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

qualified individuals and organizations determined appropriate by the Secretary, to include representatives of health and advocacy organizations, State and local governments, and public health officials, shall—

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

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

''(C) GOALS FOR ENHANCING SURVEILLANCE.—In carrying out activities under this subsection, the Secretary shall seek to accomplish the following goals:

''(i) Collecting thorough, complete, and high-quality death scene investigation data, clinical history, and autopsy findings.

''(ii) Collecting standardized information about the environmental and medical circumstances of death (including the sleep environment and quality of the death scene investigation).

''(iii) Supporting multidisciplinary infant death reviews, such as those performed by child death review committees, to collect and review the information and classify and characterize SUID using a standardized classification system.

''(iv) Facilitating the sharing of information to improve the public reporting of surveillance and vital statistics describing the epidemiology of SUID.

''(2) STANDARD PROTOCOL FOR DEATH SCENE INVESTIGATION.—

''(A) IN GENERAL.—The Secretary, in consultation with forensic pathologists, medical examiners, coroners, medicolegal death scene investigators, law enforcement personnel, emergency medical technicians and paramedics, public health agencies, and other individuals and organizations determined appropriate by the Secretary, shall—

''(i) provide for the continued dissemination of a standard death scene investigation protocol; and

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

''(B) CONTENT OF DEATH SCENE PROTOCOL.—The protocol disseminated under subparagraph (A) shall include information on—

''(i) the current and past medical history of the infant;

''(ii) family medical history;

''(iii) the circumstances surrounding the death, including any suspicious circumstances;

''(iv) the sleep position and sleep environment of the infant; and

''(v) any accidental or environmental factors associated with death.

''(3) GUIDELINES FOR A STANDARD AUTOPSY PROTOCOL.—The Secretary, in consultation with the Attorney General of the United States, forensic pathologists, medical examiners, coroners, pediatric pathologists, pediatric cardiologists, pediatric neuropathologists, geneticists, infectious disease specialists, and other individuals and organizations determined appropriate by the Secretary, shall—

''(A) develop guidelines for a standard autopsy protocol for SUID; and

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

''(4) TRAINING.—The Secretary, in consultation with the Attorney General of the United States, may—

''(A) conduct or support—

''(i) training activities for medical examiners, coroners, medicolegal death scene investigators, law enforcement personnel, and emergency medical technicians or paramedics concerning death scene investigations for SUID, including the use of standard death scene investigation protocols disseminated under paragraph (2); and

''(ii) training activities for medical examiners, coroners, and forensic pathologists concerning standard autopsy protocols for SUID developed under paragraph (3); and

''(B) make recommendations to health professional organizations regarding the integration of protocols disseminated or developed under this subsection, and training conducted or supported under this paragraph, into existing training and continuing education programs.

''(c) SUDDEN UNEXPLAINED DEATH IN CHILDHOOD 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 death in childhood (SUDC), including the following:

''(1) SURVEILLANCE.—The Secretary, in consultation with the Director of the National Institutes of Health, shall provide for surveillance efforts to gather sociodemographic, death scene investigation, clinical history, and autopsy information on SUDC cases through the review of existing records on SUDC, including through the utilization of existing surveillance systems (including the Sudden Death in the Young Registry).

''(2) GUIDELINES FOR A STANDARD AUTOPSY PROTOCOL.—The Secretary, in consultation with the Attorney General of the United States, forensic pathologists, medical examiners, coroners, pediatric pathologists, pediatric cardiologists, pediatric neuropathologists, geneticists, infectious disease specialists, and other individuals and organizations determined appropriate by the Secretary, may—

''(A) develop guidelines for a standard autopsy protocol for SUDC; and

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

''(3) REVIEW OF APPLICABILITY OF PROGRAMS AND ACTIVITIES.—Not later than 18 months after the date of enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the Director of the National Institutes of Health, shall complete an evaluation of the possibility of carrying out or intensifying, with respect to SUDC, the types of programs and activities that are authorized to be carried out under subsection (b) with respect to SUID.

''(d) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall submit to the Congress a report on the implementation of this section. Such report shall include—

''(1) the results of the evaluation under subsection (c)(3); and

''(2) a description of any activities that—

''(A) are being carried out by the Centers for Disease Control and Prevention in consultation with the National Institutes of Health relating to stillbirth, SUID, or SUDC; and

''(B) are in addition to the activities being carried out pursuant to this section.

''(e) DEFINITIONS.—In this section:

''(1) The term 'stillbirth' means a spontaneous fetal death that—

''(A) occurs at 20 or more weeks gestation; or

''(B) if the age of the fetus is not known, involves a fetus weighing 350 grams or more.

''(2) The terms 'sudden unexpected infant death' and 'SUID' mean the death of an infant less than 1 year of age—

''(A) which occurs suddenly and unexpectedly; and

''(B) whose cause—

''(i) is not immediately obvious prior to investigation; and

''(ii) is either explained upon investigation or remains unexplained.

''(3) The terms 'sudden unexplained death in childhood' and 'SUDC' mean the sudden death of a child 1 year of age or older which remains unexplained after a thorough case investigation that includes—

''(A) a review of the clinical history and circumstances of death; and

''(B) performance of a complete autopsy with appropriate ancillary testing.

''(f) FUNDING.—No additional funds are authorized to be appropriated for the purpose of carrying out this section, and this section shall be carried out using amounts otherwise available for such purpose.''.

The SPEAKER pro tempore. 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.

□ 1745

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 to insert extraneous material into 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. 669, the Sudden Unexpected Death Data Enhancement and Awareness Act, introduced by my colleague, Mr. PALLONE of New Jersey.

Prevention of stillbirth, sudden unexpected infant death, and sudden unexplained death in children depends upon the collection of data related to the biological, social, and environmental factors associated with these outcomes.

The Centers for Disease Control and Prevention collects data through existing surveillance systems in order to identify the extent of the problem and risk factors.

Sudden unexpected infant death rates decreased in the 1990s during the Back to Sleep campaign, but have remained unchanged since then. It is time for us to address this problem.

H.R. 669 authorizes activities at the Centers for Disease Control to help improve the understanding of stillbirth, sudden unexpected infant death, and sudden unexplained death in children by improving data collection, increasing surveillance strategies, and setting guidelines and protocols for death scene investigations.

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

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

I rise with great pride to be speaking in support of H.R. 669, the Sudden Unexpected Death Data Enhancement and Awareness Act.

This has been an issue that I have worked on for many years in Congress. In particular, it is one of the many bills that I partnered with my late

friend, Senator Frank Lautenberg. I also want to thank Congressman PETER KING as well, since he worked with me on this.

Stillbirth and unexpected infant death affect tens of thousands of families every year, according to data from CDC, and sudden infant death syndrome is the leading cause of death for infants up to 12 months old. Unfortunately, too many families in this country suffer these tragic events, but what makes matters even worse is their struggle with the process to help find answers.

Currently, there is a lack of comprehensive, high-quality data to best understand why these events occur in the first place. The intent of the bill has always been to better utilize the Federal Government's activities in this area.

Specifically, it would expand and standardize surveillance and data collection for stillbirth and sudden unexpected infant death and sudden unexplained death in childhood at the Centers for Disease Control and Prevention.

In addition, it would improve the development of standard protocols for use in death scene investigations and autopsies surrounding these deaths and also allow the Secretary of HHS to conduct training activities regarding these protocols.

The bill also requires CDC, in consultation with NIH, to submit a report to Congress on current activities related to stillbirth, SUID, and SUDC and evaluate the possibility of expanding programs related to SUDC specifically.

Let me close, Mr. Speaker, by personally thanking Laura Crandall, cofounder and codirector of the CJ Foundation's SUDC program. This issue hits close to home for Laura, but in the face of tragedy, she decided to work to help others who also suffered.

She has been a great advocate for this bill and has spread awareness of SUDC in communities all across the country. I thank her for her strength, determination, and dedication.

Mr. Speaker, this bill isn't everything I think the CDC can be doing to address the needs of families across the country, but it represents a critical step on a very tragic issue that deserves our attention.

I urge my colleagues to support its passage, and I yield back the balance of my time.

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

Mr. WAXMAN. Mr. Speaker, I rise in support of H.R. 669, the Sudden Unexpected Death Data Enhancement and Awareness Act.

Stillbirths—the loss of a pregnancy after 20 weeks of gestation—occur for approximately 26,000 women in the United States each year. The Centers for Disease Control and Prevention (CDC) estimate there are 4,000 sudden unexplained infant deaths (SUID) in children under age one each year as well. Sudden Unexplained Deaths in Childhood (SUDC) occur in children over the age of 12 months, with an estimated incidence of 1.2 deaths per 100,000 children.

CDC currently oversees a number of initiatives to collect data on these tragic deaths. H.R. 669 would help to improve surveillance on SUID, SUDC, and stillbirths. Improving data on the number and root causes of these unexplained deaths will be a critical step in advancing our efforts to reduce them.

I want to commend the sponsors of this legislation, Ranking Member PALLONE and Congressman KING, for their leadership on this issue. I would also like to thank Chairman UPTON, Chairman PITTS, and all of our staff for helping to bring this bill through the Energy and Commerce Committee and to the floor today.

I support this legislation and urge my colleagues to do the same.

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. 669, as amended.

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

A motion to reconsider was laid on the table.

WAKEFIELD ACT OF 2014

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4290) to amend the Public Health Service Act to reauthorize the Emergency Medical Services for Children Program, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4290

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 ''Wakefield Act of 2014''.

SEC. 2. REAUTHORIZATION OF EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910(d) of the Public Health Service Act (42 U.S.C. 300w–9(d)) is amended by striking ''fiscal year 2014'' and inserting ''each of fiscal years 2015 through 2019''.

The SPEAKER pro tempore. 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 to insert extraneous materials into 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. 4290, the Wakefield Act of 2014, introduced by Mr. MATHESON of Utah and Mr. KING of New York.

Children have special health needs, especially in the field of emergency medical services. The emergency and trauma care system has been slow to develop an adequate response to these unique needs.

Some problems are endemic in emergency services, such as fragmentation and poor coordination among pre-hospital services, hospitals, and public health. The problem is worse for children when hospitals lack the appropriate medical personnel, pediatric supplies, or transfer agreements that lead to better care within the golden hour, when chances of survival of an accident are higher.

In 1984, Congress passed the Emergency Medical Services for Children as part of the Preventive Health Amendments of 1984. Last reauthorized in 2010, the program aims to reduce child and youth mortality and morbidity caused by severe illness and trauma.

H.R. 4290 reauthorizes the Emergency Medical Services for Children program through 2019. The program supports education and training of EMS providers and identifies models that can increase pediatric care in rural and tribal communities.

The bill also supports the Pediatric Emergency Care Applied Research Network that facilitates collaborative research on pediatric emergency services.

I ask my colleagues to support emergency medical services for children by voting for this important piece of legislation, and I reserve the balance of my time.

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

I rise in support of H.R. 4290, the Wakefield Act of 2014, a bill to reauthorize the Emergency Medical Services for Children program.

The Emergency Medical Services for Children program was established 30 years ago. The program includes a number of grant programs to help States to assess and improve pediatric emergency care; improve emergency services for children in rural, tribal, and other communities; and support research in pediatric emergency medicine.

The legislation before us today will reauthorize the Emergency Medical Services for Children program for another 5 years, so that this critical program can continue its lifesaving work.

I want to offer my thanks to Congressman MATHESON and Congressman KING for sponsoring the bill and to Chairman UPTON, Chairman PITTS, Ranking Member WAXMAN, and our staffs for working on this bill in the Energy and Commerce Committee.

I urge Members to support this legislation, and I reserve the balance of my time.

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

Mr. PALLONE. Mr. Speaker, I yield as much time as he may consume to