVICES.—The term ''remote patient monitoring services'' means services furnished through remote patient monitoring technology.

(ii) REMOTE PATIENT MONITORING TECHNOLOGY.—The term ''remote patient monitoring technology'' means a coordinated system that uses one or more home-based or mobile monitoring devices that automatically transmit vital sign data or information on activities of daily living and may include responses to assessment questions collected on the devices wirelessly or through a telecommunications connection to a server that complies with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996, as part of an established plan of care for that patient that includes the review and interpretation of that data by a health care professional.

(3) REPORTS.—Not later than 24 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress—

(A) a report containing the results of the study conducted under paragraph (1); and

(B) a report containing the results of the study conducted under paragraph (2).

A report required under this paragraph shall be submitted together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate. The Comptroller General may submit one report containing the results described in subparagraphs (A) and (B) and the recommendations described in the previous sentence.

(e) RULE OF CONSTRUCTION REGARDING HEALTHCARE PROVIDER STANDARDS OF CARE.—

(1) MAINTENANCE OF STATE STANDARDS.—The development, recognition, or implementation of any guideline or other standard under any Federal health care provision shall not be construed—

(A) to establish the standard of care or duty of care owed by a health care provider to a patient in any medical malpractice or medical product liability action or claim; or

(B) to preempt any standard of care or duty of care, owed by a health care provider to a patient, duly established under State or common law.

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

(A) FEDERAL HEALTH CARE PROVISION.—The term ''Federal health care provision'' means any provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act.

(B) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity—

(i) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

(ii) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

(C) MEDICAL MALPRACTICE OR MEDICAL PRODUCT LIABILITY ACTION OR CLAIM.—The term ''medical malpractice or medical product liability action or claim'' means a medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality

Improvement Act of 1986 (42 U.S.C. 11151(7))) and includes a liability action or claim relating to a health care provider's prescription or provision of a drug, device, or biological product (as such terms are defined in section 201 of the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act).

(D) STATE.—The term ''State'' includes the District of Columbia, Puerto Rico, and any other commonwealth, possession, or territory of the United States.

(3) PRESERVATION OF STATE LAW.—No provision of the Patient Protection and Affordable Care Act (Public Law 111–148), title I or subtitle B of title II of the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), or title XVIII or XIX of the Social Security Act shall be construed to preempt any State or common law governing medical professional or medical product liability actions or claims.

**SEC. 10. DELAY IN IMPLEMENTATION OF PENALTY FOR FAILURE TO COMPLY WITH INDIVIDUAL HEALTH INSURANCE MANDATE.**

(a) IN GENERAL.—Section 5000A(c) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(5) DELAY IN IMPLEMENTATION OF PENALTY.—Notwithstanding any other provision of this subsection, the monthly penalty amount with respect to any taxpayer for any month beginning before January 1, 2019, shall be zero.''.

(b) DELAY OF CERTAIN PHASE INS AND INDEXING.'

(1) PHASE IN OF PERCENTAGE OF INCOME LIMITATION.—Section 5000A(c)(2)(B) of such Code is amended—

(A) by striking ''2014'' in clause (i) and inserting ''2019'', and

(B) by striking ''2015'' in clauses (ii) and (iii) and inserting ''2020''.

(2) PHASE IN OF APPLICABLE DOLLAR AMOUNT.—Section 5000A(c)(3)(B) of such Code is amended—

(A) by striking ''2014'' and inserting ''2019'', and

(B) by striking ''2015'' (before amendment by subparagraph (A)) and inserting ''2020''.

(3) INDEXING OF APPLICABLE DOLLAR AMOUNT.—Section 5000A(c)(3)(D) of such Code is amended—

(A) by striking ''2016'' in the matter preceding clause (i) and inserting ''2021'', and

(B) by striking ''2015'' in clause (ii) and inserting ''2020''.

(4) INDEXING OF EXEMPTION BASED ON HOUSEHOLD INCOME.—Secton 5000A(e)(1)(D) of such Code is amended—

(A) by striking ''2014'' (before amendment by subparagraph (B)) and inserting ''2019'', and

(B) by striking ''2013'' and inserting ''2018''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2013.

The SPEAKER pro tempore. The gentleman from Pennsylvania (Mr. PITTS), the gentleman from California (Mr. WAXMAN), the gentleman from Michigan (Mr. CAMP), and the gentleman from Michigan (Mr. LEVIN) each will control 15 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 to revise and extend their remarks and to include extraneous materials on H.R. 4015.

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 sustainable growth rate, or SGR, is the formula through which Medicare reimburses physicians. Since 2003, Congress has voted 17 times for temporary patches, or ''doc fixes,'' to avert ever larger cuts to providers.

The uncertainty of the SGR threatens doctors' ability to continue practicing medicine and accepting Medicare patients and endangers seniors' access to care.

Absent congressional action, providers face a 24 percent cut on April 1, 2014. To stave off this cut, we can either pass another ''patch'' and kick the can down the road again, or we can repeal this flawed formula for good.

Today's bill, H.R. 4015, firmly repeals the SGR and replaces it with payment reform policy that has been agreed upon by the bipartisan leaders of the Energy and Commerce, the Ways and Means, and Senate Finance Committees.

As chairman of the Energy and Commerce Health Subcommittee, I have been working for the past 3 years on legislation to permanently repeal the SGR, and I am very pleased that on February 6, 2014, we reached a bipartisan, bicameral agreement, embodied in today's legislation.

Unfortunately, since then, Senate Majority Leader REID has refused to negotiate with us on how to pay for this package. So we have brought forward H.R. 4015, which is fully paid for by delaying implementation of the individual mandate—a policy supported by both Republicans and Democrats.

The bill enjoys more than 100 cosponsors and the support of over 700 national and State provider and stakeholder groups. So I urge all of my colleagues to vote for H.R. 4015 to ensure that our seniors have access to the doctors they know and trust.

I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, to start the debate on our side, I yield 2 minutes to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. I thank my friend from California for yielding to me.

Mr. Speaker, I rise in strong opposition, not to the policy before us, but to the poison pill pay-for attached to this much-needed SGR repeal-and-replace legislation.

I support the bipartisan, bicameral agreement contained in H.R. 4015 for numerous reasons. There is almost universal agreement that the sustainable growth rate is a flawed formula and, therefore, Congress has been left to temporarily patch physician reimbursement for far too long.

This bill permanently repeals the SGR and provides physicians with a small increase in pay for the first 5 years. I want to see our physician workforce fairly compensated for providing high-quality care to our constituents. The SGR fails to adequately do this. This legislation incentivizes physicians to focus on providing quality care instead of a high quantity of care.

Finally, while it has always been extremely expensive to permanently repeal and replace the SGR, it is now estimated to cost less than $140 billion. This is less than half the cost of what it would have been a few years ago. While the costs remain significant, I believe that it is imperative we permanently fix physician payment now.

That is why I am so furious Republicans are wasting valuable time by pairing this much-needed legislation with yet another ridiculous Affordable Care Act repeal vote. After more than 50 repeal votes, I think it is clear to everyone where both Democrats and Republicans stand on the Affordable Care Act. We don't need another repeal vote.

The current SGR patch expires in 17 days. We should be focused on finding bipartisan pay-fors to permanently fix the SGR instead of having Republicans push through yet another bill that will surely die in the Senate.

Mr. PITTS. Mr. Speaker, at this time, I yield 2 minutes to the gentleman from Georgia (Mr. GINGREY), one of the cochairs of the Doctors Caucus, who has contributed a great deal to accomplish this bipartisan agreement.

Mr. GINGREY of Georgia. Mr. Speaker, today we vote to repeal the sustainable growth rate, a formula that was flawed from its 1997 beginning, and it has run its ugly course.

As cochairman of the House GOP Doctors Caucus, I would like to thank the Energy and Commerce Committee, especially Chairman UPTON, Ranking Member WAXMAN, Health Subcommittee Chairman PITTS and Ranking Member PALLONE, and especially a member of the Doctors Caucus, Vice Chair Dr. MICHAEL BURGESS, and, of course, the Ways and Means Committee and the Senate Finance Committee and their staffs for their tireless work to produce a policy which will help to ensure that seniors continue to have access to quality providers.

Included in this legislation is my bill, and it is called the Standard of Care Protection Act. It provides much-needed clarity to the practice of medicine by confirming that Federal quality incentives are no substitute in a medical malpractice case for the standards of care developed by specialty societies and determined and practiced by physicians. This is an extremely important determination that will provide fairness to both patient plaintiffs and doctors.

With the vote today, we take an important step toward replacing the flawed formula, while at the same time protecting Americans by delaying the individual mandate of ObamaCare by 5 years. While the current administration continues to add delays when it is politically expedient, this policy gives certainty to individuals that they won't be taxed or fined, Mr. Speaker, for not complying with a law that they can't afford.

This may not be the final version of the bill, but it is time for the Senate to pass their own version and appoint conferees. SGR repeal is too important for both seniors and their doctors, and we have come too far for this policy to not reach the President's desk this year.

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

Mr. PITTS. Mr. Speaker, I yield the gentleman an additional 15 seconds.

Mr. GINGREY of Georgia. Let me just say again, we have come too far for this policy to not reach the President's desk, and I mean this year. The Senate Majority Leader needs to come to the table. Let's find a suitable path forward, and let's repeal this unsustainable physician payment policy.

Mr. WAXMAN. Mr. Speaker, at this time, I am pleased to yield 2 minutes to the gentlewoman from the State of Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, every year, sometimes more than once a year, since 2003 Congress has had to step in to prevent a cut in physician payments. With input from a wide variety of stakeholders, we have tried to work together for many, many years on a solution to the flawed system to the sustainable growth rate formula. Until this year, we were out of luck, and the price tag for fixing the formula was ever increasing.

The underlying legislation that we consider today was 11 years in the making. I am very proud to cosponsor this bill because it is a compromise solution for the formula we agreed on. But sadly—sadly—the majority has prescribed a bitter pill to swallow for passage of this important bill for patients and doctors. Instead of coming to the negotiating table to discuss mutually acceptable ways to pay for this bill, the majority has decided to pay for it by delaying important provisions of the Affordable Care Act.

Everybody knows that this provision is a nonstarter. It is a nonstarter in the other body and in my Caucus right here in the House. Because of this shortsighted tactic, the Republicans have almost guaranteed that we are going to need yet another short-term SGR patch before the current one expires on March 31.

This is bad for the doctors of America. This is bad for the patients of America. Let's get real. Let's fix this problem for good. And you know, Mr. GINGREY just recognized that this bill is not going anywhere. So let's sit down. Let's do what we did with the SGR itself, and let's figure out how to pay for it.

Mr. PITTS. Mr. Speaker, may I inquire about how much time remains on each side?

The SPEAKER pro tempore. The gentleman from Pennsylvania has 10¼ minutes remaining. The gentleman from California has 11 minutes remaining.

Mr. PITTS. Mr. Speaker, at this time, I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS), a valuable member of the Health Subcommittee.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Speaker, I rise today supporting repealing the SGR formula. The SGR cuts would reduce doctors' compensation for treating Medicare patients by 24 percent. H.R. 4015 repeals and replaces SGR with a merit-based incentive payment system—MIPS—that pays doctors based on quality, not volume.

Paying doctors based on quality incentivizes physicians to be as efficient and effective as possible in keeping their patients healthy. MIPS is fully paid for by a delay of ObamaCare's individual mandate—a tax on Americans to force them to purchase more expensive health care that doesn't meet their needs.

This bill will provide doctors who treat Medicare patients with certainty, incentivize and reward doctors to keep seniors healthy with better care, and provide individuals relief under ObamaCare.

Support our seniors, our doctors, and fairness for individuals under ObamaCare. I urge my colleagues to support H.R. 4015.

Mr. WAXMAN. Mr. Speaker, at this time, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS), my good friend.

Mrs. CAPPS. I thank my colleague for yielding.

Mr. Speaker, I have long been a supporter of a permanent fix to the sustainable growth rate, or SGR. The flawed SGR harms providers and consumers alike and keeps us from true innovation in the health care sector, but for too long, the conversation has ended with everyone recognizing a problem but no one willing to find a middle ground to fix it.

□ 0930

Instead, we lumber from patch to patch, kicking the can down the road with piecemeal delays or fixes here in Congress, such as we are doing today. These disagreements let the issue linger, causing more instability in our communities while the cost of a fix continues to rise. That is why I have been so proud to be part of crafting the bipartisan, bicameral SGR fix policy.

This policy provides a positive payment update to our providers, pushes us toward a system rewarding quality and fixing the GPCI, ensuring that central coast providers and others will finally gain accurate Medicare reimbursement.

But today, this bipartisan process is being derailed once again. By tying a delay of the individual mandate to this policy, the House majority has poisoned such a bipartisan process. Access to health care for more than 50 million seniors and persons with disabilities is a serious matter. These partisan games could very well end our Nation's best shot at amending a bad policy.

I urge the majority to pull this bill, go back to the negotiating table with all of us, and help us fix Medicare provider payments once and for all.

Mr. PITTS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Nevada (Mr. HECK), another member of the Doctors Caucus.

Mr. HECK of Nevada. Mr. Speaker, I rise in support of H.R. 4015. I have always stated that the number one threat to Medicare and seniors' access to health care is the flawed SGR formula. At no time prior have we been so close in a bipartisan, bicameral way to ensuring that our seniors have access to the health care providers of their choosing, and now when we are so close is not the time to derail the progress made by using controversial pay-fors.

I will vote in favor of H.R. 4015 today because of the policy changes it represents. I ask my friends on the other side of the aisle to vote ''aye'' so we can send this bill to the Senate, and I call on the Senate to pass legislation that includes the agreed-to policy provisions with the pay-for of their choosing. Then, let's go to conference and fix the SGR once and for all.

Providing stability and predictability to our health care providers will result in stability and predictability for our seniors. Passing SGR reform is the fiscally responsible thing to do. The longer we delay, the more it will cost.

Let's give seniors the peace of mind they deserve, so that they will be able to see the Medicare provider of their choice. Let's pass H.R. 4015.

Mr. WAXMAN. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE), who is ranking member of the Health Subcommittee.

Mr. PALLONE. Mr. Speaker, I thank Mr. WAXMAN.

Mr. Speaker, today the Republican leadership once again chooses politics over substance and what is good for the American people. The current SGR patch will expire on March 31, at which point Medicare's payment to physicians will be cut by almost 24 percent. It is critical that we take meaningful action to fix the SGR before the end of the month.

We all know that the SGR formula is flawed. After 10 years of patching these cuts, after wasting $150 billion, enough is enough. It is why we began last year seriously looking at this issue, and we came up with a bipartisan, bicameral solution. In fact, if was quite the lesson in legislating. Particularly, we ended up arriving at a consensus bill on the SGR.

So I ask the Republican leadership: For what reason have you poisoned this process with an unacceptable pay-for?

This bill will pass today and go nowhere. It will not be taken up by the Senate or signed by the President. You have singlehandedly, in my belief, stomped on months and months of hard work and effort by my colleagues on both sides of the aisle and our staffs.

Late nights, weekends, hard compromises. We all saw the greater good in finally getting a permanent policy replacement for the SGR. But instead of working with our leadership, the Republicans have turned this into their 51st vote to repeal or undermine the ACA, and you are going to leave 13 million Americans uninsured if you were ever to succeed in repealing the ACA.

This is just a poison pill. The pay-for is a poison pill for something that we agreed on in terms of the substance of fixing the SGR. You could have picked other ways of paying for this. I think we are close to a consensus on the pay-for. Instead, you put in this poison pill. You are wasting valuable time where you will basically do nothing.

We only have 2 weeks left. Let's defeat this bill today, sit down over the next 2 weeks and come up with a pay-for that makes sense, not a pay-for that simply repeals the Affordable Care Act, which is working well. More and more people are signing up. I had an enrollment event this weekend in my district. People are signing up. Don't destroy the process. We have a good SGR fix.

Mr. PITTS. Mr. Speaker, I am very pleased to yield 2 minutes to the gentleman from Michigan (Mr. UPTON), the distinguished chairman of the Energy and Commerce Committee, one of the chief architects of this bill.

Mr. UPTON. Mr. Speaker, first I want to commend Republicans and Democrats for getting the policy right. This is a tough nut to crack. It was 51–0 in our committee, led by JOE PITTS, Dr. BURGESS, the Doc Caucus, Mr. WAXMAN, Mr. DINGELL, and Mr. PALLONE. We worked long and hard to get the policy right, and we worked with the other committees to do it as well.

The difficulty we always knew was going to be on the pay-for. I would suggest this: we want to work with the Senate; we want to get this thing done; pay-for is the toughest part, but let's go to conference. Let's work with the Senate to get a pay-for that can work.

Now, we know that there is a deadline coming up at the end of this month. As we look to try and find a pay-for, let me go through some of the other delays that this administration has already done:

Individual mandate delay, Americans with canceled coverage due to ObamaCare; delayed.

Individual mandate, deadline for purchasing coverage; delayed.

Individual mandates for non-ACA compliant plans; delayed by the administration.

Annual limit requirement; delayed.

MLR requirement; delayed.

MA cuts through demo bonus money; delayed.

Employer reporting; delayed.

Employer mandate; delayed.

Subsidies only in State-run exchanges; delayed.

High-risk pool closure; delayed.

Out-of-pocket waiver for group health plans; delayed.

Verification of eligibility for exchange subsidies; delayed.

Reinsurance fee for some unions; delayed.

Nondiscrimination requirement for employer coverage; delayed.

Subsidies only through the exchange; delayed.

Shop employee choice delay; delayed

Shop online purchasing; delayed.

Numerous HealthCare.gov technical; delayed.

This was never ready for prime time. We have said that from the start. If the administration has decided to delay all these things, almost two dozen, why not delay this, too? And why not use the savings then not only to help the physicians, we have to think about the seniors.

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

Mr. PITTS. I yield an additional 30 seconds to the gentleman.

Mr. UPTON. This isn't just to help our physicians, it is to help the most vulnerable, our seniors, because if we don't reimburse our docs, the ''closed'' sign is going to come up where they go for services. They are going to be denied the coverage that they have paid taxes for, that they expect to have, and yet another broken promise will be there.

If the administration can delay these things, why don't we delay this? Why don't we use the savings then to pay for a program that works, and I would suggest that we vote for this. Let's work with the Senate to get it done.

Mr. Speaker, we are here today to vote for a bill that would provide certainty and peace of mind to our nation's seniors and fairness for all Americans under the president's health care law. Repeal of the system of physician cuts under Medicare, or SGR, has been a problem that has plagued seniors, doctors, and Congress for well over a decade. These cuts have threatened access to our seniors' health care and the Medicare promise that our country has made to every American—both those in the program today and those who count on it as part of their future retirement.

Our purpose here today is Medicare reform so that we can keep the promise made to all seniors, current and future. The Medicare program is going insolvent, and Congress will need to act if we are to prevent bankruptcy. Today is one step toward keeping the Medicare promise. Many of us did roundtables with our doctors back home, I did so in Michigan, and we visited with countless seniors. We heard their concerns loud and clear and have acted.

H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act, is the product of years of bipartisan efforts to remove the threat of SGR. The legislation would once and for all repeal the broken SGR and replace it with a system that promotes the highest quality of care for seniors, eases the burden on physicians who are struggling under an increasing number of government programs that take time away from patients, and promotes new forms of health care delivery and innovation with an eye on the future.

We stand here today on the House floor in no small part because of our speaker, JOHN BOEHNER, who charged the Energy and Commerce Committee to find a workable solution to get rid of SGR. This has been a long journey with many important players on both sides of the aisle, and in both chambers. I do want to commend Health Subcommittee Chairman JOE PITTS for helping lead the effort and the bill's sponsor Dr. MICHAEL BURGESS, for his tireless commitment from day one. We also would not be here without the efforts and support of the GOP Doctors Caucus—a group who understands all too well the threat that SGR has posed. And of course I appreciate our partnership with my good friend DAVE CAMP and the Ways and Means Committee.

While this is a significant milestone, the cost of SGR repeal is not insignificant. We have strived over the past few months to find common ground with the Senate to identify a way to pay for this agreement that both chambers can support. Time is not on our side as the current patch is set to expire at the end of this month. So today the House has chosen to act rather than stand idly by and is prepared to send a bill to the Senate with a bipartisan payfor: relief for individual Americans from the mandate that they purchase government-approved insurance.

The White House has already seen fit to delay many parts of the president's health care law, including the employer mandate. And it has also quietly delayed the individual mandate for the millions of Americans whose health care plans the law cancelled. If Senate Democratic colleagues don't want to afford individuals the same rights as special interests with a direct line to the president, then I would ask them to simply pass their own fully offset SGR package and let's go to conference to iron out our differences. But make no mistake, SGR must be paid for.

We have never come this far in finding a permanent solution. But there is still much work to be done after today's vote, and I call on my Chairman RON WYDEN to pick up the torch and work with Majority Leader HARRY REID to put politics aside, stand up for our seniors and doctors, and let's solve SGR this year.

I urge all my colleagues to support H.R. 4015 and the millions of seniors who are watching us here today.

Mr. WAXMAN. Mr. Speaker, I want to point out that none of the delays that Mr. UPTON indicated on that chart would result in 13 million people losing insurance coverage and raise premiums 10–20 percent. This is not a delay that we can agree to. It hurts the Affordable Care Act, and it is a betrayal of our working together on a bipartisan basis to resolve this problem. We worked together on the policy, but we were never brought in to work together on funding that policy.

At this time I yield 2 minutes to the gentleman from Texas (Mr. GENE GREEN).

Mr. GENE GREEN of Texas. Mr. Speaker, I rise to express strong objection to the decision to use the Affordable Care Act's individual responsibility requirement to pay for the SGR reform.

This bill hijacks a thoughtful solution to a problem that has been harming Medicare beneficiaries, providers, and our budget for years and turns it

into a political stunt. This decision is a poison pill and nothing more than more partisan politics.

Congress has overridden the SGR-mandated cuts to Medicare physician payments each year since 2003. Year after year, these temporary patches have been costly and disruptive. Reforming the system is long overdue. Temporary fixes to SGR are a losing situation. The money still has to be spent, but only to just maintain the broken status quo.

The bipartisan, bicameral SGR bill is the closest we have come to fixing this problem once and for all, and this decision gets us further from that goal. Repealing the ACA is a game we have played now 51 times. Holding SGR reform hostage to destroy the ACA and deny millions of Americans access to managed care is disgraceful. Our seniors, our doctors, including the AMA, the Texas Medical Association, the California Medical Association, and the American people deserve better.

In order for our health care system to work, Americans must have insurance. Delaying or repealing the requirement that individuals obtain coverage would drive up premiums and leave millions uninsured. Again, this is purely a partisan pay-for which proves that there is not a sincere effort to finally enact SGR reform but rather just another political game.

Mr. PITTS. Mr. Speaker, I submit for the RECORD a letter from the Texas Medical Association in support of this legislation.

TEXAS MEDICAL ASSOCIATION,
*Austin, TX, March 13, 2014.*

Hon. MICHAEL C. BURGESS, MD,
*House of Representatives, Washington, DC.*

DEAR REPRESENTATIVE BURGESS: On behalf of the 47,000–plus physician and medical student members of the Texas Medical Association, I am writing to reiterate our strong support for the work you have done to effectuate the repeal of Medicare's Sustainable Growth Rate (SGR) formula. In conjunction with your Texas colleague, Kevin Brady, you have gotten closer to solving this challenging issue than ever before. And you have done so with the support of every member of the Texas delegation, both Democratic and Republican, on the Energy & Commerce and Ways & Means Committees.

Perhaps more than anyone in Congress, you understand the frustration and anxiety that the ongoing SGR uncertainty creates for practicing physicians. You have worked tirelessly to craft a piece of legislation that not only repeals the SGR immediately, but also guarantees positive updates for physicians for five years, removes potential causes of liability against physicians, and eliminates some unnecessary bureaucratic red tape that prevents physicians from concentrating on patient care.

We especially appreciate your ongoing consultation and dialogue with TMA and Texas physicians throughout this process.

As you know well, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 has made it this far because of a bipartisan, bicameral agreement on the need to replace the SGR. We are committed to helping you finish the task.

Sincerely,

STEPHEN L. BROTHERTON, MD,
*President.*

Mr. Speaker, I yield 1 minute to the gentleman from Indiana (Mr. BUCSHON), another member of the Doctors Caucus.

Mr. BUCSHON. Mr. Speaker, I rise today in support of this legislation. As a practicing physician for over 15 years, the majority of my patients were Medicare patients. I know firsthand how flawed the SGR is. By not repealing this flawed system, to remain in business, many doctors across America will be forced to limit the number of Medicare patients that they see, and many may refuse to see Medicare patients all together.

Failing to act or voting ''no'' on this legislation will limit seniors' access to their doctors. This will be especially dangerous in rural areas where there are already physician shortages. It is time we finally solve this problem and ensure that Medicare patients have access to their chosen doctors.

I urge my colleagues to stand up for all of the seniors in America and support this legislation.

Mr. WAXMAN. Mr. Speaker, I yield 2 minutes to the gentleman from North Carolina (Mr. BUTTERFIELD).

Mr. BUTTERFIELD. Mr. Speaker, I rise in strong opposition to this bill. This began as a bipartisan effort, but, predictably, this has devolved into nothing but another attempt by House Republicans to dismantle the Affordable Care Act. Here we go again. Over 4.2 million people have signed up for affordable insurance so far, and the numbers are growing.

We all support a permanent repeal of the sustainable growth rate because the SGR in current law is anything but sustainable. We are demanding more out of our doctors and health care professionals. We are asking that they operate with maximum efficiency to play their part in reining in health care spending, and they deserve the same from Congress.

Unfortunately, my Republican colleagues don't share that view. That is why they have offered a pay-for that they know will be completely unacceptable to most Democrats and certainly stands no chance of passage in the Senate. The President has even said he would veto this bill, and rightfully so.

The American Medical Association, which represents most of the doctors throughout the country, and I am disappointed that the Texas Medical Association is at variance with their national association, but the AMA and the AARP and a dozen other organizations representing health care providers and hospitals and seniors have decried Republican partisan tactics. They don't like this.

We have 5 legislative days before the last SGR extension runs out on March 31. Five days. Should Republicans not come to their senses in time, I want doctors to know that a nearly 30 percent cut to their reimbursement should be laid squarely at the feet of my Republican friends here in the House. Doctors need predictability and certainty so they can best serve their patients. If a permanent solution to the SGR is not reached soon, doctors will be forced to make tough decisions about which patients they will see and those which they can no longer afford to see.

Mr. PITTS. May I inquire of the time remaining.

The SPEAKER pro tempore. The gentleman from Pennsylvania has 4¾ minutes remaining. The gentleman from California has 3½ minutes remaining.

Mr. PITTS. Mr. Speaker, at this time I am pleased to yield 1 minute to the gentleman from Tennessee (Mr. ROE), another cochair of the Doctors Caucus.

Mr. ROE of Tennessee. Mr. Speaker, this physician rises in strong support of H.R. 4015, the SGR repeal. This bicameral, bipartisan compromise will preserve seniors' access to needed medical care and give physicians certainty about how Medicare will pay them for their services.

□ 0945

This bill also lays the groundwork for a gradual transition to a reimbursement system that rewards value instead of volume.

The House, by passing H.R. 4015, will take a big step toward the permanent repeal of a flawed payment formula that has hampered physicians since 1997, but we can't allow the process to stop here.

I encourage our Senate colleagues to pass a bill as soon as possible, so that we can move into conference and find a mechanism to repeal this bill.

I would like to thank the members and staff of the committees for their tireless efforts on this bill, particularly my friend Dr. MIKE BURGESS, who has long championed this reform.

I encourage my colleagues to support H.R. 4015. Mr. Speaker, the American Medical Association represents less than 20 percent of the physicians in this country.

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

Mr. PITTS. Mr. Speaker, at this time, I am pleased to yield 1 minute to the gentlelady from North Carolina (Mrs. ELLMERS), who is another important member of the Health Subcommittee.

Mrs. ELLMERS. Mr. Speaker, I rise today in support of H.R. 4015, the SGR repeal.

This has been a long time coming, and I am very excited to be part of it. I want to see this legislation move forward.

I want to agree and disagree with my esteemed colleagues across the aisle. This does boil down to patient care. This will negatively affect our seniors if we do not solve this problem for Medicare reimbursement. It is patient access that is the core of this issue.

However, when we speak about associations, such as the AMA—or the American Medical Association—we are talking about a group who only represents about 11 percent of physicians

across this country, and that number decreases every year.

There is a reason for that. They are not representing doctors in this country, and their voice is not as strong as it once was and should be.

With that, Mr. Speaker, I thank you for this time, and I thank my colleagues for this important message today. I hope all Members support the SGR reform.

Mr. WAXMAN. Mr. Speaker, I yield myself 2 minutes.

This should be a moment of bipartisanship where we finally fix this sustainable growth rate in Medicare physician reimbursement. None of us think it is supportable. Doctors are always facing the peril of a deep cut if we don't patch it up or fix it permanently. It is time to fix it permanently.

We worked together on a bipartisan basis on our committee and came up with a policy to replace the SGR. The Ways and Means Committee and the Senate Finance Committee followed us, and they did their approach, and we all worked out one uniform approach with the idea that we are finally going to end this nonsense of threatening the doctors that take care of Medicare patients.

This is an issue of patient access to medical care that has been promised under Medicare; yet the Republicans are now insisting we pay for the permanent fix. Well, this has come up many, many times. Sometimes, we paid for it, but sometimes, we didn't pay for it; but we always made sure that there was a fix on a bipartisan basis.

Instead, today, the Republicans, without talking to us—they wanted to talk to us about the policy, but without talking to us—are trying to pay for this by hurting the Affordable Care Act.

What they are doing is putting a partisan poison pill offset, an offset that would cause 13 million people to lose insurance coverage and would raise premiums by 10 to 20 percent for everybody else in the exchange. They have to know this is not acceptable; we can't support it.

They are now coming here to the floor saying that there is some attempt by the Democrats to undermine our policy agreement. Well, let's stop blaming each other. Let's get to work and resolve this problem and vote down this bill.

I reserve the balance of my time.

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

Mr. WAXMAN. I have one more speaker.

Mr. PITTS. We have one more speaker. I reserve the balance of my time.

Mr. WAXMAN. You have one more speaker? I yield back the balance of my time.

Mr. PITTS. At this time then, Mr. Speaker, I yield the balance of my time to the gentleman from Texas, Dr. BURGESS, the prime sponsor of this legislation, who has worked tirelessly to achieve this day.

Mr. BURGESS. Mr. Speaker, I want to thank my friend from Pennsylvania for yielding me the time, the chairman of the subcommittee, for making this possible to bring this bill to the floor today.

I want to thank Chairman UPTON of the full committee and Ranking Member WAXMAN of the full committee for also making this possible. It has been a lot of hard work getting us to this point.

Chairman UPTON talked about delays. I would just point out that there has been yet another delay, the delay of the closure of the risk pools because—let's be honest—the Affordable Care Act is not ready to take on those people who have preexisting conditions, so they felt it necessary to keep the risk pools open for an additional length of time.

I want to talk to my friends on the Democratic side of the aisle. I particularly want to talk to those who have only been here one or two terms. The last time we had a bill like this on the floor of the House, Democrats were in charge.

Mr. DINGELL was chairman of our Energy and Commerce Committee. He brought a bill to the floor, H.R. 3961, which was an SGR repeal bill.

This bill had already been rejected by the Senate, so it really had no chance of going anywhere. This bill was not paid for. The policy was awful and would have given us two SGRs, instead of one; but nevertheless, that bill came to the floor.

It only garnered one Republican vote. I was that vote. I was that vote because I thought it was important that the Nation's doctors heard that we were willing to work together across party lines, if need be, to solve this problem for them. I wanted to preserve the process going forward.

Ladies and gentlemen, the bill you have on the floor today, H.R. 4015, is not the destination. It is the key that gets you through the door to get to that destination.

For 4½ weeks, since February 6, the policy has been out there for all to see. We have awaited anyone from the Senate side who wanted to talk to us about negotiating bipartisan pay-fors—radio silence.

Look, I don't know what rule XIV is over in the Senate, but it is apparently pretty important. The majority leader in the other body has brought this bill up under rule XIV; but they were doing nothing before.

For 4 weeks, this policy languished without them picking it up. Now that the House is moving—now that the House is moving a bill and will likely pass the bill today with a decent pay-for that is, in fact, bipartisan because 27 Democrats voted for this very pay-for last week on the floor of this House—in fact, it was unanimous if we were exempting firefighters or veterans from the individual mandate in the Affordable Care Act.

This is a bipartisan pay-for. It has passed the floor of this House in a bipartisan fashion. It is ready to go. We call upon our colleagues in the other body. Use whatever Senate procedures you need to, but get this done because the clock is ticking. The clock is ticking towards March 31.

We all know what happens to the Nation's seniors on that date. We all know what happens to their doctors. Let us get this done.

Mr. PITTS. I yield back the balance of my time.

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

I rise today, Mr. Speaker, to strongly support H.R. 4015, the SGR Repeal and Provider Payment Modernization Act, as amended.

The Ways and Means Committee and Energy and Commerce Committee and Senate Finance Committee have worked in a bipartisan manner to develop a permanent physician payment fix repeal.

Years of hearings, discussion drafts, and ongoing dialogues with stakeholders have resulted in H.R. 4015, a bipartisan, bicameral agreement on SGR replacement policy.

This bill has over 100 cosponsors, has the support of 18 Members of the House Doctors Caucus, and 600 national and State organizations representing physicians and other professionals.

There is a reason for all of this support. H.R. 4015 has a lot to like. It repeals the outdated SGR formula and gives seniors the certainty that they will have access to their doctors.

It incentivizes better care and better results for seniors that rely on the Medicare program, and it breaks the cycle of uncertainty for doctors and their patients, providing permanent relief and improving how Medicare pays doctors.

We must not let this opportunity pass by. Time is short. If we do not act, in just 2 weeks, doctors will see a 24 percent cut in their Medicare reimbursement, jeopardizing seniors' access to care.

We must safeguard taxpayer dollars. That is why we pay for permanent repeal by delaying the health care law's individual mandate for 5 years. Americans across the country are facing higher costs, losing the coverage they have and like, and are seeing smaller paychecks as a result of ObamaCare.

Last week, the administration announced that it would continue to expand certain exemptions from the individual mandate for 2 years. This proposal would extend that further—would extend further what the administration is already doing and give all Americans relief from the mandates and penalties of ObamaCare. It is only fair.

I urge all members to support H.R. 4105. I reserve the balance of my time.

Mr. Speaker, I ask unanimous consent that the gentleman from Texas (Mr. BRADY) control the remainder of the time.

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

There was no objection.

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

What is going on here? The Republicans are bringing up a totally partisan bill to thwart a bipartisan bill. They are tossing aside common ground for barren ground, another Affordable Care repeal vote. They are throwing out a historic bipartisan breakthrough to permanently end and replace the broken Medicare physician payment formula, once again turning to totally partisan politics.

The breakthrough achieved by our committees would permanently replace the deeply flawed SGR formula with a system designed to build on delivery system reform, reforms that move Medicare physician payments toward a more accountable value-driven system.

The underlying policy agreement is broadly supported by both provider communities and beneficiaries; but today's exercise is opposed by groups representing seniors, doctors, health plans, and others because it guts the Affordable Care Act through a 5-year delay to the individual mandate.

What would the result be? According to CBO and the Joint Task Committee, the Republican bill would increase the number of uninsured Americans by 13 million. What is more, the bill would raise individual market health insurance premiums by 10 to 20 percent for those who remain insured.

Last week, we saw the 50th vote. This is now the 51st vote to undermine the Affordable Care Act. So much for good faith and so much for good will.

Instead of working to find common ground to finish the job on a bipartisan solution vital to fixing a problem in our health care system, House Republicans are taking once again a cynical step in a very familiar direction, concerned only about the November election.

I urge my colleagues to vote ''no,'' and I reserve the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

Enough really is enough. The unfair way Medicare pays our local doctors to treat our seniors has gone on for far too long.

It is making it harder for seniors to see a doctor they know and who knows them. It is chasing local doctors out of Medicare and out of private practice, and it is encouraging too much waste and too many unnecessary procedures within Medicare.

As chairman of the Health Subcommittee of Ways and Means, my top priority has been to find a permanent, reliable 21st century solution that both political parties and physicians can embrace.

□ 1000

H.R. 4015 repeals the current flawed formula for reimbursing our doctors, and it ends the yearly threat of massive cuts.

In working with America's physicians, it establishes a more patient-centered approach that provides stability to our doctors, rewards them for high-quality care, begins to streamline the red tape our physicians face, and encourages better coordination and prevention. Over time, it transitions to a model that rewards value over volume by using the real-life approaches that doctors use, not what Washington wants.

H.R. 4015 is a solid foundation from which to build an even better Medicare system, and it has overwhelming support from physicians. This is a major step forward, but we need to finish the job. We need to work together—Republicans and Democrats, the House and the Senate—to figure out how to make this policy a reality in a way that doesn't increase the deficit.

There may be disagreements over how to pay for this reform. That is understandable as it is difficult, and today's bill is not the last word. Let's continue to advance this long overdue solution and commit to finding a bipartisan solution between the House and the Senate. The clock is ticking, so let's act together today.

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

Mr. LEVIN. Mr. Speaker, it is now my pleasure to yield 2 minutes to the gentleman from New York (Mr. RANGEL).

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

Mr. RANGEL. Thank you, Chairman LEVIN.

Mr. Speaker, this bill has nothing to do with paying the doctors who work every day in giving medical care to Medicare patients. It has to do with destroying the Affordable Care Act for the 51st time.

I am certain that those who are listening to the debate and who know what is going on believe it is ridiculous to try to defeat a bill that has been signed into law, because they know that the Senate is not going to pass it, and they know—the Republicans, that is—that the President would veto it.

So why do they do it?

They do it because there is a small group of people in the Republican Party that doesn't mind politically dying. I don't mind their taking down the party if that is their intent, but they are taking down the Democrats and the reputations of the House of Representatives as well. Somewhere along the line, the Speaker has to do again what he has done before, and that is to say, ''Enough of this. We are not going to allow the wings of the Congress to be broken on one side just because some people want their way.''

So I assume that nobody in these districts has insurance problems. I assume that everyone is insured and is working in these districts in which they are trying to destroy the Affordable Care Act and that they don't have any preconditions that restrict them from getting health care. They all are working and they all are happy. I just hope that, one day before this year ends, the Republicans will come to their senses and will try to gain the respectability and the credibility that they once enjoyed.

I am a die-hard Democrat, but I don't want this country just to have one party. We do need two responsible parties in order to guide this Nation through its democratic process.

Mr. BRADY of Texas. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Louisiana (Mr. BOUSTANY), a physician and a key member of the Ways and Means Committee. I cannot describe how much of an important role he has played in finding this new solution to how we reimburse doctors under Medicare.

Mr. BOUSTANY. I applaud Chairman BRADY's leadership on this issue. He has been instrumental in getting us to this point.

Mr. Speaker, I rise in support of this bill after 3 long years of working on the policy to actually get to a bipartisan, bicameral agreement on policy and divided government. It has not been easy, but we have managed to get an agreement on a policy to repeal automatic annual cuts to physicians. A 24 percent cut in just a matter of weeks is facing doctors under this flawed formula.

Now, Congress first promised to repeal this formula more than a decade ago. Democrats repeated the promise when we were debating ObamaCare. They failed to put it in there. They failed to address it in ObamaCare. The passage of this important bipartisan legislation would finally honor that promise, that of protecting seniors' access to doctors. A doctor-patient relationship is built on trust and high quality. It ensures quality measures going forward, and it creates certainty for physicians and seniors.

I want to point out something because our friends have not given the full story here.

We have agreed on the policy, but we have a problem in coming up with the pay-fors. It is a tough conversation, but the talks have broken down in a divided government. Senate leadership has refused to negotiate in good faith and to discuss responsible ways to pay for the bill's $138 billion price tag. We are going to pass this bill to get those discussions started. Republicans proposed savings from the delay of ObamaCare's very unpopular individual mandate.

Now, I don't think it is acceptable to do nothing, and I don't think it is acceptable for the Senate Majority Leader and others in the Senate to just put their heads in the sand on this. I hope that the Senate will pass a version of H.R. 4015, giving us time to get together to hash out the differences. We are so close. We are on the goal line in this work that has been undone for years. It is time to get it done.

The President's own budget lists bipartisan Medicare reforms that the President put on the table that could

easily raise the bulk of savings needed to repeal the SGR, and we could do this without shifting more costs to our Nation's credit card and without resorting to budget gimmicks or by imposing massive new cuts on hospitals and other providers. We have a clear path. We can get this done in a bipartisan way.

Mr. Speaker, as a heart surgeon who has cared for thousands of seniors under the Medicare program, I urge my House and Senate colleagues to pass this bill. Let's get down to the negotiations of how we are going to pay for it in good faith, and let's finalize an agreement on how to fix this longstanding problem, which has been a thorn not only in the sides of doctors but which has been a real problem for Medicare access, a real problem for seniors seeking access to a high-quality doctor-patient relationship.

Mr. Speaker, I have had enough. It is time to get this done. Pass this bill.

Mr. LEVIN. Mr. Speaker, I yield myself 15 seconds.

I say to my colleague that what you are doing, essentially, is undercutting bipartisanship with pure partisan politics. Pointing to the Senate is pure mythology.

I now yield 3 minutes to the gentleman from Washington (Mr. MCDERMOTT), the ranking member on the Health Subcommittee.

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

Mr. MCDERMOTT. Mr. Speaker, this 51st attempt to repeal the ACA by stopping the individual mandate is part of the long-term propaganda campaign done by the Republicans to destroy the health care plan that the President put together.

They know that we agree on the policy—everybody here agrees on the policy—but they put a poison pill in it. They knew that this amendment of how to pay for it—that is, by delaying the mandate—would kill any Democratic support in the House. They have no intention of passing this bill. This bill is directed at the propaganda campaign to the people at Koch Brothers and at FOX News so that anybody who is watching this will get the idea that somehow it is a bad bill.

The fact is that people are benefiting every single day. The AARP and the American Medical Association have denounced this bill because they want the SGR—the doctors' payment reform—to go through, and they know that the Republicans have designed this to fail.

A mandate that has been supported even by the Tea Party—before the Tea Party said ''we have got to be against it''—is what is at issue here. Doctors and health insurance companies will not be able to operate if you don't have an individual mandate. The Republicans said this. The Heritage Institute said it. Everybody said it, but they want to kill it.

This is an alternative universe that we are creating with this propaganda campaign. We see wild claims about people who live in inner cities in that they are somehow worthless and that they don't want to take care of their families and feed them, and we hear things coming out of the Speaker's office that clearly aren't true about the ACA.

Let's suppose that actually happened. What would happen if we repealed and destroyed the ACA today?

We would get rid of 13 million people on the rolls by 2018. We would take away health insurance. Health insurance premiums would rise 10 to 20 percent by 2018. Millions of Americans would not be able to afford the health care they need.

This is a failure of leadership. They would rather run a propaganda campaign to hold onto the House. We watched in Florida just in the last week when $13 million, I guess, was spent on that campaign to tar the Affordable Care Act. That is what this is all about. No one should be the least bit confused. That is not what America wants. America wants health security.

Vote ''no'' on this bill.

Mr. BRADY of Texas. Mr. Speaker, I am really pleased to yield 3 minutes to the gentleman from Pennsylvania (Mr. KELLY), a gentleman who is one of the newest members of the Ways and Means Committee. He is a businessman, but he is a real fighter for Pennsylvania's seniors and doctors.

Mr. KELLY of Pennsylvania. I thank the gentleman.

Mr. Speaker, there are very few times in my life in which I have really had the privilege of representing people who are so dear to me. I just think, if you were to look at our generation, we would all have to agree that we grew up in the greatest towns, at the greatest times, with the greatest parents, preachers, teachers, and coaches, grandmas and grandpas, and aunts and uncles.

This is the people's House. This is not a Republican House or a Democrat House. This is the people's House. What are we talking about today?

My goodness. This is so disappointing that we are so worried about the next election that we can't see the direction that we are going in—to be able to offer peace of mind to those folks who have made the greatest sacrifices, who have made the greatest contributions, and who have done the best that they could to make sure that the next generation had the same opportunities they had.

This is not a doc fix. This is a senior fix.

As my mother lay dying and my sister and my father, they were surrounded by a loving family, and they were also surrounded by caring doctors. Why would we make this about an election? Why would we not look inward to whom it is we are trying to protect? Why can we not protect the most vulnerable in our society right now, especially in their end days and in their end times and say, ''You can lay your head on a pillow tonight, knowing that your doctor is going to be there for you, that I will be beside you, that I will be by your bed, saying the rosary; and when you have finally gone, I can't wait until the next time we are able to meet each other again in Heaven''? Why would we make their last days so difficult? Why would we make it so uncertain?

So we talk about an SGR, but where I come from, it is not bad, and it is not a doc fix—it is a senior fix.

When can we possibly put politics behind us and start to look at what is best for the people we represent?

I am a Representative of Pennsylvania's Third District—so privileged and so proud to be able to do it, not boastful proud, but thankful proud that I can actually go and do something for the people who raised me, who taught me, who coached me, and who have walked me through the most difficult parts of my life and that I can look back at their lives and say, ''But you sacrificed so much that I could be here.''

Can we not just come together and do something that really is a big thank-you and a kiss on the forehead as they lay there, wondering, ''Where are those folks that we did so much for?''

My goodness. My friends on the other side, this is not about politics—this is about people. We are in the people's House, and these are things that we must do.

Mr. Chairman, I thank you so much for doing this and for bringing peace of mind to the people we represent, but I can't tell you how disappointing it is today to hear this turn into some kind of political debate that has nothing to do with the fate of those seniors and of those people whom we love so much and who have done so much for us.

Mr. LEVIN. Mr. Speaker, I yield myself 15 seconds.

I say to the gentleman from Pennsylvania that the problem is your bill is nothing but a political bill. It is nothing except about the November election—nothing but.

I now yield 2 minutes to the gentleman from Oregon (Mr. BLUMENAUER), an active, distinguished member of our committee.

□ 1015

Mr. BLUMENAUER. Thank you, Mr. LEVIN.

I was somewhat embarrassed by the remarks of my friend, who is from Butler, Pennsylvania, the hometown of my wife, because it is the Republicans who have decided to make this bill about the next election.

There is no reason the House Republicans put the medical community through this charade again and again, year after year, except to use the SGR as a tool for power, partisan advantage, and fundraising.

This political tool disrupts the lives of millions of medical providers and tens of millions of their patients who rely upon them.

We had, in fact, been making remarkable progress in both the Commerce Committee and the Ways and Means Committee on a bipartisan solution. Instead, the Republicans have hijacked this bipartisan solution and made it so bad that even the American Medical Association rejects it.

What then should we do? First, we should reject this bill overwhelmingly. It certainly will never be enacted into law.

What should we do then? I would argue that we ought to just reset the baseline.

Remember the alternative minimum tax? We finally decided it would never be imposed. Adjusted the budget to reflect the fact that it will never happen. And if you won't do that, at least give the medical community procedural fairness.

KEVIN BRADY said, Let's work in a bipartisan approach. He admits that this isn't going to be the last word. Well, let's try procedural fairness. Allow the bipartisan proposal on the floor under an open rule for a full debate and amendment.

Now there is a novel thought. Let the legislative process work and let the House work its will. Then this shameful charade will end.

Mr. BRADY of Texas. Mr. Speaker, may I inquire how much time is remaining?

The SPEAKER pro tempore. Each side has 5 minutes remaining.

Mr. BRADY of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. REED), one of our key members of the Ways and Means Committee, who has brought the concerns of New York doctors to our attention.

Mr. REED. I thank Chairman BRADY for yielding the time.

Mr. Speaker, I rise today to talk about the very important issue that this bill is here to address. We have at the end of the month a cliff where our providers under Medicare are going to be looking at a 24 percent cut in their reimbursements for caring for our seniors.

What are we doing today? The other side is engaging in political theater rather than deal with the issue at hand.

We have an opportunity, Mr. Speaker, to fix a problem out of Washington, D.C., that has repeatedly been coming up since 2003—and do it on a long-term, permanent basis. We have spent $150 billion in minor patches to the doc fix over that period of time.

Today, we have an opportunity—through the bipartisan work on the policy that will resolve this issue once and for all—to do it at a cost of $138 billion. That would take care of this threat to our seniors and to the doctors that are providing for them on a permanent basis. That is the right thing to do.

So what is the argument over? Well, how we are going to pay for it?

My friends in the other Chamber on the other side of this esteemed building here feel we should continue the status quo of Washington, D.C., and not pay for our policy decisions that we decide here in Washington.

We have put forth a proposed solution on this side of the aisle to say, Look, let's take what you are doing to the employer mandate under the Affordable Care Act by extending a delay for the employer mandate that they have already done for the White House to the individuals who are subject to the Affordable Care Act.

Doesn't that make sense? Isn't that the fair thing to do? Isn't that the right thing to do?

If you are going to delay it for Big Business, why don't you delay it for moms and pops and sons and daughters across America and use that money in savings to pay for a permanent solution here in Washington, D.C., when it comes to paying for our doctors as they care for our elderly and our seniors?

That is a commonsense proposal, and yet we play political theater on this important issue. We can't do that. Our hardworking taxpayers back home, Mr. Speaker, deserve better.

I came here to Washington, D.C., to do something: to change the status quo. We have an opportunity to take an issue that has been pending ad nauseam since 2003 and get it taken care of permanently and give that certainty, that ability for our providers, for our seniors, to know what they are going to get paid and to make sure that our seniors have the comfort of knowing that their doctors are going to have their doors open to take care of them when they need them the most. That is what we should be focusing on, Mr. Speaker.

I encourage my colleagues to support this legislation and get this permanent solution in place.

Mr. LEVIN. I yield 1½ minutes to the gentleman from New Jersey (Mr. PASCRELL), a member of our committee.

Mr. PASCRELL. Mr. Speaker, to quote a very famous President:

There they go again.

This is an alternative universe, through the Speaker, that you are trying to create.

For years, we have been talking about how to reform SGR and how to pay for our Medicare providers. I, along with my Democratic colleagues—and some Republicans—supported past efforts to repeal and replace SGR once and for all, but we have never been able to get it done.

That changed late last year. The Energy and Commerce Committee passed unanimously a bill to repeal and replace SGR. Building on that proposal, Republicans and Democrats on the Senate Finance Committee and in the Ways and Means Committee here, which I sit on, came together and passed the bill that repeals SGR and replaces it with a payment system that rewards providers for delivering quality care to our seniors.

What you have done, through the Speaker, is to take months of thoughtful bipartisan policymaking and thrown it away in order to score some really poor and cheap political points. All you are trying to do is undermine affordable care.

What are you going to do with the 13 million people who can't get affordable care if we delay the personal mandate? You have never come up with an answer. You have never had an answer to what are you going to do about health care. All you can do is criticize and criticize.

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

Mr. LEVIN. I yield the gentleman an additional 30 seconds.

Mr. PASCRELL. Delaying the individual mandate will result in 13 million fewer Americans getting health insurance through the ACA and higher premiums for those with health insurance.

You want it to fail. You don't want it to succeed. You forgot what you did back 9 years ago when we passed the premium D. We went back to our districts and made it work, even though we voted against it. That is the American way.

Learn the American way. It works. Don't go on recess.

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

The SPEAKER pro tempore. The Chair would ask Members to address their remarks to the Chair and not to others in the second person.

Mr. LEVIN. Mr. Speaker, I yield 1 minute to the gentleman from Minnesota (Mr. NOLAN).

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

Mr. NOLAN. Mr. Speaker, I rise in support of my colleague DAN KILDEE's efforts to reinstate the health care tax credit. Unfortunately, it was rejected by the House Republicans under yet another closed rule.

Having served in this Congress at an earlier time in my life, I am astonished how undemocratic this institution has become. Back in the day, if you had an amendment, you got an opportunity to offer it. You had an opportunity to debate it until all the debate was exhausted and then you had an opportunity to vote on it. What a tragedy that the people's House seems to hardly be a democratic institution any longer.

When this program that I am talking about here, the health care tax credit, expired in January, thousands of retired workers on the Iron Range in my district of Minnesota saw their pensions cut in half. These are former employees of companies like LTV and National Steel—giants in American manufacturing. Some of these hardworking men and women are responsible for pulling America out of the Great Depression, helping us win World War II, supplying the world with superior products made in America.

Mr. Speaker, let us have a vote. Let's start opening up the rules in this Chamber.

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

Mr. LEVIN. It is now my pleasure to yield 1 minute to the gentlelady from California (Ms. PELOSI), our very distinguished leader.

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding, and I thank him for his relentless and persistent leadership in helping America's seniors, today manifested in his support for the SGR and his opposition to this ill-designed approach by the Republicans.

Mr. Speaker, today, House Republicans are proving that their obsession with tearing down the Affordable Care Act is blurring their vision and that it has no boundaries.

For their 51st vote to repeal or undermine the Affordable Care Act, Republicans are turning their partisanship against the health and security of our Nation's seniors.

The House Republican leadership's political games are threatening to derail months of bipartisan, bicameral—House and Senate—progress on a permanent Medicare doc fix, threatening our seniors' ability to see their doctors and get the health care they need.

Earlier this week, the AARP, the National Committee to Preserve Social Security and Medicare, the National Council on Aging, and other key seniors' advocacy groups wrote to congressional leadership to make it clear that the Republicans' actions would ''inject partisan politics into bipartisan legislation,'' and that this ''undermines the months of hard work done by committees, their staffs, and concerned stakeholders.''

The Republicans' approach has been rejected not only by the senior advocacy groups but by providers, doctors, insurers, and seniors. Yet they persist with their reckless partisan antics even as time quickly runs down to address the sustainable growth rate formula before the end of the month.

Twice this week, Republicans blocked the House from considering a fully paid-for measure that includes the reforms to the SGR supported by both Democrats and Republicans in the House and in the Senate and on the committees.

Why have Republicans chosen to proceed in this manner after months of bipartisan progress? Why didn't Republican leadership work with Democrats to find acceptable offsets? We need to get this done—and Republicans know that their badly partisan effort is a nonstarter.

If passed, it would spike health insurance premiums by 10 to 20 percent, according to the Congressional Budget Office. It would cause 13 million fewer Americans to be insured, says the Congressional Budget Office.

What does this mean to families? If you have a child in your family between the ages of 18 and 26, they would no longer be able to be on their parents' policy. Under the Affordable Care Act, being a woman is no longer a preexisting medical condition. The Republican actions here today would reverse that and take us back to a time where women paid more for policies simply because they were women.

It would, again, reject, eliminate the very important provision of the Affordable Care Act about not being denied coverage because you have a preexisting medical condition. Tens of millions of families—probably a hundred million people—are affected by not being denied coverage because of a preexisting medical condition. That is how many people it would affect.

□ 1030

It would eliminate the requirement of the Affordable Care Act that there be no cap, either annual or lifetime limit, on the health insurance that you would receive. For these and other reasons, this is a really bad idea.

We may only hope that, after this 51st vote, Republicans' fever will break, and they will return to work with Democrats to pass bipartisan, bicameral legislation as a permanent doc fix that seniors need before the end of the month.

We are going out today, again, with work undone; 10 days before we come back the 24th of March. The SGR expires at the end of March.

We shouldn't be wasting time on this foolishness and recklessness. We should be finding a solution. That is what the American people sent us here to do.

The Republican fixation with destroying the health security of millions of Americans through their efforts to destroy the Affordable Care Act imperil the permanent ''doc fix,'' and that must stop.

Congress is wasting time again, as I said, on these endless, wasteful votes. Time should be spent renewing emergency unemployment insurance, raising the minimum wage, rebuilding America by investing in education and building our infrastructure, creating jobs.

The American people deserve better than this. They deserve a Congress that works to strengthen the middle class, tackle the opportunity gap, create jobs, and build an economy that works for everyone.

I urge my colleagues to vote against this bill, and I hope that when we return after the recess week, yet another recess week, Republicans will be ready to get serious and be ready to get back to work for a permanent doc fix so that our seniors will be served.

The SPEAKER pro tempore. The gentleman from Texas (Mr. BRADY) has 2 minutes, and the gentleman from Michigan (Mr. LEVIN) has 1 minute remaining.

Mr. BRADY of Texas. Mr. Speaker, I am prepared to close.

Mr. LEVIN. Mr. Speaker, I yield myself the balance of my time.

I will place into the RECORD the following letters from American Health Insurance Plans, Blue Cross Blue Shield, the California Medical Association, from AFSCME, and also from the Alliance for Retired Americans. These are just a few of the examples of letters and communications from opponents.

You know, you can just boil this down to a few words. The Republicans are so intent on manipulating everything so that they think they can strengthen themselves for November that they put a poison pill into a bipartisan product, a product that we worked months to perfect.

So there is no shame. March is irrelevant; November seems to be everything.

This bill cannot become law. This is an effort simply of a political nature.

I very much urge you, at this last minute, rethink what you are doing. It is so transparent. It is so transparent.

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

MARCH 11, 2014.

Hon. JOHN BOEHNER,
*Speaker, House of Representatives,*
*Washington, DC.*
Hon. NANCY PELOSI,
*House Democratic Leader, House of Representatives*
*Washington, DC.*

DEAR SPEAKER BOEHNER AND LEADER PELOSI: On behalf of America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA), we are writing to express our strong opposition to repealing or delaying the Affordable Care Act's (ACA) individual mandate as part of the Medicare physician payment reform bill.

Our members believe it is critically important to modernize the Medicare physician payment system to promote improvements in quality, value, and patient outcomes. However, we have deep concerns about packaging the Medicare physician payment bill with legislation that would sever the link between the ACA's individual mandate and its market reforms. The experience of states that attempted this in the 1990s demonstrates that removing this important linkage will result in more uninsured Americans, higher costs, and reduced choices for individuals and families. To avoid these outcomes, we are asking Congress to reject efforts to repeal or delay the individual mandate in the debate on Medicare physician payment reform.

Thank you for considering our views on these important issues.

Sincerely,

KAREN IGNAGNI,
*President and CEO,*
*America's Health Insurance Plans.*
SCOTT P. SEROTA,
*President and CEO,*
*BlueCross BlueShield Association.*

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AFSCME,
*Washington, DC, March 11, 2014.*

DEAR REPRESENTATIVES: On behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME), I write with regret to oppose legislation which reforms physician payments under Medicare (H.R. 4015). AFSCME strongly supports repealing and replacing the flawed Medicare payments system for physicians. However, we oppose this bill because it pays for the needed reforms by robbing seniors and millions of families of the peace of mind that comes from having affordable health care insurance.

For decades, Congress has had an annual ritual of blocking a scheduled cut to physicians' Medicare reimbursement payments as

required under the Sustainable Growth Rate. Each time Congress has approved a short-term relief for the scheduled cut to physicians' Medicare payments, it has increased beneficiaries' Part B premiums. Congress should reform Medicare payments for doctors, but it should hold seniors harmless and not undermine the Affordable Care Act (ACA) in the process.

The bill delays the individual mandate in the ACA. This will hurt families trying to get affordable health coverage through the health care exchanges in their states. H.R. 4015 threatens important consumer protections. The ACA prohibits denying coverage due to a pre-existing condition, charging individuals more for coverage based on health status and dropping coverage if an individual becomes ill. Without a required duty that the uninsured must get coverage, these consumer protections become harder to sustain.

Medicare is a huge success story because it shares the cost from unexpected illness and injury among a large group of healthy and less healthy seniors. Like Medicare, the ACA depends on a good balance of young and healthy individuals along with older and sicker individuals. The required duty to obtain coverage will drive more of the uninsured (including the young and healthy) to seek information about the ACA. When they do, they will discover that good quality, affordable coverage is available to them at last. The so-called savings from delaying the individual mandate creates an imbalance in the population covered. This leads to higher costs for everybody in the exchange.

By the end of February, four million individuals had obtained private insurance coverage through the federal and state exchanges. Every day, more families are gaining the peace of mind that comes with comprehensive and affordable health coverage. We urge you to oppose H.R. 4015 so that more families can realize that peace of mind.

Sincerely,

CHARLES M. LOVELESS,
*Director of Government Affairs.*

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CALIFORNIA MEDICAL ASSOCIATION,
*Washington, DC, March 10, 2014.*

Re H.R. 4015 ''The SGR Repeal and Medicare Modernization Act of 2014''

Hon. JOHN BOEHNER,
*Speaker, House of Representatives, Washington, DC.*
Hon. NANCY PELOSI,
*Minority Leader, House of Representatives, Washington, DC.*

CMA POSITION: SUPPORT THE POLICY; OPPOSE THE OFFSET AS A NON-VIABLE, BICAMERAL OPTION

DEAR SPEAKER BOEHNER AND LEADER PELOSI: On behalf of the California Medical Association, I want to express our strong support for the hard-fought and long-awaited Medicare SGR reform POLICY in the bipartisan and bicameral legislation, H.R. 4015 ''The SGR Repeal and Medicare Modernization Act of 2014.'' We applaud the work and the perseverance of the House and Senate Committees to achieve a bipartisan agreement to repeal the flawed Medicare SGR and institute a reasonable new payment system. Congress has not made this much progress in a decade.

While we share the frustration that there is not a clear legislative path for bipartisan funding offsets, we are extremely disappointed with the recent decision to pursue a partisan funding source—the repeal of the ACA's individual mandate. Regardless of our position on the ACA, this is not an acceptable, viable funding option in the U.S. Senate. And therefore, it could result in another 9-month patch which is simply unacceptable to California physicians.

Congress' failure to address this issue has harmed access to care for all patients in California. It has forced California physicians out of Medicare and some out of practice. Medicare rates lag 25% behind the costs to provide care. It has stifled innovation and left small practices without the resources to invest in quality and electronic health records. The cost of a decade of short-term patches total $153 billion—more than the cost to adopt this legislation. Even the Wall Street Journal has called the SGR budgeting a ''sham'' and called upon Congress to ''simply pass the bill as is and forgo the pretense of fake-paying for it.''

We strongly urge Congress to build on the bipartisan, bicameral process for finalizing this important legislation. We urge a negotiation on bipartisan funding sources before March 31.

Sincerely,

RICHARD E. THORP, MD,
*President.*

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ALLIANCE FOR RETIRED AMERICANS,
*Washington, DC, March 13, 2014.*

DEAR REPRESENTATIVE: On behalf of the four million members of the Alliance for Retired Americans, I am writing to oppose the passage of H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act. While the February 2014 agreement reached by the House and Senate to fix the sustainable growth rate formula in Medicare's physician reimbursement was bicameral and bipartisan, this legislation is not.

This legislation turns its back on a good faith agreement by including an irresponsible pay-for. Under this egregious proposal, doctors would be paid on the backs of uninsured Americans. This is simply unacceptable. To add insult to injury, the legislation permanently fixes SGR and provides a 0.5 percent update for doctors, but does not permanently extend the Qualified Individual (QI) program, an extender that always accompanies the SGR patch.

The QI program pays the monthly Medicare Part B premiums for seniors and individuals with disabilities who have incomes of 120% to 135% of the Federal Poverty Level (FPL)—about $13,700 to $15,300 for an individual—and assets no higher than $7,080 for an individual. It is disturbing to us that the authors of this proposal found money to provide an update for physicians, who on average make upwards of $200,000 per year, but not for low-income Medicare beneficiaries.

The Alliance for Retired Americans is supportive of fixing Medicare's physician payment formula and stands ready to work with Congress to come up with an acceptable offset. Financing options could include using the Overseas Contingency Operations (OCO) funds or the Medicare Drug Discount Act, which would save the government $141 billion over ten years. These options would cover the permanent fix without shifting costs on to Medicare beneficiaries.

However, as it currently stands, we cannot support this legislation that slams uninsured Americans. We urge you to oppose H.R. 4015.

Sincerely,

RICHARD J. FIESTA,
*Executive Director.*

Mr. BRADY of Texas. Mr. Speaker, I yield myself the balance of my time.

First, I want to commend and thank our Democrat colleagues on the Ways and Means Committee and the staff for working so hard, along with Energy and Commerce and the Finance Committee in the Senate, to find a good, solid solution. I think we have made a big step forward. We have got some work to do. I know we can do it.

I went to see my doctor the other week. He is 66 years old, looks like he is 46; kind of makes me mad. But he has got a successful practice, a very good doctor.

He told me he would like to keep practicing for another 5 or 6 years, and he said: But KEVIN, I am not going to. This will probably be my last year. Medicare has just made it too hard for him to stay this practice.

As I left the examining room, I looked at his assistant who has been with him 30-some years, all his professional staff, a full waiting room, and I thought, what are we doing chasing a doctor like this out of practice early? Who is going to replace him? Who is going to take care of these people?

He is not alone. In Texas, less than half of Texas family physicians take new Medicare patients. Many of them are rethinking their relationship with Medicare. Others are closing their private practices. So more and more seniors are chasing fewer and fewer doctors, and that is the dilemma we face today.

Maybe I am an optimist, but I think we are 90 percent of the way toward solving this solution. We have broad support for this policy and this bill.

We have a duty to make sure our seniors have access to their doctors, and Democrats and Republicans have been putting in a lot of work to solve this problem. Yeah, we have some work to do.

Now is the time to permanently fix the way we reimburse our doctors. As we move forward, let's work in a bipartisan way, across the Chambers, across the parties to get it done. I am absolutely confident we can do that.

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

Mr. HOLT. Mr. Speaker, I rise in opposition to H.R. 4015, a transparently phony attempt to fix the flawed Medicare payment system.

For 17 years, we have neglected to address the erring formula by which we compensate Medicare physicians. By repealing and replacing the inadequate Sustainable Growth Rate, we have the power to improve Medicare for our seniors and more fairly reimburse their health care providers.

Today's vote should be about redesigning the Medicare payment structure so that we reward physicians for the quality of health care provided, not the quantity of procedures performed. We should be considering how to transform our health care system to one that encourages value driven care and incentivizes the coordination of critical services to meet the needs of our aging population.

But today's vote is not a sincere effort to improve the delivery of care for the nearly 50 million seniors and people with disabilities who rely on Medicare. In fact, today's vote is yet another attempt to destabilize the private health insurance market and subvert the Affordable Care Act. The Republicans have presented a false choice between jeopardizing access to care for our seniors, or dangerously

increasing the cost of health care for all Americans by delaying the Affordable Care Act's individual responsibility provision. Make no mistake: shifting access to affordable health insurance farther and farther out of reach for millions of Americans is not an ''offset''— it is a scandal.

While I support the underlying attempt to replace the Sustainable Growth Rate, I cannot in good conscience vote for this bill because this ''fix'' creates far more problems than it solves.

Mr. HONDA. Mr. Speaker, I rise today in opposition to the version of H.R. 4015 that Republican leadership has brought to the floor of the House.

The Balanced Budget Act of 1997 created SGR in an attempt to control spending in the Medicare program, and it was adopted for TRICARE as well. For years, this methodology has consistently produced unrealistic expenditure targets. These targets trigger untenable reductions in payment rates to doctors providing services to Medicare patients.

As a result, Congress has buried the true cost of this policy through annual Congressional overrides of these scheduled cuts. Each of these short-term ''fixes'' has achieved the important goal of averting an immediate crisis in access to physicians for Medicare beneficiaries, but has exacerbated a longer-term crisis in Medicare financing.

Continued short term patches create instability in the health care system and the economy as a whole. Doctors have been hamstrung by yearly doubt about what reimbursement rates will be, and patients have had to pay the eventual price in uneven, substandard quality of care.

The SGR needs to be repealed and the Medicare payment system needs to be reformed now. To accomplish this, I signed on as a co-sponsor of the original version of the bipartisan bill H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014.

H.R. 4015 proposes five years of 0.5% payment increases for the Medicare physician fee schedule before freezing payments at that level for five additional years. It also supports alternative payment models, and creates a new Merit-Based Incentive Payment System (MIPS) for those who stay on the fee-for-service payment model.

Despite months of bipartisan work to forge this compromise, House Republicans amended the bill to delay the individual mandate requirement in the Affordable Care Act. This unconscionable political stunt to undermine the Affordable Care Act puts our Medicare health system in jeopardy at a critical time, with payment rates set to drop dramatically on April 1, 2014.

I am committed to reforming our Medicare system and repealing the SGR, but the bill House Republican leadership brought to the House floor fails to strengthen Medicare, or help Americans get access to affordable health care. I cannot support the flawed amended version of the bill.

Medicare has guaranteed essential health protections to seniors and certain disabled persons for nearly four decades. I believe Medicare is more than just a program, it is a covenant that exists between the government and the American people.

I support fixing and reforming this system permanently, but H.R. 4015 as amended is not the way to do that, and so I urge my colleagues to oppose this bill.

Ms. SCHWARTZ. Mr. Speaker, I rise today in opposition of H.R. 4015, legislation Republicans have introduced to gut the Affordable Care Act to pay for a bipartisan, bicameral agreement to repeal Medicare's broken Sustainable Growth Rate (SGR) formula.

For months, we have worked in a bipartisan, good-faith effort to develop a permanent solution for Medicare's physician payment system that has threatened seniors' access to care for more than a decade. In February 2013, I introduced the bipartisan Medicare Physician Payment Innovation Act (H.R. 574) with Rep. JOE HECK (R–NV) to repeal the SGR and set out a clear path toward comprehensive reforms of Medicare payment and delivery systems. Last month, three committees, including Ways and Means, on which I serve, announced a bipartisan, bicameral agreement that incorporates the overarching framework of my legislation and includes several specific provisions.

Finding common ground on a responsible way to pay for a permanent SGR fix was never going to be easy, but that does not mean it should be used to score political points. Seniors must have access to their doctors and time is running out. I strongly urge Republicans to join Democrats to act on this significant bipartisan opportunity to enact a permanent solution that provides more security and certainty for seniors and their doctors.

Mr. COURTNEY. Mr. Speaker, I regret that I cannot be present for today's session, as I am joining Admiral Mike Connor, Commander of our nation's submarine forces, on a visit to an in-service Virginia class submarine to see firsthand the skill of our submariners and the vital role they play in our nation's defense. It will also give me a chance to review and discuss the Navy's FY 15 request for Virginia class submarine construction and the Ohio Class Replacement Program, critical issues for the Second District of Connecticut. Had I been present, however, I would have voted ''no'' on the SGR Repeal and Medicare Provider Payment Modernization Act (H.R. 4015).

For too long, the sustainable growth rate (SGR) formula has created a weight of uncertainty not only for Medicare beneficiaries and veterans, but more broadly throughout our health care system. For the past decade, health care providers from around the country have had to leave their practices to travel to Washington and ask for relief from SGR's automatic rescission. This is not right. It is counterproductive and wasteful. And, a permanent fix—which I strongly support and have worked on a bipartisan basis to achieve—is long overdue.

Committee efforts in the House and Senate to repeal the SGR formula permanently have been a bipartisan, bicameral bright spot in the 113th Congress. Unfortunately, the injection of a partisan fiscal offset into H.R. 4015 has decimated previous, widespread endorsements of the proposal, now generating opposition from the American Medical Association (AMA) and the American Association of Retired People (AARP). The White House has also announced that if President Obama were presented with this measure, he would veto it. As amended, I too cannot support H.R. 4015 and had I been present for the vote on the legislation, I would have voted ''no.''

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in support of legislation to repeal the Sustainable Growth Rate and update Medicare's payment system without the amendment to undermine the individual mandate of the Affordable Care Act.

While there are positive provisions in H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014, an amendment added by Chairman DAVE CAMP would delay the Affordable Care Act's individual mandate by five years.

Commonly referred to as the ''doc fix,'' SGR Repeal has been on the table since the beginning of this Congress and desperately requires action. This legislation would repeal the cuts to physician Medicare payments and allow for small increases over 10 years. The second part of this legislation would make MEDPAC and GAO report more to Congress, including new payment rules that became final this year. There would also be additional protections against Medicare fraud.

However, if this legislation passes with the Camp Amendment, the 5-year delay of the individual mandate provision will increase the number of uninsured Americans by 13 million in 2018. A CBO analysis said that premiums would likely increase 10–20 percent in the individual marketplace during the years without a mandate penalty.

I urge my colleagues to heed my warning about this new effort to undermine the Affordable Care Act.

Ms. JACKSON LEE. Mr. Speaker, I rise to speak in strong opposition to H.R. 4015, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 because of the passage of the Rule to this bill.

I am not alone in opposing this irresponsible measure. I am joined by AARP, Alliance for Retired Americans, American Academy of Family Physicians, American Geriatrics Society, American Osteopathic Association, Center for Medicare Advocacy, Inc., Families USA, Medicare Rights Center, National Committee to Preserve Social Security and Medicare, National Association of Area Agencies on Aging, and the National Council on Aging.

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

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

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

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

As with any business, medical clinics and physician offices have payrolls to meet, bills to pay, and expenses to meet as they become due. If revenues are not sufficient to cover costs, the business will not long survive.

Thus, it is critical that we not disrupt timely and adequate payment to Medicare providers, but that is exactly what will happen at the end of this month if the SGR is not approved by the House and the Senate and signed into law by President Obama.

The problem with H.R. 4015 is what happened when the Rule for this bill passed the House.

The rule for H.R. 4015 added language that would delay the Affordable Care Act's implementation of the individual mandate.

I oppose the bill for two reasons:

It corrupts what was a strongly supported bipartisan bill to sustain physician reimbursement rates for medical services approved under Medicare, and

It is another attempt by the Republicans to mislead the public regarding the Affordable Care Act.

I know that many predicted that the Affordable Care Act would cause havoc on the nation's health care system. But it is not the ACA that is causing havoc—it is the 50 desperate but futile attempts by the Tea Party to scuttle a law that has been passed by Congress, signed by the President, upheld by the Supreme Court.

The most threatening actions to our nation's healthcare system by Tea Party Republicans are their attacks on Medicare.

In 2014, according to the Kaiser Foundation 16 percent of the nation's people have medical insurance under Medicare:

Texas has 12 percent of its residents insured under Medicare;

Arkansas, Florida and Vermont have 19 percent of their residents insured under Medicare;

West Virginia and Maine have 21 percent of their residents insured under Medicare; and

Kentucky, Mississippi, Missouri, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Wisconsin, Ohio, Oklahoma, and Oregon have 18 percent of their residents insured under Medicare.

Every state has more than 10 percent of their residents insured by Medicare.

The uncertainly created by the majority regarding Medicare reimbursement over the last several years has forced physicians to re-evaluate continuing their medical practice and frustrated hospitals working to make budget projections over several years into the future—this is critical to business decision making.

Because of uncertainty created by Medicare physician reimbursement—physicians and hospitals have been forced to close their offices, reduce services, or merge.

When patients find they cannot keep their physician or that their options for health care are being affected—it is not because of the Affordable Care Act.

Our nation has taken a momentous step in creating a mindset that good health is a personal responsibility with the enactment of the Affordable Care Act. The health care law did not automatically enroll all citizens into the program; it was specifically designed to be an opt-in process.

There are tens of thousands of visitors each day to the website and despite problems with the initial rollout of the online health insurance registration process, millions have enrolled and experience the peace of mind that comes from having affordable, high quality health insurance that is there when you need it.

So it is puzzling that with less than 70 legislative days remaining in the Second Session of the 113th Congress, we are still seeing attempts to end the Affordable Care Act.

It is very troubling that a bill critical to the provision of payments to physicians that treat Medicare patients is not safe from the partisan political games of the House of Republicans.

The House should be considering legislation to address the most pressing needs of the American people. Today, we should be debating legislation to extend emergency unemployment insurance benefits. The House should be debating a jobs creation bill to put Americans who are seeking employment back to work.

We know that for every person who gets a job—three others are still searching for employment.

This is another attempt to undermine the Affordable Care Act. Instead of trying to repeal the Affordable Care Act, House Republicans are now seeking ways to impede or frustrate its implementation.

After shutting down the federal government last year in an attempt to end the Affordable Care Act, they have resorted to their latest gimmick of attaching to a critically needed piece of legislation to make sure our nation's seniors continue to have access to physicians and hospitals an attempt to harm Obamacare.

I ask my colleagues to support Medicare patients and their physicians by rejecting the bill.

Mr. DEFAZIO. Mr. Speaker, today I will vote against H.R. 4015 despite being a cosponsor of the original bill. It should not have been that way. H.R. 4015 as originally drafted repealed the misguided SGR formula and laid out a reasonable path toward reimbursing doctors based on the quality of care that they provide. The bill had 118 bipartisan cosponsors. I heard from medical professionals all over Oregon who were hopeful that Congress would actually be able to pass H.R. 4015 and finally do away with short term SGR fixes.

Unfortunately Republican House leadership squandered this opportunity. Instead of finding a bipartisan way to pay for H.R. 4015, House Republican leadership inserted an ideological pay-for that would leave 13 million people uninsured according to the Congressional Budget Office. Because of this partisan gimmick, the Senate will never take up H.R. 4015. That leaves our nation's medical professionals exactly where they were before the vote—facing an approximately 27% cut in Medicare and TRICARE reimbursements if Congress doesn't fix the SGR before March 31st.

In 1997 I voted against creating the faulty SGR formula. I opposed the 1997 law because it balanced the budget on the backs of seniors and health care providers by substantially cutting Medicare. By delaying these cuts instead of permanently fixing the SGR formula, the potential cuts have grown every year.

Rather than cutting medical coverage for 13 million Americans, Congress should pay for H.R. 4015 by allowing Medicare to negotiate prescription drug prices. Every single other developed country in the world permits their government to negotiate drug prices for all of their citizens. In the U.S. private insurance companies negotiate prices, and the Veterans Administration negotiates prices, but the federal government is prevented from negotiating drug prices for Medicare. This means that drug companies are free to charge Medicare recipients higher prices than anyone else in the world. Allowing the federal government to negotiate drug prices for Medicare would fully pay for the SGR fix. The House could have ensured proper reimbursements for doctors and reduced drug prices for seniors in one bill today. Instead we voted on a bill that is going nowhere.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 515, the previous question is ordered on the bill, as amended.

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.

MOTION TO RECOMMIT

Mr. LOEBSACK. Mr. Speaker, I have a motion to recommit at the desk.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. LOEBSACK. I am opposed in its current form.

Mr. PITTS. Mr. Speaker, I reserve a point of order against the motion to recommit.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. Loebsack moves to recommit the bill H.R. 4015 to the Committee on Ways and Means with instructions to report the same back to the House forthwith with the following amendment:

At the end of the bill, add the following:

**SEC. ___. PROHIBITION ON MEDICARE CUTS OR VOUCHERS.**

Nothing in this Act shall reduce benefits under the Medicare program under title XVIII of the Social Security Act, eliminate guaranteed health insurance benefits available to seniors or individuals with disabilities under such program, or establish a Medicare voucher plan that provides limited payments to Medicare beneficiaries in order to purchase health care in the private sector.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Iowa is recognized for 5 minutes in support of his motion.

Mr. LOEBSACK. Mr. Speaker, this is the final amendment to the bill, which will not kill the bill or send it back to the committee. If adopted, the bill will immediately proceed to final passage, as amended.

I regularly meet with seniors across Iowa, and far too often I hear that many of them are struggling to make ends meet, just as I am sure that many of my colleagues hear from their seniors as well. They tell me how much they rely on Medicare in order to stay healthy and just to afford their daily necessities.

Mr. Speaker, our seniors did not get us into this fiscal mess that we are in today, and I think we have to keep that in mind. It is unfair to punish them for Washington's irresponsible behavior. That is why we have got to protect Medicare for seniors who have worked a lifetime to pay into it.

This also is an issue I will say that is personal to me. I grew up in a family that struggled to make ends meet. I often talked about how I grew up in poverty. My mom was a single parent who struggled with mental illness, and literally, in the fourth grade, we landed at the doorstep of my maternal grandmother.

My grandmother often relied on Social Security survivor benefits to care for me and my siblings. Without the promise of health care through Medicare, she would not have been able to afford to put food on the table.

No senior—and I think all of us in this body can agree—no senior should have to choose between paying their bills or paying for their medication.

Mr. Speaker, replacing Medicare with a voucher system would end the guarantee of health care and financial security for our seniors as well. Vouchers would force seniors to pay more and more of their health care costs out of pocket.

In these tough economic times, we need to find ways to be more efficient while maintaining quality care.

I know that seniors don't want a voucher that forces them to buy insurance that may not meet their needs because they tell me that every single time I meet with them. They do not want their health care to be subject to the whims of insurance companies looking to make a profit when they, those seniors, get sick.

They don't want higher costs, and they certainly don't want reduced benefits. They want to keep Medicare the way it is, a guaranteed benefit they can count on when they need it. They paid into it, and they deserve it.

Mr. Speaker, I ask my colleagues on both sides of the aisle to support this final amendment to the bill.

I yield back the balance of my time.

Mr. PITTS. Mr. Speaker, I withdraw my point of order and claim the time in opposition to the motion.

The SPEAKER pro tempore. The reservation is withdrawn.

The gentleman from Pennsylvania is recognized for 5 minutes.

Mr. PITTS. Mr. Speaker, to begin with, I would just like to acknowledge all the good work on both sides of the aisle in reaching the bipartisan policy agreement in the SGR, and especially want to thank our staff, Clay Alspach and Robert Horne and Chris Pope, and everyone on both sides of the aisle and their staff, for all the good work.

Mr. Speaker, this bill before us presents each and every Member of this body a simple choice: Do we patch Medicare, or do we fix it?

Do we choose to fight for the Medicare promise that this country has made to every American, or do we vote against it?

My friends, I am voting today to keep the Medicare promise to Americans. We must not let another opportunity to save Medicare for our seniors fall by the wayside.

If Washington is broken, today is an opportunity to fix it. The bill before us is bipartisan, and the pay-for is one President Obama has used himself many times in the past.

My colleagues, did you scream hypocrisy when President Obama delayed the mandate for special interests here in D.C.? Then why would you scream hypocrisy now?

The time for political games is over. It is time for Members of this body to choose. Are you on the side of seniors in your district that depend on Medicare, or are you against them? Are you on the side of younger Americans who keep telling us they are struggling under an ObamaCare plan that forces them to choose between groceries and health care? Are you for saving Medicare, or will you vote to let it go bankrupt?

What kind of country are we living in when our own government has reduced the American Dream to a choice between health care and groceries?

This motion to recommit embraces the tired gimmicks of yesterday that the public has grown to distrust. You have a clear choice. You either vote ''no'' and stand up for what is right, to give our seniors the peace of mind they deserve, or you can vote ''yes'' on this motion to recommit and demonstrate to the American public that political games are more important to you than their health and welfare.

I, for one, will be voting with seniors this morning, and I would encourage all of my colleagues to do the same.

Vote ''no'' on the motion to recommit.

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

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for any electronic vote on the question of passage of the bill.

The vote was taken by electronic device, and there were—yeas 191, nays 226, not voting 14, as follows:

[Roll No. 134]

YEAS—191

Barber
Barrow (GA)
Beatty
Becerra
Bera (CA)
Bishop (GA)
Bishop (NY)
Blumenauer
Bonamici
Brady (PA)
Braley (IA)
Brown (FL)
Brownley (CA)
Bustos
Butterfield
Capps
Capuano
Cárdenas
Carney
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Cooper
Costa
Crowley
Cuellar
Cummings
Davis (CA)
DeFazio
DeGette
Delaney
DeLauro
DelBene
Deutch
Doggett
Doyle
Duckworth
Edwards
Ellison
Engel
Enyart
Eshoo
Esty
Farr
Fattah
Foster
Fudge
Gabbard
Gallego
Garamendi
Garcia
Grayson
Green, Al
Green, Gene
Grijalva
Gutiérrez
Hahn
Hanabusa
Hastings (FL)
Heck (WA)
Higgins
Himes
Hinojosa
Holt
Honda
Horsford
Hoyer
Huffman
Israel
Jackson Lee
Jeffries
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kelly (IL)
Kennedy
Kildee
Kilmer
Kind
Kirkpatrick
Kuster
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham (NM)
Luján, Ben Ray (NM)
Lynch
Maffei
Maloney, Carolyn
Maloney, Sean
Matheson
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNerney
Meeks
Meng
Michaud
Miller, George
Moore
Moran
Murphy (FL)
Nadler
Napolitano
Neal
Negrete McLeod
Nolan
O'Rourke
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Pelosi
Perlmutter
Peters (CA)
Peters (MI)
Peterson
Pingree (ME)
Pocan
Polis
Price (NC)
Quigley
Rahall
Rangel
Richmond
Roybal-Allard
Ruiz
Ruppersberger
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schneider
Schrader
Schwartz
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sinema
Sires
Slaughter
Speier
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Tsongas
Van Hollen
Vargas
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Waxman
Welch
Yarmuth

NAYS—226

Aderholt
Amash
Bachus
Barletta
Barr
Barton
Benishek
Bentivolio
Bilirakis
Bishop (UT)
Black
Blackburn
Boustany
Brady (TX)
Bridenstine
Brooks (AL)
Brooks (IN)
Broun (GA)
Buchanan
Bucshon
Burgess
Byrne
Calvert
Camp
Campbell
Cantor
Capito
Carter
Cassidy
Chabot
Chaffetz
Coble
Coffman
Cole
Collins (GA)
Collins (NY)
Conaway
Cook
Cotton
Cramer
Crawford
Crenshaw
Daines
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Duffy
Duncan (SC)
Duncan (TN)
Ellmers
Farenthold
Fincher
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foxx
Frelinghuysen
Gardner
Garrett
Gerlach
Gibbs
Gibson
Gingrey (GA)
Gohmert
Goodlatte
Gowdy
Granger
Graves (GA)
Graves (MO)
Griffin (AR)
Griffith (VA)
Grimm
Guthrie
Hall
Hanna
Harper
Harris
Hartzler
Hastings (WA)
Heck (NV)
Hensarling
Herrera Beutler
Holding
Hudson
Huelskamp
Huizenga (MI)
Hultgren
Hunter
Hurt
Issa
Jenkins
Johnson (OH)
Johnson, Sam
Jolly
Jones
Jordan
Joyce
Kelly (PA)
King (IA)
King (NY)
Kingston
Kinzinger (IL)
Kline
Labrador
LaMalfa
Lamborn
Lance
Lankford
Latham
Latta
LoBiondo
Long
Lucas
Luetkemeyer
Lummis
Marchant
Marino
Massie
McAllister
McCarthy (CA)
McCaul
McClintock
McHenry
McKeon
McKinley
McMorris Rodgers
Meadows
Meehan
Messer
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mullin
Mulvaney
Murphy (PA)
Neugebauer
Noem
Nugent
Nunes
Nunnelee
Olson
Palazzo
Paulsen
Pearce
Perry
Petri
Pittenger
Pitts
Poe (TX)
Pompeo
Posey
Price (GA)
Reed
Reichert
Renacci
Ribble
Rice (SC)
Rigell
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rooney
Ros-Lehtinen
Roskam
Ross
Rothfus
Royce
Runyan
Ryan (WI)
Salmon
Sanford
Scalise
Schock
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Southerland
Stewart
Stivers
Stockman
Stutzman
Terry
Thompson (PA)
Thornberry
Tiberi
Tipton
Turner
Upton
Valadao
Wagner
Walberg

Walden
Walorski
Weber (TX)
Webster (FL)
Wenstrup
Westmoreland
Whitfield
Williams
Wilson (SC)
Wittman
Wolf
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IN)

NOT VOTING—14

Amodei
Bachmann
Bass
Courtney
Culberson
Davis, Danny
Dingell
Frankel (FL)
Franks (AZ)
Gosar
Rokita
Rush
Smith (WA)
Wilson (FL)

□ 1107

Mr. MICA changed his vote from ''yea'' to ''nay.''

Ms. LOFGREN and Mr. CICILLINE changed their vote from ''nay'' to ''yea.''

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

Stated for:

Ms. FRANKEL of Florida. Mr. Speaker, on rollcall No. 134, the motion to recommit for H.R. 4015, had I been present, I would have voted "yes."

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

The yeas and nays were ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 238, nays 181, not voting 12, as follows:

[Roll No. 135]

YEAS—238

Aderholt
Amash
Bachus
Barber
Barletta
Barr
Barrow (GA)
Barton
Benishek
Bentivolio
Bera (CA)
Bilirakis
Bishop (UT)
Black
Blackburn
Boustany
Brady (TX)
Bridenstine
Brooks (AL)
Brooks (IN)
Broun (GA)
Buchanan
Bucshon
Burgess
Byrne
Calvert
Camp
Campbell
Cantor
Capito
Carter
Cassidy
Chabot
Chaffetz
Coble
Coffman
Cole
Collins (GA)
Collins (NY)
Conaway
Cook
Cotton
Cramer
Crawford
Crenshaw
Daines
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Duffy
Duncan (SC)
Duncan (TN)
Ellmers
Farenthold
Fincher
Fitzpatrick
Fleischmann
Fleming
Flores
Forbes
Fortenberry
Foxx
Frelinghuysen
Garcia
Gardner
Garrett
Gerlach
Gibbs
Gibson
Gingrey (GA)
Gohmert
Goodlatte
Granger
Graves (GA)
Graves (MO)
Griffin (AR)
Griffith (VA)
Grimm
Guthrie
Hall
Hanna
Harper
Harris
Hartzler
Hastings (WA)
Heck (NV)
Hensarling
Herrera Beutler
Holding
Hudson
Huelskamp
Huizenga (MI)
Hultgren
Hunter
Hurt
Issa
Jenkins
Johnson (OH)
Johnson, Sam
Jolly
Jones
Jordan
Joyce
Kelly (PA)
King (IA)
King (NY)
Kingston
Kinzinger (IL)
Kline
Labrador
LaMalfa
Lamborn
Lance
Lankford
Latham
Latta
LoBiondo
Long
Lucas
Luetkemeyer
Lummis
Marchant
Marino
Massie
Matheson
McAllister
McCarthy (CA)
McCaul
McClintock
McHenry
McIntyre
McKeon
McKinley
McMorris Rodgers
Meadows
Meehan
Messer
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mullin
Mulvaney
Murphy (FL)
Murphy (PA)
Neugebauer
Noem
Nugent
Nunes
Nunnelee
Olson
Palazzo
Paulsen
Pearce
Perry
Peters (CA)
Peterson
Petri
Pittenger
Pitts
Poe (TX)
Pompeo
Posey
Price (GA)
Rahall
Reed
Reichert
Renacci
Ribble
Rice (SC)
Rigell
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Rokita
Rooney
Ros-Lehtinen
Roskam
Ross
Rothfus
Royce
Runyan
Ryan (WI)
Salmon
Sanford
Scalise
Schneider
Schock
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Sinema
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Southerland
Stewart
Stivers
Stockman
Stutzman
Terry
Thompson (PA)
Thornberry
Tiberi
Tipton
Turner
Upton
Valadao
Wagner
Walberg
Walden
Walorski
Weber (TX)
Webster (FL)
Wenstrup
Westmoreland
Whitfield
Williams
Wilson (SC)
Wittman
Wolf
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IN)

NAYS—181

Beatty
Becerra
Bishop (GA)
Bishop (NY)
Blumenauer
Bonamici
Brady (PA)
Braley (IA)
Brown (FL)
Brownley (CA)
Bustos
Butterfield
Capps
Capuano
Cárdenas
Carney
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Cooper
Costa
Crowley
Cuellar
Cummings
Davis (CA)
DeFazio
DeGette
Delaney
DeLauro
DelBene
Deutch
Doggett
Doyle
Duckworth
Edwards
Ellison
Engel
Enyart
Eshoo
Esty
Farr
Fattah
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Grayson
Green, Al
Green, Gene
Grijalva
Gutiérrez
Hahn
Hanabusa
Hastings (FL)
Heck (WA)
Higgins
Himes
Hinojosa
Holt
Honda
Horsford
Hoyer
Huffman
Israel
Jackson Lee
Jeffries
Johnson (GA)
Johnson, E. B.
Kaptur
Keating
Kelly (IL)
Kennedy
Kildee
Kilmer
Kind
Kirkpatrick
Kuster
Langevin
Larsen (WA)
Larson (CT)
Lee (CA)
Levin
Lewis
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham (NM)
Luján, Ben Ray (NM)
Lynch
Maffei
Maloney, Carolyn
Maloney, Sean
Matsui
McCarthy (NY)
McCollum
McDermott
McGovern
McNerney
Meeks
Meng
Michaud
Miller, George
Moore
Moran
Nadler
Napolitano
Neal
Negrete McLeod
Nolan
O'Rourke
Owens
Pallone
Pascrell
Pastor (AZ)
Payne
Pelosi
Perlmutter
Peters (MI)
Pingree (ME)
Pocan
Polis
Price (NC)
Quigley
Rangel
Richmond
Roybal-Allard
Ruiz
Ruppersberger
Ryan (OH)
Sánchez, Linda T.
Sanchez, Loretta
Sarbanes
Schakowsky
Schiff
Schrader
Schwartz
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sires
Slaughter
Speier
Swalwell (CA)
Takano
Thompson (CA)
Thompson (MS)
Tierney
Titus
Tonko
Tsongas
Van Hollen
Vargas
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters
Waxman
Welch
Wilson (FL)
Yarmuth

NOT VOTING—12

Amodei
Bachmann
Bass
Courtney
Culberson
Davis, Danny
Dingell
Franks (AZ)
Gosar
Gowdy
Rush
Smith (WA)

□ 1115

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PERSONAL EXPLANATION

Mr. FRANKS of Arizona. Mr. Speaker, had I been present, I would have voted "yes" on rollcall No. 132 on H.R. 3189, I would have voted "yes" on rollcall No. 129 on H.R. 3973, and I would have voted "yes" on rollcall No. 135 on H.R. 4015.

## MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has passed without amendment bills and a concurrent resolution of the House of the following titles:

H.R. 2650. An act to allow the Fond du Lac Band of Lake Superior Chippewa in the State of Minnesota to lease or transfer certain land.

H.R. 4076. An act to address shortages and interruptions in the availability of propane and other home heating fuels in the United States, and for other purposes.

H. Con. Res. 93. Concurrent resolution directing the Clerk of the House of Representatives to make technical corrections in the enrollment of H.R. 3370.

The message also announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 1456. An act to award the Congressional Gold Medal to Shimon Peres.

S. 2147. An act to amend Public Law 112–59 to provide for the display of the congressional gold medal awarded to the Montford Point Marines, United States Marine Corps, by the Smithsonian Institution and at other appropriated locations.

## ADJOURNMENT TO TUESDAY, MARCH 18, 2014

Mr. HASTINGS of Washington. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 1 p.m. on Tuesday, March 18, 2014.

The SPEAKER pro tempore (Mr. MCALLISTER). Is there objection to the request of the gentleman from Washington?

There was no objection.

## CELEBRATING NATIONAL WOMEN'S HISTORY MONTH

(Ms. ROS-LEHTINEN asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. ROS-LEHTINEN. Mr. Speaker, due to National Women's History Month every March, we celebrate the tremendous contributions of women who have helped make this Nation the greatest on Earth.