Hawaii (Mr. SCHATZ) were added as cosponsors of S. 396, a bill to establish the Proprietary Education Oversight Coordination Committee.

S. 431

At the request of Mr. THUNE, the name of the Senator from Mississippi (Mr. WICKER) was added as a cosponsor of S. 431, a bill to permanently extend the Internet Tax Freedom Act.

S. 474

At the request of Mr. TOOMEY, the names of the Senator from Oklahoma (Mr. INHOFE) and the Senator from Nevada (Mr. HELLER) were added as cosponsors of S. 474, a bill to require State educational agencies that receive funding under the Elementary and Secondary Education Act of 1965 to have in effect policies and procedures on background checks for school employees.

S. 498

At the request of Mr. CORNYN, the name of the Senator from Missouri (Mr. BLUNT) was added as a cosponsor of S. 498, a bill to allow reciprocity for the carrying of certain concealed firearms.

S. 517

At the request of Mr. WYDEN, the name of the Senator from New Mexico (Mr. HEINRICH) was added as a cosponsor of S. 517, a bill to extend the secure rural schools and community self-determination program, to restore mandatory funding status to the payment in lieu of taxes program, and for other purposes.

S. 524

At the request of Mr. WHITEHOUSE, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 524, a bill to authorize the Attorney General to award grants to address the national epidemics of prescription opioid abuse and heroin use.

S. 532

At the request of Mr. BLUMENTHAL, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 532, a bill to improve highway-rail grade crossing safety, and for other purposes.

S. 546

At the request of Ms. HEITKAMP, the name of the Senator from Missouri (Mrs. MCCASKILL) was added as a cosponsor of S. 546, a bill to establish the Railroad Emergency Services Preparedness, Operational Needs, and Safety Evaluation (RESPONSE) Subcommittee under the Federal Emergency Management Agency's National Advisory Council to provide recommendations on emergency responder training and resources relating to hazardous materials incidents involving railroads, and for other purposes.

S. 554

At the request of Mr. CARDIN, the names of the Senator from New Hampshire (Mrs. SHAHEEN), the Senator from California (Mrs. FEINSTEIN), the Senator from New Jersey (Mr. BOOKER), the Senator from New Mexico (Mr. HEINRICH) and the Senator from Massachusetts (Mr. MARKEY) were added as cosponsors of S. 554, a bill to provide for the compensation of Federal employees affected by a lapse in appropriations.

S. 568

At the request of Mr. BROWN, the names of the Senator from Rhode Island (Mr. WHITEHOUSE), the Senator from Connecticut (Mr. BLUMENTHAL), the Senator from Michigan (Mr. PETERS), the Senator from Minnesota (Mr. FRANKEN) and the Senator from Virginia (Mr. KAINE) were added as cosponsors of S. 568, a bill to extend the trade adjustment assistance program, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. COLLINS (for herself and Mr. SCHUMER):

S. 578. A bill to amend title XVIII of the Social Security Act to ensure more timely access to home health services for Medicare beneficiaries under the Medicare program; to the Committee on Finance.

Ms. COLLINS. Mr. President, I rise today on behalf of myself and Senator SCHUMER to introduce legislation to ensure that our seniors and disabled citizens have timely access to home health services under the Medicare program.

Nurse practitioners, physician assistants, certified nurse midwives and clinical nurse specialists are all playing increasingly important roles in the delivery of health care services, particularly in rural and medically underserved areas of our country where physicians may be in scarce supply. In recognition of their growing role, Congress, in 1997, authorized Medicare to begin paying for physician services provided by these health professionals as long as those services are within their scope of practice under State law.

Despite their expanded role, these advanced practice registered nurses and physician assistants are currently unable to order home health services for their Medicare patients. Under current law, only physicians are allowed to certify or initiate home health care for Medicare patients, even though they may not be as familiar with the patient's case as the non-physician provider. In fact, in many cases, the certifying physician may not even have a relationship with the patient and must rely upon the input of the nurse practitioner, physician assistant, clinical nurse specialist or certified nurse midwife to order the medically necessary home health care. At best, this requirement adds more paperwork and a number of unnecessary steps to the process before home health care can be provided. At worst, it can lead to needless delays in getting Medicare patients the home health care they need simply because a physician is not readily available to sign the form.

The inability of advanced practice registered nurses and physician assistants to order home health care is particularly burdensome for Medicare beneficiaries in medically underserved areas, where these providers may be the only health care professionals available. For example, needed home health care was delayed by more than a week for a Medicare patient in Nevada because the physician assistant was the only health care professional serving the patient's small town, and the supervising physician was located 60 miles away.

A nurse practitioner told me about another case in which her collaborating physician had just lost her father and was not available. As a consequence, the patient experienced a 2 day delay in getting needed care while they waited to get the paperwork signed by another physician.

Another nurse practitioner pointed out that it is ridiculous that she can order physical and occupational therapy in a subacute facility but cannot order home health care. One of her patients had to wait eleven days after being discharged before his physical and occupational therapy could continue simply because the home health agency had difficulty finding a physician to certify the continuation of the same therapy that the nurse practitioner had been able to authorize when the patient was in the facility.

The Home Health Care Planning Improvement Act will help to ensure that our Medicare beneficiaries get the home health care that they need when they need it by allowing physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives to order home health services. Our legislation is supported by a broad coalition of organizations, including the AARP, the National Council on Aging, the American Geriatrics Society, the National Association for Home Care and Hospice, the American Nurses Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, the American College of Nurse Midwives, and the Visiting Nurse Associations of America. I urge my colleagues to join us as cosponsors of this important legislation.

Mr. President, I ask unanimous consent that a letter of support be printed in the RECORD.

There being no objection, the text of the material was ordered to be printed in the RECORD, as follows:

FEBRUARY 25, 2015.

Hon. SUSAN COLLINS,
U.S. Senate, Washington, DC.
Hon. CHUCK SCHUMER,
U.S. Senate, Washington, DC.

DEAR SENATOR COLLINS AND SENATOR SCHUMER: Thank you for introducing the bipartisan Home Health Care Planning Improvement Act of 2015. We, the undersigned groups, pledge our continued support of your efforts to obtain passage of this important legislation in the 114th Congress. As you know, the bill authorizes nurse practitioners, clinical nurse specialists, certified nurse-midwives and physician assistants as eligible health care professionals who can certify patient eligibility for home health care services under Medicare. This critical

change would improve access to important home health care services, and potentially prevent additional hospital, sub-acute care facility and nursing home admissions—all of which are costly to the consumer, the taxpayer and Medicare.

The undersigned organizations are committed to ensuring that consumers have access to health care providers who are qualified, educated, and certified to provide high quality primary care, chronic care management, and other services that keep them living a high quality life, with dignity, in locations of their choice.

Although current law has long recognized advanced practice registered nurses and physician assistants as authorized Medicare providers, and allows these clinicians to certify eligibility for nursing home care for their patients, it precludes these same practitioners from certifying patient eligibility for home health care services. This is an unnecessary barrier to care and adds at least one more step in the process of accessing home health care services by requiring the provider to find a physician to certify eligibility. In addition, time delays to locate a physician to certify eligibility, particularly in rural and underserved areas, can result in an extended hospital stay or nursing home admission because the beneficiary could not be moved back to or remain at home without home health care services.

There are decades of data supporting the ability of these providers to deliver high quality care to people of all ages, including Medicare recipients with multiple chronic conditions. Advanced practice registered nurses are often the only care providers available in health professional shortage areas such as urban, rural, and frontier regions. Given the existing and future projected primary care physician shortages, and the coming of increased numbers of Medicare eligible patients, the need will be even greater for all qualified providers to be allowed to certify home health care eligibility.

The Home Health Care Planning Improvement Act would help to ensure that Medicare beneficiaries in need of home health care services whose providers are nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants would be able to directly access home health care by referral from their providers. This bill would provide beneficiaries continued access to care and increase the likelihood that they would experience better health and a higher quality of life. Additionally, outside experts assessed the impact of the bill earlier last year and projected a Medicare savings of $7.1 million in 2015 and up to a ten-year savings of $252.6 million. This analysis also notes the potential to reduce beneficiary admissions to and lengths of stay in institutional settings under the policy change.

We appreciate your continued leadership and are committed to working with you to ensure that this bipartisan legislation is passed and placed on the President's desk for signature at the first opportunity. The time is now to ensure that patients have timely access to the quality, cost effective care they need. For any questions, please contact governmentaffairs@aanp.org or 703–740–2529.

Thank you for your help.

Sincerely,

AARP, AFT Nurses and Health Professionals, AMDA-The Society for Post-Acute and Long-Term Care Medicine, Alzheimer's Foundation of America, American Academy of Nursing, American Academy of Physician Assistants, American Association of Colleges of Nursing, American Association of Heart Failure Nurses, American Association of Nurse Practitioners, American Association of Occupational Health Nurses, American College of Nurse-Midwives, American Geriatrics Society, American Nephrology Nurses' Association, American Nurses Association, American Organization of Nurse Executives.

American Pediatric Surgical Nurses Association, American Psychiatric Nurses Association, Association of Community Health Nursing Educators, Association of Public Health Nurses, Association of Rehabilitation Nurses, Center for Medicare Advocacy, Gerontological Advance Practice Nurses Association, International Society of Psychiatric-Mental Health Nurses, The Jewish Federations of North America, Justice in Aging, Leading Age, Medicare Rights Center, National Academy of Elder Law Attorneys, National Association for Home Care & Hospice.

National Association of Clinical Nurse Specialists, National Association of Neonatal Nurses, National Association of Neonatal Nurse Practitioners, National Association of Pediatric Nurse Practitioners, National Association of Professional Geriatric Care Managers, National Black Nurses Association, National Committee to Preserve Social Security and Medicare, National Consumer Voice for Quality Long-Term Care, National Council on Aging, National Organization of Nurse Practitioner Faculties, Organization for Associate Degree Nursing, OWL—The Voice of Women 40+, Public Health Nursing Section, American Public Health Association, VNAA—The Visiting Nurse Associations of America, Women's Institute for a Secure Retirement.

By Mr. DURBIN (for himself, Mr. NELSON, Mr. BLUMENTHAL, Mr. MARKEY, and Ms. KLOBUCHAR):

S. 588. A bill to require the Consumer Product Safety Commission to establish a consumer product safety standard for liquid detergent packets to protect children under the age of five from injury or illness, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. DURBIN. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 588

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 ''Detergent Poisoning And Child Safety Act of 2015'' or the ''Detergent PACS Act of 2015''.

SEC. 2. SPECIAL PACKAGING AND OTHER REQUIREMENTS FOR LIQUID DETERGENT PACKETS.

(a) DEFINITIONS.—In this Act:

(1) COMMISSION.—The term ''Commission'' means the Consumer Product Safety Commission.

(2) CONSUMER PRODUCT.—The term ''consumer product'' has the meaning given such term in section 3(a) of the Consumer Product Safety Act (15 U.S.C. 2052(a)).

(3) DETERGENT PACKET.—The term ''detergent packet'' means a consumer product that consists of a detergent enclosed in a water soluble outer layer.

(4) LIQUID DETERGENT PACKET.—The term ''liquid detergent packet'' means a consumer product that consists of a substantially liquid or gel detergent enclosed in a water soluble outer layer.

(5) SPECIAL PACKAGING.—The term ''special packaging'' has the meaning given that term in section 2 of the Poison Prevention Packaging Act of 1970 (15 U.S.C. 1471).

(b) SAFETY STANDARDS REQUIRED.—

(1) IN GENERAL.—Except as provided in subsection (c)(1), not later than 540 days after the date of the enactment of this Act, the Commission shall promulgate a final rule that establishes safety standards for liquid detergent packets to protect children who are younger than 5 years of age from injury or illness caused by exposure to such packets.

(2) ELEMENTS.—The final rule promulgated under paragraph (1) shall—

(A) require special packaging for liquid detergent packets;

(B) include standards to address the design and color of liquid detergent packets to—

(i) make them less attractive to children;

(ii) reduce the likelihood of exposure to detergent; and

(iii) otherwise reduce risks related to the ingestion or aspiration of, or ocular contact with, detergent and other potential injury risks of liquid detergent packets;

(C) include standards to address the composition of liquid detergent packets to make the consequences of exposure less severe; and

(D) prescribe warning labels that—

(i) adequately inform consumers of the potential risks of injury and death caused by liquid detergent packets;

(ii) are conspicuous and visible at the point of sale;

(iii) clarify hazard patterns, including known consequences of such hazards; and

(iv) identify actions needed to avoid injury.

(3) TREATMENT AS CONSUMER PRODUCT SAFETY STANDARD.—A rule promulgated under paragraph (1) shall be treated as a consumer product safety standard described in section 7(a) of the Consumer Product Safety Act (15 U.S.C. 2056(a)).

(4) RULEMAKING.—

(A) IN GENERAL.—A rule under paragraph (1) shall be promulgated in accordance with section 553 of title 5, United States Code.

(B) INAPPLICABILITY OF CERTAIN REQUIREMENTS.—Section 9 of the Consumer Product Safety Act (15 U.S.C. 2058) shall not apply to a rulemaking under paragraph (1).

(c) ADOPTION OF VOLUNTARY STANDARD.—

(1) IN GENERAL.—Subsection (b)(1) shall not apply if the Commission determines that—

(A) a voluntary standard pertaining to liquid detergent packets manufactured or imported for use in the United States protects children as described in subsection (b)(1);

(B) such voluntary standard is or will be in effect not later than 1 year after the date of the enactment of this Act; and

(C) such voluntary standard is developed by ASTM International Subcommittee F15.71 on Liquid Laundry Packets, or such other entity as the Commission considers a successor to ASTM International Subcommittee F15.71.

(2) PUBLICATION OF DETERMINATION.—If the Commission makes a determination under paragraph (1), the Commission shall publish such determination in the Federal Register.

(3) TREATMENT OF VOLUNTARY STANDARD.—If the Commission determines that a voluntary standard meets the conditions in paragraph (1), such standard shall be treated as a consumer product safety standard described in section 7(a) of the Consumer Product Safety Act (15 U.S.C. 2056(a)) beginning on the date that is the later of—

(A) the date that is 180 days after the date of the publication under paragraph (2) of such determination; or

(B) the effective date specified in the voluntary standard.

(4) REVISION OF VOLUNTARY STANDARD.—

(A) NOTICE OF REVISION.—If a voluntary standard is treated as a consumer product safety standard under paragraph (3) and such standard is revised by ASTM International

after the Commission makes a determination under paragraph (1), ASTM International shall notify the Commission of such revision not later than 60 days after making such revision.

(B) TREATMENT OF REVISIONS.—A voluntary standard with respect to which the Commission receives notice under subparagraph (A) shall be treated as a consumer product safety standard described in section 7(a) of the Consumer Product Safety Act (15 U.S.C. 2056(a)), promulgated in lieu of the prior version, effective 180 days after the date the Commission is notified of the revision under subparagraph (A), unless not later than 90 days after receiving that notice the Commission determines that the revised voluntary standard does not meet the requirements of paragraph (1)(A), in which case the Commission shall continue to enforce the prior version.

(d) FUTURE RULEMAKING.—

(1) IN GENERAL.—The Commission may, at any time after promulgating a final rule under subsection (b)(1) or making a determination under subsection (c)(1), promulgate such rules in accordance with section 553 of title 5, United States Code, as the Commission considers appropriate to protect, to the maximum degree practicable, children as described in subsection (a)(1).

(2) TREATMENT AS CONSUMER PRODUCT SAFETY STANDARD.—A rule promulgated under paragraph (1) shall be treated as a consumer product safety standard described in section 7(a) of the Consumer Product Safety Act (15 U.S.C. 2056(a)).

(3) INAPPLICABILITY OF CERTAIN REQUIREMENTS.—Section 9 of the Consumer Product Safety Act (15 U.S.C. 2058) shall not apply to a rulemaking under paragraph (1).

(e) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Commission shall submit to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on risks posed by detergent packets to young children and how the Commission is working to protect such children from such risks.

(2) MATTERS COVERED.—The report required by paragraph (1) shall include the following:

(A) A quantitative assessment of annual national pediatric exposure to detergent packets, including the number of exposure incidents, the means of exposure (whether by ingestion, aspiration, or ocular contact), the clinical effects of the exposures, and medical outcomes.

(B) An assessment as to whether the rule promulgated under subsection (b)(1) or the voluntary standard adopted under subsection (c), as the case may be, has been effective in protecting young children from injury or illness caused by exposure to detergent packets.

(C) Such recommendations for legislative or administrative action as the Commission may have to protect young children as described in subparagraph (B).

(3) PUBLICATION.—The Commission shall make the report required by paragraph (1) available to the public on Internet website of the Commission.

By Mrs. FEINSTEIN (for herself and Mrs. BOXER):

S. 596. A bill to amend the Federal Water Pollution Control Act to establish a grant program to support the restoration of San Francisco Bay; to the Committee on Environment and Public Works.

Mrs. FEINSTEIN. Mr. President, I rise on behalf of myself and Senator BOXER to introduce legislation to further the restoration of the San Francisco Bay.

San Francisco Bay is truly a national treasure. Encompassing approximately 550 square miles, it is the largest estuary on the west coast, and is vital to the Nation for both ecological and economic reasons. It is home to more than 1,000 plant and wildlife species, roughly 77 percent of California's remaining perennial estuarine wetlands, and an important stopover for birds along the Pacific Flyway. Marshes around the bay help prevent flooding, protecting more than 40 cities in nine counties, one of the Nation's busiest seaports, and two international airports. The bay is critical to the region's economy, which if it were its own nation, would be the world's 19th largest economy.

Over the last 150 years, the water quality and health of the San Francisco Bay Estuary have been diminished by pollution, invasive species, loss of wetland habitat and other factors. The degradation has not only impacted fish and wildlife, but has also reduced the estuary's ability to support important economic activities such as commercial and sport fishing, shipping, agriculture, recreation, and tourism.

Federal funding in recent years has started the Bay's recovery process by investing in projects that improve water quality and restore critical habitat. These investments, $43 million between 2008 and 2015, were critical to leveraging $145 million from other partners. But much work remains.

That is why I am pleased to introduce the San Francisco Bay Restoration Act with Senator BOXER, Ranking Member of the Senate Environment and Public Works Committee. Companion legislation has also been introduced in the U.S. House of Representatives by Congresswoman JACKIE SPEIER.

This bill was first introduced in the 112th Congress. The Senate Committee on Environment and Public Works reported favorably on the bill in both the 112th and 113th Congresses and recommended its passage.

This bill recognizes the important restoration work that must be done to restore and protect the iconic San Francisco Bay. It authorizes $5 million a year for restoration work between 2015 and 2019, prioritizing funding for projects that will protect and restore vital estuarine habitat for migratory waterfowl, shorebirds, and wildlife; improve and restore water quality and rearing habitat for fish; and in turn reinvigorate recreation, tourism, and agricultural activities in and around the bay.

I urge my colleagues to join me in their support for this measure.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection the text of the bill was ordered to be printed in the RECORD, as follows:

S. 596

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 ''San Francisco Bay Restoration Act''.

SEC. 2. SAN FRANCISCO BAY RESTORATION GRANT PROGRAM.

Title I of the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.) is amended by adding at the end the following:

''SEC. 123. SAN FRANCISCO BAY RESTORATION GRANT PROGRAM.

''(a) DEFINITIONS.—In this section:

''(1) ANNUAL PRIORITY LIST.—The term 'annual priority list' means the annual priority list compiled under subsection (b).

''(2) COMPREHENSIVE PLAN.—The term 'comprehensive plan' means—

''(A) the comprehensive conservation and management plan approved under section 320 for the San Francisco Bay estuary; and

''(B) any amendments to that plan.

''(3) ESTUARY PARTNERSHIP.—The term 'Estuary Partnership' means the San Francisco Estuary Partnership, the entity that is designated as the management conference under section 320.

''(b) ANNUAL PRIORITY LIST.—

''(1) IN GENERAL.—After providing public notice, the Administrator shall annually compile a priority list identifying and prioritizing the activities, projects, and studies intended to be funded with the amounts made available under subsection (c).

''(2) INCLUSIONS.—The annual priority list compiled under paragraph (1) shall include—

''(A) activities, projects, or studies, including restoration projects and habitat improvement for fish, waterfowl, and wildlife, that advance the goals and objectives of the approved comprehensive plan;

''(B) information on the activities, projects, programs, or studies specified under subparagraph (A), including a description of—

''(i) the identities of the financial assistance recipients; and

''(ii) the communities to be served; and

''(C) the criteria and methods established by the Administrator for selection of activities, projects, and studies.

''(3) CONSULTATION.—In developing the priority list under paragraph (1), the Administrator shall consult with and consider the recommendations of—

''(A) the Estuary Partnership;

''(B) the State of California and affected local governments in the San Francisco Bay estuary watershed; and

''(C) any other relevant stakeholder involved with the protection and restoration of the San Francisco Bay estuary that the Administrator determines to be appropriate.

''(c) GRANT PROGRAM.—

''(1) IN GENERAL.—Pursuant to section 320, the Administrator may provide funding through cooperative agreements, grants, or other means to State and local agencies, special districts, and public or nonprofit agencies, institutions, and organizations, including the Estuary Partnership, for activities, studies, or projects identified on the annual priority list.

''(2) MAXIMUM AMOUNT OF GRANTS; NON-FEDERAL SHARE.—

''(A) MAXIMUM AMOUNT OF GRANTS.—Amounts provided to any individual or entity under this section for a fiscal year shall not exceed an amount equal to 75 percent of the total cost of any eligible activities that are to be carried out using those amounts.

''(B) NON-FEDERAL SHARE.—The non-Federal share of the total cost of any eligible activities that are carried out using amounts provided under this section shall be—

''(i) not less than 25 percent; and

''(ii) provided from non-Federal sources.

''(d) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Administrator to carry out this section $5,000,000 for each of fiscal years 2015 through 2019.

''(2) ADMINISTRATIVE EXPENSES.—Of the amount made available to carry out this section for a fiscal year, the Administrator shall use not more than 5 percent to pay administrative expenses incurred in carrying out this section.

''(3) RELATIONSHIP TO OTHER FUNDING.—Nothing in this section limits the eligibility of the Estuary Partnership to receive funding under section 320(g).

''(4) PROHIBITION.—No amounts made available under subsection (c) may be used for the administration of a management conference under section 320.''.

By Mr. TILLIS:

S. 597. A bill to amend section 706 of the Telecommunications Act of 1996 to provide that such section does not authorize the Federal Communications Commission to preempt the laws of certain States relating to the regulation of municipal broadband, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. TILLIS. Mr. President, I rise today to announce that along with my colleague in the House of Representatives, Representative MARSHA BLACKBURN, have introduced legislation that prohibits the Federal Communications Commission from pre-empting States with municipal broadband laws already on the books, or any other States that subsequently adopt such municipal broadband laws. The bill also includes a Sense of Congress stating that the FCC should not impose municipal broadband regulations on any state.

Earlier today, the FCC took an unprecedented and legally questionable step to allow Wilson, North Carolina, to ignore North Carolina law when expanding its municipal broadband network.

The North Carolina law the FCC preempted is intended to protect taxpayers and consumers from the financial risks we have seen many municipalities, including Wilson, face when venturing into broadband ventures that are best left to the private market to provide.

After witnessing how some local governments wasted taxpayer dollars and accumulated millions in debt through poor decision making, the legislatures of states like North Carolina and Tennessee passed commonsense, bipartisan laws that protect hardworking taxpayers and maintain the fairness of free-market competition. Representative BLACKBURN and I recognize the need for Congress to step in and take action to keep unelected bureaucrats from acting contrary to the expressed will of the American people through their State legislatures.

By Mr. CARDIN (for himself, Mr. CRAPO, and Mr. NELSON):

S. 598. A bill to improve the understanding of, and promote access to treatment for, chronic kidney disease, and for other purposes; to the Committee on Finance.

Mr. CARDIN. Mr. President, I rise in support of the bipartisan Chronic Kidney Disease Improvement in Research and Treatment Act of 2015, which I am introducing with Senators CRAPO and NELSON today. This legislation seeks to make a real difference in the lives of Americans suffering from kidney disease and end-stage renal disease.

Kidney disease is the 9th leading cause of death in the United States, and unfortunately, more than one in ten Americans today suffer from some form of kidney disease. More than 615,000 Americans are living with kidney failure or end-stage renal disease, which is an irreversible condition that can be fatal without a kidney transplant or life-sustaining dialysis. 430,000 patients in our country rely on life-sustaining dialysis care to survive.

This legislation seeks to promote research, expand patient choice, and improve care coordination for these hundreds of thousands of patients. Specifically, it would identify the gaps in research and improve the coordination of Federal research efforts. The bill would require the Government Accountability Office to submit a comprehensive report analyzing current federally funded research projects regarding chronic kidney disease and identifying knowledge gaps that are not being addressed through those research efforts. It would also direct the Department of Health and Human Services to evaluate and report on the biological, social, and behavioral factors related to kidney disease and efforts to slow the progression of disease in minority populations disproportionately affected by this disease.

This legislation would improve access to pre-dialysis kidney education programs to better manage patients' kidney disease and even prevent kidney failure in some cases. Nephrologists and other health professionals would be incentivized to work in underserved rural and urban areas, and current payment policies would be modified to encourage home dialysis, which is not incentivized under the current Medicare payment structure. Patients with acute kidney injury would also be allowed to receive treatments through dialysis providers, therefore reducing costs associated with care provided in the more expensive hospital outpatient setting. Perhaps most importantly, our legislation would establish a voluntary coordinated care program that would incentivize doctors and dialysis facilities to work together to improve the coordination of care and reduce costly hospitalization.

Lastly, the bill would expand the options for patients by allowing individuals diagnosed with kidney failure to enroll in the Medicare Advantage program and reauthorizing on a permanent basis the Medicare Advantage Special Needs Plan for patients with kidney failure.

I urge my colleagues to join me, Senator CRAPO and Senator NELSON in supporting the Chronic Kidney Disease Improvement in Research and Treatment Act of 2015, which will improve the care of patients who suffer from kidney disease and end-stage renal disease.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection the text of the bill was ordered to be printed in the RECORD, as follows:

S. 598

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 ''Chronic Kidney Disease Improvement in Research and Treatment Act of 2015''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—IMPROVING UNDERSTANDING OF CHRONIC KIDNEY DISEASE THROUGH EXPANDED RESEARCH AND COORDINATION

SEC. 101. IDENTIFYING GAPS IN CHRONIC KIDNEY DISEASE RESEARCH.

(a) REPORT.—Not later than one year after the date of enactment of this Act, the Comptroller General of the United States shall develop and submit to Congress a comprehensive report assessing the adequacy of Federal expenditures in chronic kidney disease research relative to Federal expenditures for chronic kidney disease care.

(b) CONTENTS.—The report required by this section shall—

(1) analyze the current chronic kidney disease research projects being funded by Federal agencies;

(2) identify, including by surveying the kidney care community, areas of chronic kidney disease knowledge gaps that are not part of current Federal research efforts;

(3) report on the level of Federal expenditures on kidney research as compared to the amount of Federal expenditures on treating individuals with chronic kidney disease; and

(4) identify areas of kidney failure knowledge gaps in research to assess treatment patterns associated with providing care to minority populations that are disproportionately affected by kidney failure.

SEC. 102. COORDINATING RESEARCH ON CHRONIC KIDNEY DISEASE.

(a) INTERAGENCY COMMITTEE.—The Secretary of Health and Human Services shall establish and maintain an interagency committee for the purpose of improving the coordination of chronic kidney disease research.

(b) REPORTS.—For the purpose described in subsection (a), the interagency committee established under such subsection shall issue public reports that—

(1) include a strategic plan, including recommendations for—

(A) improving communication and coordination among Federal agencies;

(B) procedures for monitoring Federal chronic kidney disease research activities; and

(C) ways to maximize the efficiency of the Federal chronic kidney disease research investment and minimize the potential for unnecessary duplication;

(2) include a portfolio analysis that provides information on chronic kidney disease research projects, organized by the strategic plan objectives; and

(3) address such other topics as the interagency committee determines appropriate.

(c) MEETINGS.—The interagency committee established under subsection (a) shall meet not less frequently than semi-annually.

SEC. 103. UNDERSTANDING THE PROGRESSION OF KIDNEY DISEASE AND TREATMENT OF KIDNEY FAILURE IN MINORITY POPULATIONS.

Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) complete a study on—

(A) the social, behavioral, and biological factors leading to kidney disease;

(B) efforts to slow the progression of kidney disease in minority populations that are disproportionately affected by such disease; and

(C) treatment patterns associated with providing care, under the Medicare program under title XVIII of the Social Security Act, the Medicaid program under title XIX of such Act, and through private health insurance, to minority populations that are disproportionately affected by kidney failure; and

(2) submit to Congress a report on the results of such study.

SEC. 104. IDENTIFYING MEDICARE PAYMENT DISINCENTIVES FOR TRANSPLANT AND POST-TRANSPLANT CARE.

Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on any disincentives in the payment systems under the Medicare program under title XVIII of the Social Security Act that create barriers to kidney transplants and post-transplant care for beneficiaries with end-stage renal disease.

TITLE II—PROMOTING ACCESS TO CHRONIC KIDNEY DISEASE TREATMENTS

SEC. 201. INCREASING ACCESS TO MEDICARE KIDNEY DISEASE EDUCATION BENEFIT.

(a) IN GENERAL.—Section 1861(ggg) of the Social Security Act (42 U.S.C. 1395x(ggg)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), by inserting '' or stage V'' after ''stage IV'';

(B) in subparagraph (B), by inserting ''or of a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)) assisting in the treatment of the individual's kidney condition'' after ''kidney condition''; and

(2) in paragraph (2)—

(A) by striking subparagraph (B); and

(B) in subparagraph (A)—

(i) by striking ''(A)'' after ''(2)'';

(ii) by striking ''and'' at the end of clause (i);

(iii) by striking the period at the end of clause (ii) and inserting ''; and'';

(iv) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively; and

(v) by adding at the end the following:

''(C) a renal dialysis facility subject to the requirements of section 1881(b)(1) with personnel who—

''(i) provide the services described in paragraph (1); and

''(ii) is a physician (as defined in subsection (r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in subsection (aa)(5)).''.

(b) PAYMENT TO RENAL DIALYSIS FACILITIES.—Section 1881(b) of such Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(15) For purposes of paragraph (14), the single payment for renal dialysis services under such paragraph shall not take into account the amount of payment for kidney disease education services (as defined in section 1861(ggg)). Instead, payment for such services shall be made to the renal dialysis facility on an assignment-related basis under section 1848.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to kidney disease education services furnished on or after January 1, 2016.

SEC. 202. IMPROVING ACCESS TO CHRONIC KIDNEY DISEASE TREATMENT IN UNDERSERVED RURAL AND URBAN AREAS.

(a) DEFINITION OF PRIMARY CARE SERVICES.—Section 331(a)(3)(D) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(D)) is amended by inserting ''and includes renal dialysis services'' before the period at the end.

(b) NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.—Section 338A(a)(2) of the Public Health Service Act (42 U.S.C. 254l(a)(2)) is amended by inserting '', including nephrologists and non-physician practitioners providing renal dialysis services'' before the period at the end.

(c) NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM.—Section 338B(a)(2) of the Public Health Service Act (42 U.S.C. 254l–1(a)(2)) is amended by inserting '', including nephrologists and non-physician practitioners providing renal dialysis services'' before the period at the end.

SEC. 203. PROMOTING ACCESS TO HOME DIALYSIS TREATMENTS.

Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclause:

''(IX) A renal dialysis facility (as defined in section 1881).''.

SEC. 204. EXPANDING ACCESS FOR PATIENTS WITH ACUTE KIDNEY INJURY.

Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended—

(1) in paragraph (1), by inserting ''or acute kidney injury'' after ''individuals who have been determined to have end stage renal disease'';

(2) in paragraph (2)(A), by inserting ''or acute kidney injury'' after ''end stage renal disease'';

(3) in paragraph (2)(B), by inserting ''or acute kidney injury'' after ''end stage renal disease'';

(4) in paragraph (3), in the matter preceding subparagraph (A), by inserting ''or acute kidney injury'' after ''end stage renal disease'';

(5) in paragraph (11)(A), by inserting ''or acute kidney injury'' after ''end stage renal disease'';

(6) in paragraph (11)(B), by inserting ''or acute kidney injury'' after ''end stage renal disease'';

(7) in paragraph (14)(B)—

(A) in clause (ii), by inserting ''or acute kidney injury'' after ''end stage renal disease'';

(B) in clause (iii), by inserting ''or acute kidney injury'' after ''end stage renal disease''; and

(C) in clause (iv), by inserting ''or acute kidney injury'' after ''end stage renal disease''; and

(8) in paragraph (14)(H)(i), by inserting ''or acute kidney injury'' after ''end stage renal disease''.

TITLE III—CREATING ECONOMIC STABILITY FOR PROVIDERS CARING FOR INDIVIDUALS WITH CHRONIC KIDNEY DISEASE

SEC. 301. STABILIZING MEDICARE PAYMENTS FOR SERVICES PROVIDED TO BENEFICIARIES WITH STAGE V CHRONIC KIDNEY DISEASE RECEIVING DIALYSIS SERVICES.

Section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) is amended—

(1) in subparagraph (D), in the matter preceding clause (i), by striking ''Such system'' and inserting ''Subject to subparagraph (J), such system''; and

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

''(J)(i) For payment for renal dialysis services furnished on or after January 1, 2016, under the system under this paragraph—

''(I) the payment adjustment described in clause (i) of subparagraph (D) shall not take into account comorbidities;

''(II) the payment adjustment described in clause (ii) of such subparagraph shall not be included;

''(III) the standardization factor described in the final rule published in the Federal Register on November 8, 2012 (77 Fed. Reg. 67470), shall be established using the most currently available data (and not historical data) and adjusted on an annual basis, based on such available data, to account for any change in utilization of drugs and any modification in adjustors applied under this paragraph; and

''(IV) the Secretary shall take into account reasonable costs consistent with paragraph (2)(B) when calculating such payments.

''(ii) Not later than January 1, 2016, the Secretary shall amend the ESRD facility cost report to—

''(I) include the per treatment network fee (as described in paragraph (7)) as an allowable cost; and

''(II) eliminate the limitation for reporting medical director fees on such reports in order to take into account the wages of a board-certified nephrologist.''.

SEC. 302. PROVIDING INDIVIDUALS WITH KIDNEY FAILURE ACCESS TO MANAGED CARE AND COORDINATED CARE PROGRAMS.

(a) EXPANDING ACCESS TO MEDICARE ADVANTAGE.—

(1) ELIGIBILITY UNDER MEDICARE ADVANTAGE.—

(A) IN GENERAL.—Section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)) is amended—

(i) by striking subparagraph (B); and

(ii) by striking ''ELIGIBLE INDIVIDUAL.—'' and all that follows through ''In this title''

and inserting ''ELIGIBLE INDIVIDUAL.—In this title''.

(B) CONFORMING AMENDMENT.—Section 1852(b)(1) of the Social Security Act (42 U.S.C. 1395w–22(b)(1)) is amended—

(i) by striking subparagraph (B); and

(ii) by striking ''BENEFICIARIES.—'' and all that follows through ''A Medicare+Choice organization'' and inserting ''BENEFICIARIES.—A Medicare Advantage organization''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply with respect to plan years beginning on or after January 1, 2016.

(2) EDUCATION.—Section 1851(d)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–21(d)(2)(A)(iii)) is amended by inserting before the period at the end the following '', including any additional information that individuals determined to have end stage renal disease may need to make informed decisions with respect to such an election''.

(3) QUALITY METRICS.—Section 1852(e)(3)(A) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)(A)) is amended by adding at the end the following new clause:

''(v) REQUIREMENTS WITH RESPECT TO INDIVIDUALS WITH ESRD.—In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data, determined in consultation with the kidney care community, that permits the measurement of health outcomes and other indices of quality with respect to individuals determined to have end stage renal disease.''.

(b) PERMANENT EXTENSION OF MEDICARE ADVANTAGE ESRD SPECIAL NEEDS PLANS AUTHORITY.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)) is amended by inserting '', in the case of a specialized MA plan for special needs individuals who have not been determined to have end stage renal disease,'' before ''for periods before January 1, 2017''.

(c) VOLUNTARY ESRD COORDINATED CARE GAINSHARING PROGRAM.—

(1) IN GENERAL.—Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(15)(A) Not later than January 1, 2017, the Secretary shall, in accordance with this paragraph, establish an ESRD Care Coordination gainsharing program for nephrologists, renal dialysis facilities, and providers of services that develop coordinated care organizations to provide a full range of clinical and supportive services (as described in subparagraph (D)) to individuals determined to have end stage renal disease.

''(B) Under such program, subject to subparagraph (C), the payment amounts renal dialysis facilities and providers of services described in subparagraph (A) would otherwise receive under paragraph (14) and nephrologists described in subparagraph (A) would otherwise receive under section 1848 with respect to dialysis services furnished by such a facility, provider, or nephrologist during a year, shall be increased by a portion of the amount (as determined by the Secretary) of actual reductions in expenditures under this title attributable to the coordinated care organization developed by such facility, provider, or nephrologist involved, taking into account non-dialysis expenditures under parts A and B, during the preceding calendar year. The payment amount under this subparagraph shall be provided to a nephrologist, renal dialysis facility, and provider of services that developed the coordinated care organization not later than March 31 of the year after the year during which such services are provided by such nephrologist, facility, or provider.

''(C) The aggregate incentive payment amounts provided under such program for a year may not exceed the amount equal to 2 percent less than the estimated total amount of non-dialysis expenditures under parts A and B for 2017 for items and services that are not related to dialysis or transplant services.

''(D) For purposes of subparagraph (A), the full range of clinical and supportive services includes at least the following:

''(i) Primary care and other preventative services.

''(ii) Specialty care for co-morbidities or non-renal acute conditions, including at least podiatry, cardiology, and orthopedics.

''(iii) Vascular access.

''(iv) Laboratory testing and diagnostic imaging.

''(v) Pharmacy care management.

''(vi) Patient, family, and caregiver education.

''(vii) Psychiatric, behavioral therapy, and counseling services.

''(E) In providing payment incentive amounts under such program, the Secretary shall apply a risk adjustment methodology that—

''(i) uses risk adjuster factors applied under part C; and

''(ii) adjusts such payments to exclude the top 2 percent of outliers.

''(F) In establishing such program, the Secretary shall ensure that each of the following is satisfied:

''(i) The program allows for all types and sizes of renal dialysis facilities and providers of services described in subparagraph (A), including profit and not-for-profit, urban and rural, as well as all other types and sizes of such facilities and providers, to participate.

''(ii) The program rewards high quality, efficient facilities and providers through gainsharing.

''(iii) For purposes of determining the actual reductions in expenditures under this title attributable to a coordinated care organization described in subparagraph (A), the program includes a market-based benchmark system that will not be rebased against which such expenditures shall be compared.

''(iv) The program results in reductions of expenditures under parts A and B for services that are not dialysis-related services.

''(v) The program allows new applicants to participate in the program after the initial implementation period.

''(vi) The program establishes clear quality metrics in consultation with the kidney care community.

''(vii) The program provides for waivers of Federal laws or requirements, in consultation with interested stakeholders.

''(viii) Under such program the Secretary attributes individuals described in subparagraph (A) who receive treatment through a care coordination organization described in such subparagraph to such organization rather than to any other payment model that requires beneficiary attribution.

''(ix) Under such program the Secretary provides quarterly Medicare parts A and B claims data to facilities and providers described in subparagraph (A) participating in such program.

''(G) Not later than 3 years after the date of the implementation of the ESRD Care Coordination gainsharing program, the Secretary shall submit to Congress a report on the waivers granted under subparagraph (F)(vii) and the effectiveness of such waivers in allowing the coordination of care.''.

(2) CONFORMING AMENDMENTS.—

(A) SECTION 1881.—Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended—

(i) in each of paragraphs (12)(A) and (13)(A), by striking ''paragraph (14)'' and inserting ''paragraphs (14) and (15)''; and

(ii) in paragraph (14)(A)(i), by inserting ''and paragraph (15)'' after ''Subject to subparagraph (E)''.

(B) SECTION 1848.—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) VOLUNTARY ESRD COORDINATED CARE PROGRAM.—For provisions related to incentive payment amounts to nephrologists under the ESRD Care Coordination gainsharing program, see section 1881(b)(15).''.

(d) PATIENT INFORMATION REQUIREMENT.—The Secretary of Health and Human Services shall require hospitals that furnish items and services to individuals entitled to benefits under part A of title XVIII of the Social Security Act or eligible for benefits under part B of such title and who subsequently receive dialysis services at a renal dialysis facility (as defined in section 1881 of such Act (42 U.S.C. 1395rr)) to provide to such facility health information with respect to such individual, including a discharge summary and co-morbidity information, upon request of the facility, not later than 7 days after notification by the hospital of the provision of such services to such individual or of the determination that such individual has end stage renal disease, as applicable.

Mr. CRAPO. Mr. President, I rise to speak on the importance of the Chronic Kidney Disease Improvement in Research and Treatment Act being introduced today. This legislation will not only pave the way for enhanced research opportunities and allow physicians greater flexibility in how and where they treat patients, but, importantly, will provide increased access to care for those with chronic and end-stage kidney disease, particularly in rural and underserved areas. As our Nation continues to face dangerously high levels of debt, it is imperative we prioritize initiatives such as this while simultaneously ensuring we do not worsen our already fragile fiscal picture. Prior to passage, as with any piece of legislation, a responsible offset that is budget neutral must be included.

By Mr. CARDIN (for himself, Mr. TOOMEY, and Ms. COLLINS):

S. 599. A bill to extend and expand the Medicaid emergency psychiatric demonstration project; to the Committee on Finance.

Mr. CARDIN. Mr. President, today Senators TOOMEY and COLLINS and I are introducing the Improving Access to Emergency Psychiatric Care Act of 2015, which will build on the current 3-year Medicaid Emergency Psychiatric Demonstration Project to provide timely and cost-effective treatment to people who are experiencing an emergency psychiatric crisis.

We know that emergency psychiatric care delivered in general hospitals and freestanding psychiatric hospitals is a life-saving service for individuals with severe mental illnesses. In addition, a Government Accountability Office report, GAO–09–347, on hospital emergency departments concluded the difficulties in transferring, admitting, or

discharging psychiatric patients from the emergency department contribute to overcrowding in our Nation's emergency rooms.

Community-based psychiatric hospitals, like Sheppard Pratt Health System in my home State of Maryland, could help relieve these back-ups in emergency departments; however, due to a longstanding Medicaid statutory provision called the Institution for Mental Disease, IMD, exclusion, patients receiving care in these freestanding psychiatric hospitals are not covered if the patients are between the ages of 21 and 64, and the hospitals cannot get Medicaid Federal matching payments for these services.

In response to this problem, bipartisan legislation was first introduced in the Senate in 2003 by Senators Olympia Snowe and Kent Conrad, who were joined by Senators SUSAN COLLINS and RON WYDEN, to address this problem by allowing Federal Medicaid matching payments to freestanding psychiatric hospitals for emergency psychiatric cases. In 2010, based on this legislation, Congress authorized a three-year demonstration that was intended to expand the number of emergency inpatient psychiatric beds available in communities. Currently, 11 States, including my State of Maryland, and the District of Columbia are participating in this demonstration.

The purpose of the demonstration is to determine whether allowing Federal Medicaid matching payments to freestanding psychiatric hospitals for emergency psychiatric cases improves access to and quality of medically necessary care, improves discharge planning for demonstration beneficiaries, and has a positive impact on Medicaid cost and utilization. The preliminary data shows that, of the total number of Medicaid beneficiaries admitted to these freestanding psychiatric hospitals, 84 percent had just one admission during the entire first year of the demonstration. The average length of stay was a short 8.2 days and, in 88 percent of the admissions, the patients were discharged home.

The current demonstration project would end no later than December 31, 2015; however, the final evaluation of this project by CMS is not expected to be completed until 1 year later, in the fall of 2016.

The purpose of the bipartisan legislation we are introducing today is to allow the Secretary of Health and Human Services to continue the current demonstration project until the Secretary submits a report to Congress with her recommendations, based on the final evaluation, regarding whether the current demonstration should be extended for an additional 3 years and whether additional States should be allowed to participate in the demonstration, or September 30, 2016, whichever occurs first.

Importantly, in order to extend the current demonstration project until the report is submitted, the Secretary must determine that overall Medicaid spending in the participating state is not expected to increase during the extension of the demonstration project for a maximum of nine months, and the Chief Actuary of CMS must also certify that the extension is not projected to result in an increase in net Medicaid program spending. If, in her report, the Secretary recommends extending the demonstration project for an additional three years and/or expanding it to include other States, the same requirements regarding Medicaid spending would need to be met, ensuring budget neutrality. At the completion of those additional 3 years, the demonstration project would come to a close unless Congress passes authorizing legislation to continue and/or expand the demonstration project.

We have a real crisis in this country for millions of Americans who cannot get timely access to life-saving emergency inpatient psychiatric treatment. The Medicaid program is a vital source of support for people with mental disorders, funding more than 50 percent of state and local spending on mental health services. This outdated IMD policy is penalizing the disabled and poor. It is also contributing to inefficiencies in our health care system and likely adding to the cost of care. The legislation introducing today would help ensure that the neediest have access to hospital care when they need it and strengthen our Nation's health care system. It is an incremental, targeted approach with built-in cost safeguards, so I hope my colleagues will join with me to support this legislation.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 599

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 ''Improving Access to Emergency Psychiatric Care Act''.

SEC. 2. EXTENSION AND EXPANSION OF MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) IN GENERAL.—Subsection (d) of section 2707 of Public Law 111–148 (42 U.S.C. 1396a note) is amended to read as follows:

''(d) LENGTH OF DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the demonstration project established under this section shall be conducted for a period of 3 consecutive years.

''(2) TEMPORARY EXTENSION OF PARTICIPATION ELIGIBILITY FOR SELECTED STATES.—

''(A) IN GENERAL.—Subject to paragraph (3), a State selected as an eligible State to participate in the demonstration project on or prior to March 13, 2012, shall, upon the request of the State, be permitted to continue to participate in the demonstration project through the date described in subparagraph (B) if—

''(i) the Secretary determines that the continued participation of the State in the demonstration project is not expected to increase spending under title XIX of the Social Security Act; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such extension for that State is projected to reduce (or is projected not to result in any increase in) net program spending under title XIX of the Social Security Act.

''(B) DATE DESCRIBED.—The date described in this subparagraph is the earlier of—

''(i) the date on which Secretary submits the recommendations required under subsection (f)(3); or

''(ii) September 30, 2016.

''(3) EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—

''(A) ADDITIONAL EXTENSION.—Taking into account the recommendations submitted to Congress pursuant to subsection (f)(3), the Secretary may, if the Secretary determines that extension and expansion of the demonstration project satisfies the criteria for the temporary extension under subparagraphs (A) and (B) of paragraph (2)—

''(i) extend the demonstration project through December 31, 2019; and

''(ii) permit any eligible State participating in the demonstration project as of the date such recommendations are submitted to continue to participate in the project.

''(B) OPTION FOR EXPANSION TO ADDITIONAL STATES.—Taking into account the recommendations submitted to Congress pursuant to subsection (f)(3), the Secretary may expand (including on a nationwide basis) the number of eligible States participating in the demonstration project during the extension period established under subparagraph (A) if, with respect to any new eligible State—

''(i) the Secretary determines that the participation of the State in the demonstration project is not expected to increase spending under title XIX of the Social Security Act; and

''(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that the participation of the State in the demonstration project is projected to reduce (or is projected not to result in any increase in) net program spending under title XIX of the Social Security Act.

''(4) AUTHORITY TO ENSURE BUDGET NEUTRALITY.—The Secretary annually shall review each participating State's demonstration project expenditures to ensure compliance with the requirements of paragraphs (2)(A), (2)(B), (3)(B)(i), and (3)(B)(ii) (as applicable). If the Secretary determines with respect to a State's participation in the demonstration project that the State's net program spending under title XIX of the Social Security Act has increased as a result of the State's participation in the project, the Secretary shall treat the demonstration project excess expenditures of the State as an overpayment under title XIX of the Social Security Act.''.

(b) FUNDING.—Subsection (e) of section 2707 of such Act (42 U.S.C. 1396a note) is amended—

(1) in the subsection heading, by striking ''LIMITATIONS ON FEDERAL'';

(2) in paragraph (2)—

(A) in the paragraph heading, by striking ''5-YEAR''; and

(B) by striking ''through December 31, 2015'' and inserting ''until expended'';

(3) by striking paragraph (3);

(4) by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively;

(5) in paragraph (3) (as so redesignated), by striking ''and the availability of funds'' and inserting ''(other than States deemed to be eligible States through the application of subsection (c)(4))''; and

(6) in paragraph (4) (as so redesignated)—

(A) in the first sentence—

(i) by inserting ''(other than a State deemed to be an eligible State through the

application of subsection (c)(4))'' after ''eligible State''; and

(ii) by striking ''paragraph (4)'' and inserting ''paragraph (3)''; and

(B) by inserting after the first sentence the following ''In addition to any payments made to an eligible State under the preceding sentence, the Secretary shall, during any period in effect under paragraph (2) or (3) of subsection (d), or during any period in which a law described in subsection (f)(4)(C) is in effect, pay each eligible State (including any State deemed to be an eligible State through the application of subsection (c)(4)), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter during such period for medical assistance described in subsection (a). Payments made to States under this paragraph shall be considered to have been made under, and are subject to, the requirements of section 1903 of the Social Security Act (42 U.S.C. 1396b).''.

(c) RECOMMENDATIONS TO CONGRESS.—Subsection (f) of section 2707 of such Act (42 U.S.C. 1396a note) is amended by adding at the end the following:

''(3) RECOMMENDATION TO CONGRESS REGARDING EXTENSION AND EXPANSION OF PROJECT.—Not later than September 30, 2016, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

''(A) whether the demonstration project should be continued after December 31, 2016; and

''(B) whether the demonstration project should be expanded (including on a nationwide basis).

''(4) RECOMMENDATION TO CONGRESS REGARDING PERMANENT EXTENSION AND NATIONWIDE EXPANSION.—

''(A) IN GENERAL.—Not later than April 1, 2019, the Secretary shall submit to Congress and make available to the public recommendations based on an evaluation of the demonstration project, including the use of appropriate quality measures, regarding—

''(i) whether the demonstration project should be permanently continued after December 31, 2019, in 1 or more States; and

''(ii) whether the demonstration project should be expanded (including on a nationwide basis).

''(B) REQUIREMENTS.—Any recommendation submitted under subparagraph (A) to permanently continue the project in a State, or to expand the project to 1 or more other States (including on a nationwide basis) shall include a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that permanently continuing the project in a particular State, or expanding the project to a particular State (or all States) is projected to reduce (or is projected not to result in any increase in) net program spending under title XIX of the Social Security Act. If the Secretary determines with respect to a State's participation in the demonstration project that net program spending under title XIX of such Act has increased as a result of the project, the Secretary shall treat the demonstration project excess expenditures of the State as an overpayment under title XIX of the Social Security Act.

''(C) CONGRESSIONAL APPROVAL REQUIRED.—The Secretary shall not permanently continue the demonstration project in any State after December 31, 2019, or expand the demonstration project to any additional State after December 31, 2019, unless Congress enacts a law approving either or both such actions.

''(5) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Centers for Medicare & Medicaid Services Program Management Account to carry out this subsection, $100,000 for fiscal year 2015, to remain available until expended.''.

(d) CONFORMING AMENDMENTS.—Section 2707 of such Act (42 U.S.C. 1396a note) is amended—

(1) in subsection (c)—

(A) in paragraph (1), by striking ''An eligible State'' and inserting ''Except as otherwise provided in paragraph (4), an eligible State'';

(B) in paragraph (3), by striking ''A State shall'' and inserting ''Except as otherwise provided in paragraph (4), a State shall''; and

(C) by adding at the end the following:

''(4) NATIONWIDE AVAILABILITY.—In the event that the Secretary makes a recommendation pursuant to subsection (f)(4) that the demonstration project be expanded on a national basis, any State that has submitted or submits an application pursuant to paragraph (2) shall be deemed to have been selected to be an eligible State to participate in the demonstration project.''; and

(2) in the heading for subsection (f), by striking ''AND REPORT'' and inserting '', REPORT, AND RECOMMENDATIONS''.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 88—CELEBRATING BLACK HISTORY MONTH

Mr. BOOKER (for himself, Mr. COCHRAN, Mrs. GILLIBRAND, Mr. ISAKSON, Mr. DURBIN, Ms. MURKOWSKI, Mrs. FEINSTEIN, Mrs. MURRAY, Mr. PAUL, Mr. MERKLEY, Mr. COONS, Mr. PORTMAN, Ms. STABENOW, Mr. MURPHY, Mr. WICKER, Ms. AYOTTE, Mr. BURR, Mr. CARDIN, Mr. REED, Mr. PERDUE, Mr. TILLIS, Mr. PETERS, and Mr. SASSE) submitted the following resolution; which was considered and agreed to:

S. RES. 88

Whereas in 1776, people imagined the United States as a new country dedicated to the proposition stated in the Declaration of Independence that ''all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness . . .'';

Whereas the first Africans were brought involuntarily to the shores of America as early as the 17th century;

Whereas African Americans suffered enslavement and subsequently faced the injustices of lynch mobs, segregation, and denial of the basic and fundamental rights of citizenship;

Whereas in 2015, the vestiges of these injustices and inequalities remain evident in the society of the United States;

Whereas in the face of injustices, people of the United States of good will and of all races have distinguished themselves with a commitment to the noble ideals on which the United States was founded and have courageously fought for the rights and freedom of African Americans;

Whereas African Americans, such as Lieutenant Colonel Allen Allensworth, Constance Baker Motley, James Baldwin, James Beckwourth, Clara Brown, Ralph Bunche, Shirley Chisholm, Frederick Douglass, W. E. B. Du Bois, Ralph Ellison, Medgar Evers, Alex Haley, Dorothy Height, Lena Horne, Charles Hamilton Houston, Mahalia Jackson, Martin Luther King, Jr., the Tuskegee Airmen, Thurgood Marshall, Rosa Parks, Bill Pickett, Jackie Robinson, Aaron Shirley, Sojourner Truth, Harriet Tubman, Homer Plessy, the Greensboro Four, Maya Angelou, Arthur Ashe Jr., Booker T. Washington, Stephanie Tubbs Jones, Hiram Revels, and Blanche Bruce, along with many others, worked against racism to achieve success and to make significant contributions to the economic, educational, political, artistic, athletic, literary, scientific, and technological advancements of the United States, including the westward expansion;

Whereas the contributions of African Americans from all walks of life throughout the history of the United States reflect the greatness of the United States;

Whereas many African Americans lived, toiled, and died in obscurity, never achieving the recognition they deserved, and yet paved the way for future generations to succeed;

Whereas African Americans continue to serve the United States at the highest levels of government and military;

Whereas the birthdays of Abraham Lincoln and Frederick Douglass inspired the creation of Negro History Week, the precursor to Black History Month;

Whereas Negro History Week represented the culmination of the efforts of Dr. Carter G. Woodson, the ''Father of Black History'', to enhance knowledge of Black history through the Journal of Negro History, published by the Association for the Study of African American Life and History, which was founded by Dr. Carter G. Woodson and Jesse E. Moorland;

Whereas Black History Month, celebrated during the month of February, dates back to 1926 when Dr. Carter G. Woodson set aside a special period in February to recognize the heritage and achievement of Black people of the United States;

Whereas Dr. Carter G. Woodson stated: ''We have a wonderful history behind us. . . . If you are unable to demonstrate to the world that you have this record, the world will say to you, 'You are not worthy to enjoy the blessings of democracy or anything else.' '';

Whereas since the founding of the United States, the country imperfectly progressed towards noble goals; and

Whereas the history of the United States is the story of people regularly affirming high ideals, striving to reach such ideals but often failing, and then struggling to come to terms with the disappointment of such failure, before committing to trying again: Now, therefore, be it

Resolved, That the Senate—

(1) acknowledges that all people of the United States are the recipients of the wealth of history provided by Black culture;

(2) recognizes the importance of Black History Month as an opportunity to reflect on the complex history of the United States, while remaining hopeful and confident about the path ahead;

(3) acknowledges the significance of Black History Month as an important opportunity to recognize the tremendous contributions of African Americans to the history of the United States;

(4) encourages the celebration of Black History Month to provide a continuing opportunity for all people in the United States to learn from the past and understand the experiences that have shaped the United States; and

(5) agrees that, while the United States began as a divided Nation, the United States must—

(A) honor the contribution of all pioneers in the United States who have helped to ensure the legacy of the great United States; and