Hurt	Mullin	Schrader
Issa	Mulvaney	Schweikert
Jenkins	Murphy (PA)	Scott, Austin
Johnson (OH)	Negrete McLeod	Scott, David
Johnson, Sam	Neugebauer	Sensenbrenner
Jolly	Noem	Sessions
Jones	Nugent	Shimkus
Jordan	Nunes	Shuster
Joyce	Olson	Simpson
Kelly (IL)	Owens	Sinema
Kelly (PA)	Palazzo	Smith (MO)
King (NY)	Paulsen	Smith (NE)
Kingston	Pearce	Smith (TX)
Kinzinger (IL)	Perry	Southerland
Kirkpatrick	Peterson	Stewart
Kline	Petri	Stivers
Labrador	Pittenger	Stockman
LaMalfa	Pitts	Stutzman
Lamborn	Poe (TX)	Terry
Lance	Pompeo	Thompson (MS)
Lankford	Posey	Thompson (PA)
Latham	Price (GA)	Thornberry
Latta	Rahall	Tiberi
LoBiondo	Reed	Tipton
Loebsack	Reichert	Turner
Long	Renacci	Upton
Lucas	Ribble	Valadao
Luetkemeyer	Rice (SC)	Veasey
Lummis	Richmond	Vela
Marchant	Rigell	Wagner
Marino	Roby	Walberg
Massie	Roe (TN)	Walden
Matheson	Rogers (AL)	Walorski
McAllister	Rogers (KY)	Walz
McCarthy (CA)	Rogers (MI)	Weber (TX)
McCaul	Rohrabacher	Webster (FL)
McClintock	Rokita	Wenstrup
McHenry	Rooney	Westmoreland
McIntyre	Ros-Lehtinen	Whitfield
McKeon	Roskam	Williams
McKinley	Ross	Wilson (SC)
McMorris Rodgers	Rothfus	Wittman
Meadows	Royce	Wolf
Meehan	Ruiz	Womack
Messer	Runyan	Woodall
Mica	Ryan (WI)	Yoder
Miller (FL)	Salmon	Yoho
Miller (MI)	Sanford	Young (AK)
Miller, Gary	Scalise	Young (IN)
	Schock	

NAYS—152

Bass	Grayson	McNerney
Beatty	Green, Al	Meng
Becerra	Grijalva	Michaud
Bera (CA)	Gutiérrez	Miller, George
Bishop (NY)	Hahn	Moore
Blumenauer	Hanabusa	Moran
Bonamici	Heck (WA)	Murphy (FL)
Brady (PA)	Higgins	Nadler
Braley (IA)	Himes	Napolitano
Brown (FL)	Hinojosa	Neal
Brownley (CA)	Holt	Nolan
Butterfield	Honda	O'Rourke
Capps	Hoyer	Pallone
Capuano	Huffman	Pascrell
Cárdenas	Israel	Pastor (AZ)
Carney	Jackson Lee	Payne
Carson (IN)	Jeffries	Pelosi
Cartwright	Johnson (GA)	Perlmutter
Castro (TX)	Johnson, E. B.	Peters (CA)
Chu	Kaptur	Peters (MI)
Clay	Keating	Pingree (ME)
Cohen	Kennedy	Pocan
Connolly	Kildee	Polis
Conyers	Kilmer	Price (NC)
Cooper	Kind	Quigley
Courtney	Kuster	Rangel
Crowley	Langevin	Roybal-Allard
Cummings	Larsen (WA)	Ruppersberger
Davis (CA)	Larson (CT)	Ryan (OH)
Davis, Danny	Levin	Sánchez, Linda T.
DeFazio	Lewis	
DeGette	Lipinski	Sanchez, Loretta
Delaney	Lofgren	Sarbanes
DeLauro	Lowenthal	Schakowsky
DelBene	Lowey	Schiff
Deutch	Lujan Grisham (NM)	Schneider
Doggett	Luján, Ben Ray (NM)	Schwartz
Doyle	Lynch	Scott (VA)
Duckworth	Maffei	Serrano
Edwards	Maloney, Sean	Shea-Porter
Ellison	Matsui	Sherman
Eshoo	McCarthy (NY)	Sires
Esty	McCollum	Slaughter
Fattah	McDermott	Smith (NJ)
Foster	McGovern	Smith (WA)
Frankel (FL)		Speier
Gabbard		Swalwell (CA)
Takano	Van Hollen	Waters
Thompson (CA)	Vargas	Waxman
Titus	Visclosky	Welch
Tonko	Wasserman Schultz	Wilson (FL)
Tsongas		Yarmuth

NOT VOTING—17

Castor (FL)	Dingell	Meeks
Cicilline	Engel	Nunnelee
Clark (MA)	King (IA)	Rush
Clarke (NY)	Lee (CA)	Sewell (AL)
Davis, Rodney	Maloney, Carolyn	Tierney
DesJarlais		Velázquez

□ 1731

Ms. WATERS changed her vote from ''yea'' to ''nay.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Mr. RODNEY DAVIS of Illinois. Mr. Speaker, on rollcall No. 489, I placed voting card in machine and it did not register. Had I been present, I would have voted "yes."

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 3522, EMPLOYEE HEALTH CARE PROTECTION ACT OF 2013

Mr. BURGESS from the Committee on Rules, submitted a privileged report (Rept. No. 113–584) on the resolution (H. Res. 717) providing for consideration of the bill (H.R. 3522) to authorize health insurance issuers to continue to offer for sale current group health insurance coverage in satisfaction of the minimum essential health insurance coverage requirement, and for other purposes, which was referred to the House Calendar and ordered to be printed.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Record votes on postponed questions will be taken later.

EXTENSION OF ENFORCEMENT INSTRUCTION FOR OUTPATIENT THERAPEUTIC SERVICES IN CRITICAL ACCESS AND SMALL RURAL HOSPITALS THROUGH 2014

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4067) to provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2014.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4067

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

SECTION 1. EXTENSION OF ENFORCEMENT INSTRUCTION ON SUPERVISION REQUIREMENTS FOR OUTPATIENT THERAPEUTIC SERVICES IN CRITICAL ACCESS AND SMALL RURAL HOSPITALS THROUGH 2014.

The Secretary of Health and Human Services shall continue to apply through calendar year 2014 the enforcement instruction described in the notice of the Centers for Medicare & Medicaid Services entitled ''Enforcement Instruction on Supervision Requirements for Outpatient Therapeutic Services in Critical Access and Small Rural Hospitals for CY 2013'', dated November 1, 2012 (providing for an exception to the restatement and clarification under the final rulemaking changes to the Medicare hospital outpatient prospective payment system and calendar year 2009 payment rates (published in the Federal Register on November 18, 2008, 73 Fed. Reg. 68702 through 68704) with respect to requirements for direct supervision by physicians for therapeutic hospital outpatient services).

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

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

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

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

There was no objection.

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

Mr. Speaker, I rise today in support of H.R. 4067, which provides for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2014. This was a bill introduced by Congresswoman JENKINS of Kansas.

Mr. Speaker, this is a commonsense solution to a problem that has the potential to limit or delay access to health care for America's seniors in rural communities.

The bill would delay until the end of the year enforcement of supervision requirements for outpatient therapeutic services in critical access hospitals. This delay would give the Centers for Medicaid and Medicare Services and provider groups time to identify which services will eventually fall under the requirement.

I ask my colleagues to support this important piece of legislation and reserve the balance of my time.

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

Mr. Speaker, H.R. 4067 would suspend current enforcement of Medicare rules relating to physician supervision of staff in rural and critical access hospitals for certain outpatient therapeutic services. Enforcement of these rules was delayed from 2009 through 2013, but began again in January of this

year. My understanding is that there has not been any issue with enforcement to date and that the Medicare program has not taken any action against a facility for failure to meet physician supervision standards since January. But as this bill did not follow regular order through the committee process, we have not had an opportunity to hear from interested parties about the issue and bring to light what the implications might be of an additional delay. Frankly, the likely result of such a bill would be confusion for hospitals.

Medicare's physician supervision requirement places a premium on patient safety, and I understand that rural facilities sometimes face difficulty in securing staffing. However, it seems reasonable to me that outpatient clinics that provide services to Medicare beneficiaries should meet some basic standards for having supervisory physicians available if an emergency arises—for example, when patients are receiving potentially lethal doses of chemotherapy medication.

Meanwhile, there are countless public health issues that the committee could productively devote its time to, such as looking into the recent outbreak of Ebola, the effects of e-cigarettes, or perhaps the decline of routine vaccinations that has led to an explosion of preventable illnesses like measles. Rather, the bill before us seems to be only responsive to the fears of certain health care providers that someone could file a complaint that a facility was allowing staff to practice medicine on Medicare patients without any supervision. But isn't that the kind of thing that we might be concerned about—and want a whistleblower to report? Yet, that is just what this bill would prevent.

It remains unclear to me why an additional delay of this Medicare policy is needed. Simply saying that the Senate passed this bill by unanimous consent in February is not sufficient justification—and makes even less sense now that the calendar year is nearly over.

So, Mr. Speaker, we should be finding time to address the real and pressing public issues facing our Nation rather than those that merely cause an inconvenience or anxiety for certain health care providers.

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

Mr. BURGESS. Mr. Speaker, at this time, I would like to yield 3 minutes to the gentlewoman from Kansas, Congresswoman JENKINS, the author of the bill.

Ms. JENKINS. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 4067, a bill to provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2014.

I was proud to introduce this legislation in February, and I am pleased that Chairman UPTON and the Energy and Commerce Committee reported it favorably and brought it to the House floor today.

The 83 critical access hospitals in Kansas are the lifeblood of our rural communities, and one of the many challenges these communities face is access to health care. The presence of a facility such as a critical access hospital in a community could be the deciding factor in whether or not the next generation of children decide to raise their family in their hometown, or perhaps whether or not a business decides to locate there.

The Centers for Medicare and Medicaid Services made a decision on January 1 of this year that will make it more difficult for these rural hospitals to serve their communities. CMS informed these hospitals that physicians are now required to directly supervise outpatient services, such as drawing blood and activity therapy. This is a change in policy that will put a strain on providers while providing no quality improvements for the patients they serve.

This bill will correct that problem by reinstating the moratorium on enforcement of these unnecessary regulations. It has broad bipartisan support in Congress and the support of key stakeholders.

Mr. Speaker, I insert in the RECORD letters of support for H.R. 4067 from the American Hospital Association, the National Rural Health Association, the Kansas Hospital Association, and Anderson County Hospital, which is a critical access hospital in Garnett, Kansas, one of 1,300 nationwide.

AMERICAN HOSPITAL ASSOCIATION,
Washington, DC, May 19, 2014.

Hon. LYNN JENKINS,
U.S. House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE JENKINS: On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association is pleased to support H.R. 4067 to provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2014.

Approximately 46 million Americans live in rural areas and depend on these hospitals as an important, and often the only, source of care. Critical access and small rural hospitals face unique challenges because of their remote geographic location, scarce workforce, physician shortages and constrained financial resources with limited access to capital.

Your bill attempts to address one of these unique challenges—the issue of direct supervision for outpatient therapeutic services. In the 2009 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) mandated a new policy for ''direct supervision'' of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. CMS's policy required that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient therapeutic services. Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician, should an unforeseen event occur. While hospitals recognize the need for direct supervision for certain outpatient services that pose high risk or are very complex, CMS's policy generally applies to even the lowest risk services. Your bill would provide a needed delay in enforcement of the direct supervision policy through 2014 for critical access and small rural hospitals with fewer than 100 beds.

Again, we are pleased to support this bill and applaud your commitment to America's rural hospitals and health care providers.

Sincerely,

RICK POLLACK,
Executive Vice President.

NATIONAL RURAL HEALTH ASSOCIATION,
Washington, DC, July 28, 2014.

Hon. LYNN JENKINS,
U.S. House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE JENKINS: The National Rural Health Association applauds your leadership in introducing H.R. 4067. This bill will provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2014.

NRHA is a national nonprofit membership organization with more than 21,000 members. Our mission is to provide leadership on rural health issues. NRHA membership is made up of a diverse collection of individuals and organizations, all of whom share the common bond of ensuring all rural communities have access to quality, affordable health care.

NRHA supports your efforts to put a moratorium on the physician supervision of outpatient services requirement at CAHs and small rural hospitals until the end of 2014. If you have further questions, please do not hesitate to call Erin Mahn on my government affairs staff at 202–639–0550 or by e–mail emahn@nrharural.org.

We thank you for sponsoring this important legislation. You are truly a stalwart champion for rural America.

Sincerely,

ALAN MORGAN, CEO,
National Rural Health Association.

KANSAS HOSPITAL ASSOCIATION,
July 30, 2014.

Hon. LYNN JENKINS,
U.S. House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE JENKINS: On behalf of our 128 member hospitals, the Kansas Hospital Association is pleased to support H.R. 4067. This important legislation provides a one-year extension on the non-enforcement of the direct supervision policy for therapeutic services provided in critical access hospitals and rural hospitals with 100 or few beds.

Effective January 1, 2014, the Centers for Medicare and Medicaid Services' decided to not extend its policy to not enforce the direct supervision policy for therapeutic services provided in CAHs and rural hospitals with less than 100 beds. This new policy of enforcement on CAHs and small rural hospitals may limit the hospital's ability to provide their outpatients with basic therapeutic services. These are services that have been provided safely in rural communities throughout the years. H.R. 4067 would provide a much needed delay in enforcement of the direct supervision policy for therapeutic services through 2014.

We are pleased to support your legislation and appreciate your commitment to Kansas hospitals.

Sincerely,

TOM BELL,
President and CEO.

ANDERSON COUNTY HOSPITAL,
Garnett, KS, May 18, 2014.

Hon. LYNN JENKINS,
Longworth HOB,
Washington, DC.

DEAR REPRESENTATIVE JENKINS: As you know, I have communicated with you in the past about the consequences of the physician supervision requirements that were included in the Outpatient Prospective Payment Final Rule (OPPS) for 2014, as published in the Federal Register on December 10, 2013. These rules will have an unintended impact on the provision of outpatient therapeutic services in Critical Access Hospitals and to patient care in rural settings.

Anderson County Hospital (ACH) is a Critical Access Hospital (CAH) located in Anderson County, Kansas. Since 1994, we have operated a hospital-based rural health clinical staff by employed physicians and mid-levels, the only primary care clinic currently operating in our county. Additionally, our emergency room is staffed with physicians and mid-level practitioners 24/7. For the past two years, ACH has continued to struggle with how to meet the supervision requirements. Initially, it was that we would use a combination of ER and primary care providers to provide the direct supervision; if one of them was not immediately available, we would provide the service and not bill for it. Please keep in mind that while direct supervision does not require the provider to be in the room with the patient, they do need to be immediately available. The location of both our clinic and ER providers meet this requirement.

In a clarification received from CMS in January, they further instructed us that hospital employed practitioners in hospital-based rural health clinics, even those that are located on the same campus and adjacent to the hospital, cannot meet the direct supervision requirement for outpatient therapeutic services. This makes it nearly impossible for us to meet the supervision requirements. Although we have a full complement of staff that could provide direct supervision, the ability to use them to provide services is not in question.

These requirements present a significant hardship and expense to rural hospitals and is in direct conflict to the Conditions of Participation for CAHs. It will limit the ability to provide our outpatients with basic therapeutic services such as IV infusions, initial antibiotic therapy, emergency cardiac drugs and blood transfusions. These are services that have been provided in rural communities safely throughout the years, and will ultimately impact access to important services for the patients and communities we serve.

For those CAHs who have emergency room coverage provided by their own employed physicians, the requirements are even more difficult to meet. Since CAH conditions of participation say that the physician does not need to be in the ER, must respond to the emergency room within 30 minutes, most hospitals have protocols that allow a registered nurse to begin life saving IV therapy on a verbal order from the provider. The physician supervision requirements seem to contradict this.

The strangest part of the interpretation of these rules is that they only impact payment, not the actual provision of the services, so this is not really an issue of quality or patient safety. We are told that we are able to provide the services when needed, but unless there is documented direct supervision, we are not able to bill or be paid for the services provided.

Because of the implications of these rules and their interpretation on the provision of outpatient therapeutic services at our hospital and many others in rural settings, I ask for your support of H.R. 4067, which would put a hold on enforcement of the supervision requirements through 2014. This additional time would hopefully allow the opportunity to re-visit the many issues raised by these rules and would go a long way in alleviating the consequences of the policy that I've outlined in this letter. We must keep in mind that the intent of the CAH program was to provide access to quality patient care in rural communities. A delay in enforcement would help us refocus on that goal.

Sincerely,

DENNIS A. HACHENBERG, FACHE,
Chief Executive Officer,
Anderson County Hospital.

Ms. JENKINS. Mr. Speaker, I was born and raised in a small town in Kansas, and I feel strongly that folks in rural communities deserve access to quality health care.

I urge my colleagues to support this legislation, and I am hopeful that the Senate will soon act on it so that it may become law.

Mr. PALLONE. Mr. Speaker, I have no other speakers at this time, and so I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, I urge my colleagues to support the bill, and yield back the balance of my time.

Mr. WAXMAN. Mr. Speaker, H.R. 4067, reinstates a four month delay in the enforcement of the current Medicare rules relating to physician supervision of staff who administer certain therapeutic services in rural and critical access hospitals.

The Medicare physician supervision requirement protects patients by ensuring that Medicare beneficiaries have access to someone capable of dealing with unforeseen emergencies. While I understand that rural healthcare providers often have difficulty acquiring adequate staffing, we should not place greater value on their convenience than on the safety of Medicare beneficiaries.

Reinstating a delay of these requirements until the end of the year only potentially confuses healthcare providers and lowers the bar on patient safety that Medicare has put in place.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, H.R. 4067.

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

A motion to reconsider was laid on the table.

SUDDEN UNEXPECTED DEATH DATA ENHANCEMENT AND AWARENESS ACT

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 669) to amend the Public Health Service Act to improve the health of children and help better understand and enhance awareness about unexpected sudden death in early life, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 669

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Sudden Unexpected Death Data Enhancement and Awareness Act''.

SEC. 2. STILLBIRTH AND SUDDEN DEATHS IN THE YOUNG.

The Public Health Service Act is amended by inserting after section 317L of such Act (42 U.S.C. 247b–13) the following:

''SEC. 317L–1. STILLBIRTH AND SUDDEN DEATHS IN THE YOUNG.

''(a) STILLBIRTH ACTIVITIES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall continue to carry out activities of the Centers relating to stillbirth, including the following:

''(1) SURVEILLANCE.—

''(A) IN GENERAL.—The Secretary shall provide for surveillance efforts to collect thorough, complete, and high-quality epidemiologic information on stillbirths, including through the utilization of existing surveillance systems (including the National Vital Statistics System (NVSS) and other appropriately equipped birth defects surveillance programs).

''(B) STANDARD PROTOCOL FOR SURVEILLANCE.—The Secretary, in consultation with qualified individuals and organizations determined appropriate by the Secretary, to include representatives of health and advocacy organizations, State and local governments, public health officials, and health researchers, shall—

''(i) provide for the continued development and dissemination of a standard protocol for stillbirth data collection and surveillance; and

''(ii) not less than every 5 years, review and, as appropriate, update such protocol.

''(2) POSTMORTEM DATA COLLECTION AND EVALUATION.—The Secretary, in consultation with qualified individuals and organizations determined appropriate by the Secretary, to include representatives of health professional organizations, shall—

''(A) upon the enactment of this section, and not less than every 5 years thereafter, review existing guidelines for increasing and improving the quality and completeness of postmortem stillbirth evaluation and related data collection, including conducting and reimbursing autopsies, placental histopathology, and cytogenetic testing; and

''(B) develop strategies for implementing such guidelines and addressing any barriers to implementation of such guidelines.

''(b) SUDDEN UNEXPECTED INFANT DEATH ACTIVITIES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall continue to carry out activities of the Centers relating to sudden unexpected infant death (SUID), including the following:

''(1) SURVEILLANCE.—

''(A) IN GENERAL.—The Secretary shall provide for surveillance efforts to gather sociodemographic, death scene investigation, clinical history, and autopsy information on SUID cases through the review of existing records on SUID, including through the utilization of existing surveillance systems (including the national child death review case reporting system and SUID case registries).

''(B) STANDARD PROTOCOL FOR SURVEILLANCE.—The Secretary, in consultation with