B. HICE) that the House suspend the rules and pass the bill, H.R. 5798.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. HUELSKAMP. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

EMERGENCY CITRUS DISEASE RESPONSE ACT OF 2016

Mr. BUCHANAN. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 3957) to amend the Internal Revenue Code of 1986 to temporarily allow expensing of certain costs of replanting citrus plants lost by reason of casualty, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3957

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 ''Emergency Citrus Disease Response Act of 2016''.

SEC. 2. EXPENSING OF CERTAIN COSTS OF REPLANTING CITRUS PLANTS LOST BY REASON OF CASUALTY.

(a) IN GENERAL.—Section 263A(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(C) SPECIAL TEMPORARY RULE FOR CITRUS PLANTS LOST BY REASON OF CASUALTY.—

''(i) IN GENERAL.—In the case of the replanting of citrus plants, subparagraph (A) shall apply to amounts paid or incurred by a person (other than the taxpayer described in subparagraph (A)) if—

''(I) the taxpayer described in subparagraph (A) has an equity interest of not less than 50 percent in the replanted citrus plants at all times during the taxable year in which such amounts were paid or incurred and such other person holds any part of the remaining equity interest, or

''(II) such other person acquired the entirety of such taxpayer's equity interest in the land on which the lost or damaged citrus plants were located at the time of such loss or damage, and the replanting is on such land.

''(ii) TERMINATION.—Clause (i) shall not apply to any cost paid or incurred after December 31, 2025.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to costs paid or incurred after the date of the enactment of this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. BUCHANAN) and the gentleman from Michigan (Mr. LEVIN) each will control 20 minutes.

The Chair recognizes the gentleman from Florida.

GENERAL LEAVE

Mr. BUCHANAN. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days in which to revise and extend their remarks and to include extraneous material on H.R. 3957, currently under consideration.

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

There was no objection.

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

This bill makes a slight change to the existing law in order to help struggling farmers.

The U.S. citrus industry faces a grave threat from an incurable bacterial disease called citrus greening. While not harmful to humans, it results in bitter, hard, misshapen fruit and eventually causes trees to die.

The disease arrived in Florida in 2005 and has since infected 99 percent of the commercial citrus groves in my State as well as 50 percent of the groves in Texas. Greening has begun to march across the country and has been found in California, Louisiana, South Carolina, and Georgia. Once infected, trees must be uprooted and destroyed. Replacing citrus trees is costly, but farmers have no choice as they must replant in order to earn a living. This disease has put 62,000 citrus jobs at risk in my State alone.

The Tax Code currently allows farmers to fully deduct the cost of replanting trees that are damaged by drought, disease, or pests; but the current rule has a significant limitation: in order to get the deduction, the farmers must bear the costs of replanting the trees themselves.

My bill would let farmers bring in investors to help underwrite replanting costs without losing the immediate deduction; and, to ensure that farmers keep working their land, my bill requires them to maintain at least a 50 percent interest in their groves in order to use this deduction.

This commonsense, limited change to an existing provision in the Tax Code has broad, bipartisan support. In fact, every member of the Florida delegation, which is about 29 members—Democrats and Republicans alike—support this proposal. Citrus growers in Florida, Texas, and California have all come out in support of the bill for one simple reason: nationwide, nearly 20 million trees will need to be replaced due to greening.

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

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

There is no doubt the citrus industry is facing an emergency. A disease, referred to as ''greening,'' is rapidly spreading among citrus crops, including oranges, tangerines, grapefruits, lemons, and limes. To date, Florida orange growers have been hard hit by this disease and have been forced to abandon more than 100,000 acres of groves. It takes about 2 years for the disease to fully manifest itself; therefore, citrus crops in Texas and in California are also at risk. This bill would expand an exception that allows for the immediate expensing of replanting costs when crops are destroyed by this disease.

Under current law, minority investors only are allowed to immediately expense costs incurred for replanting when, one, the grower who incurred the loss or damage keeps a more than 50 percent interest in the property and, second, when the minority investor materially participates in the planting, maintenance, cultivation, or development of the property.

Under this bill, minority investors also would be able to immediately expense costs incurred for replanting if, one, the grower has an equity interest of not less than 50 percent in the replanted citrus plants, and the minority investor holds the remaining interest or, two, if the minority investor acquires all of the taxpayer's land on which the lost or damaged citrus plants were located, and the replanting is on such land. This bill would not require minority investors to materially participate in the planting and growing, thus making it more appealing for investors.

At a cost of $30 million over 10 years, this bill takes a modest step in helping the citrus industry attract investors and much-needed capital to fight this devastating disease.

Mr. Speaker, I yield back the balance of my time.

Mr. BUCHANAN. Mr. Speaker, I urge Members to pass this bill so that struggling farmers can have the flexibility to use the existing provisions of the Tax Code in a more ownership-type structure. Without this change, we run the risk of losing tens of thousands of jobs.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. BUCHANAN) that the House suspend the rules and pass the bill, H.R. 3957, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. HUELSKAMP. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

EXPANDING SENIORS RECEIVING DIALYSIS CHOICE ACT OF 2016

Mr. SMITH of Missouri. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5659) to amend title XVIII of the Social Security Act with respect to expanding Medicare Advantage coverage for individuals with end-stage renal disease (ESRD), as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5659

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 ''Expanding Seniors Receiving Dialysis Choice Act of 2016'' or as the ''ESRD Choice Act of 2016''.

SEC. 2. EXPANDING MEDICARE ADVANTAGE COVERAGE FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE (ESRD).

(a) EXPANDED MA ELIGIBILITY.—

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

(A) by striking subparagraph (B); and

(B) by striking ''ELIGIBLE INDIVIDUAL'' and all that follows through ''In this title, subject to subparagraph (B),'' and inserting ''ELIGIBLE INDIVIDUAL.—In this title,''.

(2) CONFORMING AMENDMENTS.—

(A) 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''.

(B) Section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)) is amended by striking ''may waive'' and all that follows through ''subparagraph and''.

(b) EXCLUDING COSTS FOR KIDNEY ACQUISITIONS FROM MA BENCHMARK.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (k)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking ''paragraphs (2) and (4)'' and inserting ''paragraphs (2), (4), and (5)''; and

(ii) in subparagraph (B)(i), by striking ''paragraphs (2) and (4)'' and inserting ''paragraphs (2), (4), and (5)''; and

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

''(5) EXCLUSION OF COSTS FOR KIDNEY ACQUISITIONS FROM CAPITATION RATES.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2019), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d)) in the area for the year.''; and

(2) in subsection (n)(2)—

(A) in subparagraph (A)(i), by inserting ''and, for 2019 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5)'' before the semicolon at the end;

(B) in subparagraph (E), in the matter preceding clause (i), by striking ''subparagraph (F)'' and inserting ''subparagraphs (F) and (G)''; and

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

''(G) APPLICATION OF KIDNEY ACQUISITIONS ADJUSTMENT.—The base payment amount specified in subparagraph (E) for a year (beginning with 2019) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.''.

(c) FFS COVERAGE OF KIDNEY ACQUISITIONS.—

(1) IN GENERAL.—Section 1852(a)(1)(B)(i) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)(i)) is amended by inserting ''or coverage for organ acquisitions for kidney transplants, including as covered under section 1881(d)'' after ''hospice care''.

(2) CONFORMING AMENDMENT.—Section 1851(i) of the Social Security Act (42 U.S.C. 1395w–21(i)) is amended by adding at the end the following new paragraph:

''(3) FFS PAYMENT FOR EXPENSES FOR KIDNEY ACQUISITIONS.—Paragraphs (1) and (2) do not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i).''.

(d) SENSE OF CONGRESS REGARDING APPLICATION OF APPROPRIATE MEDICARE ADVANTAGE RISK ADJUSTMENT FOR PAYMENT FOR INCREASED ESRD ENROLLEES.—It is the sense of Congress that in implementing the policies under this section, the Centers for Medicare & Medicaid Services should provide, in an accurate and transparent manner, for risk adjustment to payment under the Medicare Advantage program to account for the increased enrollment in Medicare Advantage plans of individuals with end-stage renal disease.

(e) EXPANDED MA 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''.

(f) REPORT.—Not later than April 1, 2022, the Administrator of the Centers for Medicare & Medicaid Services shall submit to Congress a report on the impact of the amendments made by this section on spending under the traditional Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act as well as on spending under parts C and D of such title. The report shall include an assessment of the risk adjustment payment methodologies under such parts C and D and their adequacy with respect to individuals with end-stage renal disease and such recommendations as the Administrator deems appropriate.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to plans years beginning on or after January 1, 2020.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Missouri (Mr. SMITH) and the gentleman from Michigan (Mr. LEVIN) each will control 20 minutes.

The Chair recognizes the gentleman from Missouri.

□ 1645

GENERAL LEAVE

Mr. SMITH of Missouri. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on H.R. 5659, currently under consideration.

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

There was no objection.

Mr. SMITH of Missouri. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I stand today in support of H.R. 5659, the ESRD Choice Act, and thank the Speaker for taking this effort up today on the floor.

This bipartisan legislation expands access to high-quality, affordable healthcare coverage options for Americans suffering from serious kidney illness. End-stage renal disease, or ESRD, is the only preexisting condition that explicitly prevents patients from enrolling in Medicare Advantage.

This bill removes a harmful Federal restriction that has, for too long, blocked patients with ESRD from enrolling in Medicare Advantage plans. The question is: Why should kidney disease patients be denied a choice all other Medicare beneficiaries have? The short answer is: They shouldn't. These patients should have the same option to choose Medicare Advantage.

Once this bill is passed and signed into law, my colleagues and I will be constantly watching the bureaucrats at the Centers for Medicare and Medicaid Services to make sure they fulfill their responsibilities to properly risk adjust payments to plans in an accurate and transparent manner. The bill requires a report of the effects of this legislation on risk adjustment, and I will be watching to make sure they get it right.

I also want to recognize the hard work that went into this bill and specifically thank Mr. LEWIS, Mr. BILIRAKIS, Mr. SCHRADER, and Mr. MARINO, as well as the Committee on Ways and Means and the Committee on Energy and Commerce for the hard work to remove the last preexisting conditions in Medicare Advantage.

The benefits of Medicare Advantage should be extended to all ESRD patients. It is right thing to do, and now is the time to get it done.

I reserve the balance of my time.

Mr. LEVIN. I yield myself such time as I may consume.

Mr. Speaker, more than 80 percent of the approximately 640,000 Americans living with kidney failure, or end-stage renal disease, are covered under Medicare. Unfortunately, those individuals who receive Medicare coverage as a result of their ESRD do not have access to managed care plans under the Medicare Advantage program.

This bill would make a commonsense change and enable Medicare beneficiaries with ESRD to have the same choices as all other Medicare beneficiaries. H.R. 5659 would help make sure ESRD beneficiaries in Medicare have access to the coordinated services, flexibility, and integrated care they need to fit their own individual needs.

I want to thank my fellow colleague on the Ways and Means Committee, the gentleman from Georgia (Mr. LEWIS), for his dedication and his hard work over the past years on this important bipartisan legislation. I look forward to it advancing swiftly to the President's desk to be signed into law.

I yield back the balance of my time.

Mr. SMITH of Missouri. Mr. Speaker, I yield myself such time as I may consume.

The legislation expands access to a program that has improved millions of lives. This is just one of the bipartisan solutions Americans deserve, and these are the types of solutions I hope to continue working with the chairman and my colleagues in delivering as we work to improve our healthcare system.

Dozens of folks back home in southeast and south central Missouri have contacted me with their support for this bill. Do you know what they tell me? They want a choice.

I am pleased that the House is acting on our bill today since it follows one of our core principles as we look at health care, increasing patients' options and control over their care. I urge my colleagues to support the bill.

I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Missouri (Mr. SMITH) that the House suspend the rules and pass the bill, H.R. 5659, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. AMASH. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

CONTINUING ACCESS TO HOSPITALS ACT OF 2016

Ms. JENKINS of Kansas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5613) to provide for the extension of the enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2016, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5613

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 ''Continuing Access to Hospitals Act of 2016'' or the ''CAH Act of 2016''.

SEC. 2. EXTENSION OF ENFORCEMENT INSTRUCTION ON SUPERVISION REQUIREMENTS FOR OUTPATIENT THERAPEUTIC SERVICES IN CRITICAL ACCESS AND SMALL RURAL HOSPITALS THROUGH 2016.

Section 1 of Public Law 113–198, as amended by section 1 of Public Law 114–112, is amended—

(1) in the heading, by striking ''**2014 AND 2015**'' and inserting ''**2016**''; and

(2) by striking ''and 2015'' and inserting '', 2015, and 2016''.

SEC. 3. REPORT.

Not later than one year after the date of the enactment of this Act, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6)) shall submit to Congress a report analyzing the effect of the extension of the enforcement instruction under section 1 of Public Law 113–198, as amended by section 1 of Public Law 114–112 and section 2 of this Act, on the access to health care by Medicare beneficiaries, on the economic impact and the impact upon hospital staffing needs, and on the quality of health care furnished to such beneficiaries.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Kansas (Ms. JENKINS) and the gentleman from Iowa (Mr. LOEBSACK) each will control 20 minutes.

The Chair recognizes the gentlewoman from Kansas.

GENERAL LEAVE

Ms. JENKINS of Kansas. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include any extraneous material on H.R. 5613, currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Kansas?

There was no objection.

Ms. JENKINS of Kansas. Mr. Speaker, I yield myself such time as I may consume.

I rise today in support of H.R. 5613, the Continuing Access to Hospitals Act of 2016, a policy this Congress has passed unanimously in 2014 and 2015.

Every year across Kansas, hospitals in rural communities must wait to see if they will have to comply with a burdensome Federal regulation that makes caring for patients more difficult, while providing no additional benefits.

Back in January 2014, the Centers for Medicare and Medicaid Services began enforcing a requirement that physicians must supervise outpatient therapeutic services at critical access hospitals and other small rural hospitals. This meant that routine outpatient therapeutic procedures, such as the application of a splint to a finger or a demonstration of how to use a nebulizer, had to be directly supervised by a physician.

Thankfully, Congress passed an extension of a moratorium on that supervision requirement in 2014 and again in 2015. Here we are again today to try to give a little bit of certainty to these very important rural and critical access hospitals.

There are over 1,300 critical access hospitals that serve rural Americans in nearly every State, and these facilities simply lack the resources to fulfill this burdensome mandate. Before 2014, physicians at rural hospitals were not required to directly supervise these types of outpatient therapeutic services, and asking them to do so now, after unanimously passing identical extensions the past 2 years, will only jeopardize access to care.

I reserve the balance of my time.

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

Mr. Speaker, I rise today in strong support of H.R. 5613, the Continuing Access to Hospitals Act. I am pleased the House is considering this bipartisan legislation, which I introduced with Ms. JENKINS of Kansas.

Many of Iowa's rural hospitals, just like the rural hospitals in Kansas and other parts of America, are struggling in these economic times. I have made it a point to visit all of the hospitals in my district on many occasions in order to hear directly from them about the issues they are facing and how I, as their Congressman, can help.

I have seen firsthand that rural hospitals are bedrocks of their communities, providing more than just high-quality, local access to health care. Rural hospitals also stimulate the local economy, creating jobs in the hospital and in the larger community. Without quality local health care, lives and communities are lost.

One issue I consistently hear about is the Centers for Medicare and Medicaid Services' rule strictly requiring direct supervision of outpatient therapeutic services. The enforcement of this rule will cause rural facilities to reduce therapy services, threatening access to needed procedures for rural Americans.

That is why I was proud that, last year, the legislation that Congresswoman JENKINS and I introduced to continue the prohibition on CMS from enforcing the unreasonable supervision requirements for 2015 was signed into law. That bill, however, was only a fix for 2015, as Congresswoman JENKINS pointed out. I am committed to making sure this is also solved in 2016, as well as working toward a permanent fix to provide certainty for our critical access hospitals, again, not just in Iowa or Kansas, but around the country.

The services covered by this legislation have always been provided by licensed, skilled professionals under the overall direction of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician. While there is some need for direct supervision for certain outpatient services that pose a high risk or are very complex, CMS' policy generally applies to even the lowest risk services.

This legislation will provide temporary relief that will go far in relieving the regulatory burden of direct supervision of outpatient therapeutic services for rural hospitals. This legislation, fittingly, protects hospitals that were providing and are providing quality, responsible care during the period in question.

I urge all my colleagues to support this bill today.

Again, I thank Congresswoman JENKINS. We have worked together on this now for a couple of years. I think it proves that, if folks from both parties put their heads together and offer commonsense legislation, we can get it passed. Most importantly, it proves that we can help our local hospitals and folks who live in these rural areas who need that access to those local hospitals.

I reserve the balance of my time.

Ms. JENKINS of Kansas. Mr. Speaker, I yield such time as he may consume to the gentleman from Nebraska (Mr. SMITH), an esteemed member of the House Ways and Means Committee.

Mr. SMITH of Nebraska. Mr. Speaker, I rise today in support of H.R. 5613 to once again delay enforcement of supervision requirements on critical access hospitals.

It has unfortunately become an annual ritual for us to pass legislation to block this arbitrary regulation which requires a physician to be on-site and present for the administration of most procedures, no matter how basic.

As a condition of participation in the critical access program, a facility must have 25 or fewer beds, be distant from the next closest hospital, and have a physician on call and available within