Mr. REICHERT. Mr. Speaker, after listening to my colleague's comments, Mr. DOGGETT's a little earlier, there are a lot of things that Mr. DOGGETT said that I agree with, and I know he knows that.

We have known each other for a while. He is the ranking member on the Human Resources Subcommittee, and we have been working together on lots of legislation that help address foster care and families and welfare and food stamps and aid to needy families.

Those are things that he knows that I care about passionately. And I know that the Republican party, even though tonight you may not think so, cares about people passionately and wants to solve these issues to help our most needy find employment, find an opportunity and hope in this country to provide for their family. That is what both sides I think really want.

As my colleague knows, we spent hours earlier today debating the continuing resolution for 2015. That debate will continue tomorrow.

The reason we are not debating TANF reauthorization right now is because the CR includes a provision that will extend the TANF program at the Congressional Budget Office baseline level through December 11 of this year. So that bill, not the one before us, provides for the extension of the program that the gentleman had earlier talked about.

I would also like to point out a letter that is dated July 31, 2014, date stamped, to Senator SESSIONS from Secretary Burwell. And it says, in just the first paragraph, Mr. Speaker:

> Thank you for your letter to former Secretary Kathleen Sebelius expressing concern that Temporary Assistance for Needy Families cash assistance is being used to create an increase in drug dependency. I am aware of the media reports related to individuals withdrawing cash at Automated Teller Machines (ATMs) located in establishments selling marijuana in Colorado, which has legalized the use of marijuana. I agree that any inappropriate expenditure of public funds is a cause for concern and should be addressed immediately.

This is a commonsense fix so welfare funds are used as intended to help needy families temporarily, to help them find jobs, get back on their feet, provide for their families.

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

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Washington (Mr. REICHERT) that the House suspend the rules and pass the bill, H.R. 4137.

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

A motion to reconsider was laid on the table.

IMPROVING MEDICARE POST-ACUTE CARE TRANSFORMATION ACT OF 2014

Mr. BRADY of Texas. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4994) to amend title XVIII of the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning, and for other purposes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4994

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 Medicare Post-Acute Care Transformation Act of 2014'' or the ''IMPACT Act of 2014''.

SEC. 2. STANDARDIZATION OF POST-ACUTE CARE DATA.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

''SEC. 1899B. STANDARDIZED POST-ACUTE CARE (PAC) ASSESSMENT DATA FOR QUALITY, PAYMENT, AND DISCHARGE PLANNING.

''(a) REQUIREMENT FOR STANDARDIZED ASSESSMENT DATA.—

''(1) IN GENERAL.—The Secretary shall—

''(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—

''(i) standardized patient assessment data in accordance with subsection (b);

''(ii) data on quality measures under subsection (c)(1); and

''(iii) data on resource use and other measures under subsection (d)(1);

''(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and

''(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—

''(i) provide for the submission of standardized patient assessment data under this title with respect to such providers; and

''(ii) enable comparison of such assessment data across all such providers to whom such data are applicable.

''(2) DEFINITIONS.—For purposes of this section:

''(A) POST-ACUTE CARE (PAC) PROVIDER.—The terms 'post-acute care provider' and 'PAC provider' mean—

''(i) a home health agency;

''(ii) a skilled nursing facility;

''(iii) an inpatient rehabilitation facility; and

''(iv) a long-term care hospital (other than a hospital classified under section 1886(d)(1)(B)(iv)(II)).

''(B) PAC ASSESSMENT INSTRUMENT.—The term 'PAC assessment instrument' means—

''(i) in the case of home health agencies, the instrument used for purposes of reporting and assessment with respect to the Outcome and Assessment Information Set (OASIS), as described in sections 484.55 and 484.250 of title 42, the Code of Federal Regulations, or any successor regulation, or any other instrument used with respect to home health agencies for such purposes;

''(ii) in the case of skilled nursing facilities, the resident's assessment under section 1819(b)(3);

''(iii) in the case of inpatient rehabilitation facilities, any Medicare beneficiary assessment instrument established by the Secretary for purposes of section 1886(j); and

''(iv) in the case of long-term care hospitals, the Medicare beneficiary assessment instrument used with respect to such hospitals for the collection of data elements necessary to calculate quality measures as described in the August 18, 2011, Federal Register (76 Fed. Reg. 51754–51755), including for purposes of section 1886(m)(5)(C), or any other instrument used with respect to such hospitals for assessment purposes.

''(C) APPLICABLE REPORTING PROVISION.—The term 'applicable reporting provision' means—

''(i) for home health agencies, section 1895(b)(3)(B)(v);

''(ii) for skilled nursing facilities, section 1888(e)(6);

''(iii) for inpatient rehabilitation facilities, section 1886(j)(7); and

''(iv) for long-term care hospitals, section 1886(m)(5).

''(D) PAC PAYMENT SYSTEM.—The term 'PAC payment system' means—

''(i) with respect to a home health agency, the prospective payment system under section 1895;

''(ii) with respect to a skilled nursing facility, the prospective payment system under section 1888(e);

''(iii) with respect to an inpatient rehabilitation facility, the prospective payment system under section 1886(j); and

''(iv) with respect to a long-term care hospital, the prospective payment system under section 1886(m).

''(E) SPECIFIED APPLICATION DATE.—The term 'specified application date' means the following:

''(i) QUALITY MEASURES.—In the case of quality measures under subsection (c)(1)—

''(I) with respect to the domain described in subsection (c)(1)(A) (relating to functional status, cognitive function, and changes in function and cognitive function)—

''(aa) for PAC providers described in clauses (ii) and (iii) of paragraph (2)(A), October 1, 2016;

''(bb) for PAC providers described in clause (iv) of such paragraph, October 1, 2018; and

''(cc) for PAC providers described in clause (i) of such paragraph, January 1, 2019;

''(II) with respect to the domain described in subsection (c)(1)(B) (relating to skin integrity and changes in skin integrity)—

''(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

''(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2017;

''(III) with respect to the domain described in subsection (c)(1)(C) (relating to medication reconciliation)—

''(aa) for PAC providers described in clause (i) of such paragraph, January 1, 2017; and

''(bb) for PAC providers described in clauses (ii), (iii), and (iv) of such paragraph, October 1, 2018;

''(IV) with respect to the domain described in subsection (c)(1)(D) (relating to incidence of major falls)—

''(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

''(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019; and

''(V) with respect to the domain described in subsection (c)(1)(E) (relating to accurately communicating the existence of and providing for the transfer of health information and care preferences)—

''(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2018; and

''(bb) for PAC providers described in clause (i) of such paragraph, January 1, 2019.

''(ii) RESOURCE USE AND OTHER MEASURES.—In the case of resource use and other measures under subsection (d)(1)—

''(I) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2016; and

''(II) for PAC providers described in clause (i) of such paragraph, January 1, 2017.

''(F) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual entitled to benefits under part A or, as appropriate, enrolled for benefits under part B.

''(b) STANDARDIZED PATIENT ASSESSMENT DATA.—

''(1) REQUIREMENT FOR REPORTING ASSESSMENT DATA.—

''(A) IN GENERAL.—Beginning not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A) and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall require PAC providers to submit to the Secretary, under the applicable reporting provisions and through the use of PAC assessment instruments, the standardized patient assessment data described in subparagraph (B). The Secretary shall require such data be submitted with respect to admission and discharge of an individual (and may be submitted more frequently as the Secretary deems appropriate).

''(B) STANDARDIZED PATIENT ASSESSMENT DATA DESCRIBED.—For purposes of subparagraph (A), the standardized patient assessment data described in this subparagraph is data required for at least the quality measures described in subsection (c)(1) and that is with respect to the following categories:

''(i) Functional status, such as mobility and self care at admission to a PAC provider and before discharge from a PAC provider.

''(ii) Cognitive function, such as ability to express ideas and to understand, and mental status, such as depression and dementia.

''(iii) Special services, treatments, and interventions, such as need for ventilator use, dialysis, chemotherapy, central line placement, and total parenteral nutrition.

''(iv) Medical conditions and comorbidities, such as diabetes, congestive heart failure, and pressure ulcers.

''(v) Impairments, such as incontinence and an impaired ability to hear, see, or swallow.

''(vi) Other categories deemed necessary and appropriate by the Secretary.

''(2) ALIGNMENT OF CLAIMS DATA WITH STANDARDIZED PATIENT ASSESSMENT DATA.—To the extent practicable, not later than October 1, 2018, for PAC providers described in clauses (ii), (iii), and (iv) of subsection (a)(2)(A), and January 1, 2019, for PAC providers described in clause (i) of such subsection, the Secretary shall match claims data with assessment data pursuant to this section for purposes of assessing prior service use and concurrent service use, such as antecedent hospital or PAC provider use, and may use such matched data for such other uses as the Secretary determines appropriate.

''(3) REPLACEMENT OF CERTAIN EXISTING DATA.—In the case of patient assessment data being used with respect to a PAC assessment instrument that duplicates or overlaps with standardized patient assessment data within a category described in paragraph (1), the Secretary shall, as soon as practicable, revise or replace such existing data with the standardized data.

''(4) CLARIFICATION.—Standardized patient assessment data submitted pursuant to this subsection shall not be used to require individuals to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this title.

''(c) QUALITY MEASURES.—

''(1) REQUIREMENT FOR REPORTING QUALITY MEASURES.—Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify quality measures on which PAC providers are required under the applicable reporting provisions to submit standardized patient assessment data described in subsection (b)(1) and other necessary data specified by the Secretary. Such measures shall be with respect to at least the following domains:

''(A) Functional status, cognitive function, and changes in function and cognitive function.

''(B) Skin integrity and changes in skin integrity.

''(C) Medication reconciliation.

''(D) Incidence of major falls.

''(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions—

''(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or

''(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual.

''(2) REPORTING THROUGH PAC ASSESSMENT INSTRUMENTS.—

''(A) IN GENERAL.—To the extent possible, the Secretary shall require such reporting by a PAC provider of quality measures under paragraph (1) through the use of a PAC assessment instrument and shall modify such PAC assessment instrument as necessary to enable the use of such instrument with respect to such quality measures.

''(B) LIMITATION.—The Secretary may not make significant modifications to a PAC assessment instrument more than once per calendar year or fiscal year, as applicable, unless the Secretary publishes in the Federal Register a justification for such significant modification.

''(3) ADJUSTMENTS.—

''(A) IN GENERAL.—The Secretary shall consider applying adjustments to the quality measures under this subsection taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

''(B) RISK ADJUSTMENT.—Such quality measures shall be risk adjusted, as determined appropriate by the Secretary.

''(d) RESOURCE USE AND OTHER MEASURES.—

''(1) REQUIREMENT FOR RESOURCE USE AND OTHER MEASURES.—Not later than the specified application date, as applicable to measures and PAC providers, the Secretary shall specify resource use and other measures on which PAC providers are required under the applicable reporting provisions to submit any necessary data specified by the Secretary, which may include standardized assessment data in addition to claims data. Such measures shall be with respect to at least the following domains:

''(A) Resource use measures, including total estimated Medicare spending per beneficiary.

''(B) Discharge to community.

''(C) Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates.

''(2) ALIGNING METHODOLOGY ADJUSTMENTS FOR RESOURCE USE MEASURES.—

''(A) PERIOD OF TIME.—With respect to the period of time used for calculating measures under paragraph (1)(A), the Secretary shall, to the extent the Secretary determines appropriate, align resource use with the methodology used for purposes of section 1886(o)(2)(B)(ii).

''(B) GEOGRAPHIC AND OTHER ADJUSTMENTS.—The Secretary shall standardize measures with respect to the domain described in paragraph (1)(A) for geographic payment rate differences and payment differentials (and other adjustments, as applicable) consistent with the methodology published in the Federal Register on August 18, 2011 (76 Fed. Reg. 51624 through 51626), or any subsequent modifications made to the methodology.

''(C) MEDICARE SPENDING PER BENEFICIARY.—The Secretary shall adjust, as appropriate, measures with respect to the domain described in paragraph (1)(A) for the factors applied under section 1886(o)(2)(B)(ii).

''(3) ADJUSTMENTS.—

''(A) IN GENERAL.—The Secretary shall consider applying adjustments to the resource use and other measures specified under this subsection with respect to the domain described in paragraph (1)(A), taking into consideration the studies under section 2(d) of the IMPACT Act of 2014.

''(B) RISK ADJUSTMENT.—Such resource use and other measures shall be risk adjusted, as determined appropriate by the Secretary.

''(e) MEASUREMENT IMPLEMENTATION PHASES; SELECTION OF QUALITY MEASURES AND RESOURCE USE AND OTHER MEASURES.—

''(1) MEASUREMENT IMPLEMENTATION PHASES.—In the case of quality measures specified under subsection (c)(1) and resource use and other measures specified under subsection (d)(1), the provisions of this section shall be implemented in accordance with the following phases:

''(A) INITIAL IMPLEMENTATION PHASE.—The initial implementation phase, with respect to such a measure, shall, in accordance with subsections (c) and (d), as applicable, consist of—

''(i) measure specification, including informing the public of the measure's numerator, denominator, exclusions, and any other aspects the Secretary determines necessary;

''(ii) data collection, including, in the case of quality measures, requiring PAC providers to report data elements needed to calculate such a measure; and

''(iii) data analysis, including, in the case of resource use and other measures, the use of claims data to calculate such a measure.

''(B) SECOND IMPLEMENTATION PHASE.—The second implementation phase, with respect to such a measure, shall consist of the provision of feedback reports to PAC providers, in accordance with subsection (f).

''(C) THIRD IMPLEMENTATION PHASE.—The third implementation phase, with respect to such a measure, shall consist of public reporting of PAC providers' performance on such measure in accordance with subsection (g).

''(2) CONSENSUS-BASED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), each measure specified by the Secretary under this section shall be endorsed by the entity with a contract under section 1890(a).

''(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

''(3) TREATMENT OF APPLICATION OF PRE-RULEMAKING PROCESS (MEASURE APPLICATIONS PARTNERSHIP PROCESS).—

''(A) IN GENERAL.—Subject to subparagraph (B), the provisions of section 1890A shall

apply in the case of a quality measure specified under subsection (c) or a resource use or other measure specified under subsection (d).

''(B) EXCEPTIONS.—

''(i) EXPEDITED PROCEDURES.—For purposes of satisfying subparagraph (A), the Secretary may use expedited procedures, such as ad-hoc reviews, as necessary, in the case of a quality measure specified under subsection (c) or a resource use or other measure specified in subsection (d) required with respect to data submissions under the applicable reporting provisions during the 1-year period before the specified application date applicable to such a measure and provider involved.

''(ii) OPTION TO WAIVE PROVISIONS.—The Secretary may waive the application of the provisions of section 1890A in the case of a quality measure or resource use or other measure described in clause (i), if the application of such provisions (including through the use of an expedited procedure described in such clause) would result in the inability of the Secretary to satisfy any deadline specified in this section with respect to such measure.

''(f) FEEDBACK REPORTS TO PAC PROVIDERS.—

''(1) IN GENERAL.—Beginning one year after the specified application date, as applicable to PAC providers and quality measures and resource use and other measures under this section, the Secretary shall provide confidential feedback reports to such PAC providers on the performance of such providers with respect to such measures required under the applicable provisions.

''(2) FREQUENCY.—To the extent feasible, the Secretary shall provide feedback reports described in paragraph (1) not less frequently than on a quarterly basis. Notwithstanding the previous sentence, with respect to measures described in such paragraph that are reported on an annual basis, the Secretary may provide such feedback reports on an annual basis.

''(g) PUBLIC REPORTING OF PAC PROVIDER PERFORMANCE.—

''(1) IN GENERAL.—Subject to the succeeding paragraphs of this subsection, the Secretary shall provide for public reporting of PAC provider performance on quality measures under subsection (c)(1) and the resource use and other measures under subsection (d)(1), including by establishing procedures for making available to the public information regarding the performance of individual PAC providers with respect to such measures.

''(2) OPPORTUNITY TO REVIEW.—The procedures under paragraph (1) shall ensure, including through a process consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) for similar purposes, that a PAC provider has the opportunity to review and submit corrections to the data and information that is to be made public with respect to the provider prior to such data being made public.

''(3) TIMING.—Such procedures shall provide that the data and information described in paragraph (1), with respect to a measure and PAC provider, is made publicly available beginning not later than two years after the specified application date applicable to such a measure and provider.

''(4) COORDINATION WITH EXISTING PROGRAMS.—Such procedures shall provide that data and information described in paragraph (1) with respect to quality measures and resource use and other measures under subsections (c)(1) and (d)(1) shall be made publicly available consistent with the following provisions:

''(A) In the case of home health agencies, section 1895(b)(3)(B)(v)(III).

''(B) In the case of skilled nursing facilities, sections 1819(i) and 1919(i).

''(C) In the case of inpatient rehabilitation facilities, section 1886(j)(7)(E).

''(D) In the case of long-term care hospitals, section 1886(m)(5)(E).

''(h) REMOVING, SUSPENDING, OR ADDING MEASURES.—

''(1) IN GENERAL.—The Secretary may remove, suspend, or add a quality measure or resource use or other measure described in subsection (c)(1) or (d)(1), so long as, subject to paragraph (2), the Secretary publishes in the Federal Register (with a notice and comment period) a justification for such removal, suspension, or addition.

''(2) EXCEPTION.—In the case of such a quality measure or resource use or other measure for which there is a reason to believe that the continued collection of such measure raises potential safety concerns or would cause other unintended consequences, the Secretary may promptly suspend or remove such measure and satisfy paragraph (1) by publishing in the Federal Register a justification for such suspension or removal in the next rulemaking cycle following such suspension or removal.

''(i) USE OF STANDARDIZED ASSESSMENT DATA, QUALITY MEASURES, AND RESOURCE USE AND OTHER MEASURES TO INFORM DISCHARGE PLANNING AND INCORPORATE PATIENT PREFERENCE.—

''(1) IN GENERAL.—Not later than January 1, 2016, and periodically thereafter (but not less frequently than once every 5 years), the Secretary shall promulgate regulations to modify conditions of participation and subsequent interpretive guidance applicable to PAC providers, hospitals, and critical access hospitals. Such regulations and interpretive guidance shall require such providers to take into account quality, resource use, and other measures under the applicable reporting provisions (which, as available, shall include measures specified under subsections (c) and (d), and other relevant measures) in the discharge planning process. Specifically, such regulations and interpretive guidance shall address the settings to which a patient may be discharged in order to assist subsection (d) hospitals, critical access hospitals, hospitals described in section 1886(d)(1)(B)(v), PAC providers, patients, and families of such patients with discharge planning from inpatient settings, including such hospitals, and from PAC provider settings. In addition, such regulations and interpretive guidance shall include procedures to address—

''(A) treatment preferences of patients; and

''(B) goals of care of patients.

''(2) DISCHARGE PLANNING.—All requirements applied pursuant to paragraph (1) shall be used to help inform and mandate the discharge planning process.

''(3) CLARIFICATION.—Such regulations shall not require an individual to be provided post-acute care by a specific type of PAC provider in order for such care to be eligible for payment under this title.

''(j) STAKEHOLDER INPUT.—Before the initial rulemaking process to implement this section, the Secretary shall allow for stakeholder input, such as through town halls, open door forums, and mail-box submissions.

''(k) FUNDING.—For purposes of carrying out this section, the Secretary shall provide for the transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of $130,000,000. Fifty percent of such amount shall be available on the date of the enactment of this section and fifty percent of such amount shall be equally proportioned for each of fiscal years 2015 through 2019. Such sums shall remain available until expended.

''(l) LIMITATION.—There shall be no administrative or judicial review under sections 1869 and 1878 or otherwise of the specification of standardized patient assessment data required, the determination of measures, and the systems to report such standardized data under this section.

''(m) NON-APPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995') shall not apply to this section and the sections referenced in subsection (a)(2)(B) that require modification in order to achieve the standardization of patient assessment data.''.

(b) STUDIES OF ALTERNATIVE PAC PAYMENT MODELS.—

(1) MEDPAC.—Using data from the Post-Acute Payment Reform Demonstration authorized under section 5008 of the Deficit Reduction Act of 2005 (Public Law 109–171) or other data, as available, not later than June 30, 2016, the Medicare Payment Advisory Commission shall submit to Congress a report that evaluates and recommends features of PAC payment systems (as defined in section 1899B(a)(2)(D) of the Social Security Act, as added by subsection (a)) that establish, or a unified post-acute care payment system under title XVIII of the Social Security Act that establishes, payment rates according to characteristics of individuals (such as cognitive ability, functional status, and impairments) instead of according to the post-acute care setting where the Medicare beneficiary involved is treated. To the extent feasible, such report shall consider the impacts of moving from PAC payment systems (as defined in subsection (a)(2)(D) of such section 1899B) in existence as of the date of the enactment of this Act to new post-acute care payment systems under title XVIII of the Social Security Act.

(2) RECOMMENDATIONS FOR PAC PROSPECTIVE PAYMENT.—

(A) REPORT BY SECRETARY.—Not later than 2 years after the date by which the Secretary of Health and Human Services has collected 2 years of data on quality measures under subsection (c) of section 1899B, as added by subsection (a), the Secretary shall, in consultation with the Medicare Payment Advisory Commission and appropriate stakeholders, submit to Congress a report, including—

(i) recommendations and a technical prototype, on a post-acute care prospective payment system under title XVIII of the Social Security Act that would—

(I) in lieu of the rates that would otherwise apply under PAC payment systems (as defined in subsection (a)(2)(D) of such section 1899B), base payments under such title, with respect to items and services furnished to an individual by a PAC provider (as defined in subsection (a)(2)(A) of such section), according to individual characteristics (such as cognitive ability, functional status, and impairments) of such individual instead of the post-acute care setting in which the individual is furnished such items and services;

(II) account for the clinical appropriateness of items and services so furnished and Medicare beneficiary outcomes;

(III) be designed to incorporate (or otherwise account for) standardized patient assessment data under section 1899B; and

(IV) further clinical integration, such as by motivating greater coordination around a single condition or procedure to integrate hospital systems with PAC providers (as so defined).

(ii) recommendations on which Medicare fee-for-service regulations for post-acute care payment systems under title XVIII of the Social Security Act should be altered (such as the skilled nursing facility 3-day

stay and inpatient rehabilitation facility 60 percent rule);

(iii) an analysis of the impact of the recommended payment system described in clause (i) on Medicare beneficiary cost-sharing, access to care, and choice of setting;

(iv) a projection of any potential reduction in expenditures under title XVIII of the Social Security Act that may be attributable to the application of the recommended payment system described in clause (i); and

(v) a review of the value of subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), hospitals described in section 1886(d)(1)(B)(v) of such Act (42 U.S.C. 1395ww(d)(1)(B)(v)), and critical access hospitals described in section 1820(c)(2)(B) of such Act (42 U.S.C. 1395i–4(c)(2)(B)) collecting and reporting to the Secretary standardized patient assessment data with respect to inpatient hospital services furnished by such a hospital or critical access hospital to individuals who are entitled to benefits under part A of title XVIII of such Act or, as appropriate, enrolled for benefits under part B of such title.

(B) REPORT BY MEDPAC.—Not later than the first June 30th following the date on which the report is required under subparagraph (A), the Medicare Payment Advisory Commission shall submit to Congress a report, including recommendations and a technical prototype, on a post-acute care prospective payment system under title XVIII of the Social Security Act that would satisfy the criteria described in subparagraph (A).

(3) MEDICARE BENEFICIARY DEFINED.—For purposes of this subsection, the term ''Medicare beneficiary'' has the meaning given such term in section 1899B(a)(2) of the Social Security Act, as added by subsection (a).

(c) PAYMENT CONSEQUENCES UNDER THE APPLICABLE REPORTING PROVISIONS.—

(1) HOME HEALTH AGENCIES.—Section 1895(b)(3)(B)(v) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(v)) is amended—

(A) in subclause (I), by striking ''subclause (II)'' and inserting ''subclauses (II) and (IV)'';

(B) in subclause (II), by striking ''For 2007'' and inserting ''Subject to subclause (V), for 2007'';

(C) in subclause (III), by inserting ''and subclause (IV)(aa)'' after ''subclause (II)''; and

(D) by adding at the end the following new subclauses:

''(IV) SUBMISSION OF ADDITIONAL DATA.—

''(aa) IN GENERAL.—For the year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to home health agencies and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent year, in addition to the data described in subclause (II), each home health agency shall submit to the Secretary data on such quality measures and any necessary data specified by the Secretary under such subsection (d)(1).

''(bb) STANDARDIZED PATIENT ASSESSMENT DATA.—For 2019 and each subsequent year, in addition to such data described in item (aa), each home health agency shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1899B.

''(cc) SUBMISSION.—Data shall be submitted under items (aa) and (bb) in the form and manner, and at the time, specified by the Secretary for purposes of this clause.

''(V) NON-DUPLICATION.—To the extent data submitted under subclause (IV) duplicates other data required to be submitted under subclause (II), the submission of such data under subclause (IV) shall be in lieu of the submission of such data under subclause (II). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.''.

(2) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(7) of the Social Security Act (42 U.S.C. 1395ww(j)(7)) is amended—

(A) in subparagraph (A)(i), by striking ''subparagraph (C)'' and inserting ''subparagraphs (C) and (F)'';

(B) in subparagraph (C), by striking ''For fiscal year 2014 and each subsequent rate year'' and inserting ''Subject to subparagraph (G), for fiscal year 2014 and each subsequent fiscal year'';

(C) in subparagraph (E), by inserting ''and subparagraph (F)(i)'' after ''subparagraph (C)''; and

(D) by adding at the end the following new subparagraphs:

''(F) SUBMISSION OF ADDITIONAL DATA.—

''(i) IN GENERAL.—For the fiscal year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to inpatient rehabilitation facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent fiscal year, in addition to such data on the quality measures described in subparagraph (C), each rehabilitation facility shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

''(ii) STANDARDIZED PATIENT ASSESSMENT DATA.—For fiscal year 2019 and each subsequent fiscal year, in addition to such data described in clause (i), each rehabilitation facility shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1899B.

''(iii) SUBMISSION.—Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

''(G) NON-DUPLICATION.—To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.''.

(3) LONG-TERM CARE HOSPITALS.—Section 1886(m)(5) of the Social Security Act (42 U.S.C. 1395ww(m)(5)) is amended—

(A) in subparagraph (A)(i), by striking ''subparagraph (C)'' and inserting ''subparagraphs (C) and (F)'';

(B) in subparagraph (C), by striking ''For rate year'' and inserting ''Subject to subparagraph (G), for rate year'';

(C) in subparagraph (E), by inserting ''and subparagraph (F)(i)'' after ''subparagraph (C)''; and

(D) by adding at the end the following new subparagraphs:

''(F) SUBMISSION OF ADDITIONAL DATA.—

''(i) IN GENERAL.—For the rate year beginning on the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to long-term care hospitals and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, and each subsequent rate year, in addition to the data on the quality measures described in subparagraph (C), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(iv)(II)) shall submit to the Secretary data on the quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1).

''(ii) STANDARDIZED PATIENT ASSESSMENT DATA.—For rate year 2019 and each subsequent rate year, in addition to such data described in clause (i), each long-term care hospital (other than a hospital classified under subsection (d)(1)(B)(iv)(II)) shall submit to the Secretary standardized patient assessment data required under subsection (b)(1) of section 1899B.

''(iii) SUBMISSION.—Such data shall be submitted in the form and manner, and at the time, specified by the Secretary for purposes of this subparagraph.

''(G) NON-DUPLICATION.—To the extent data submitted under subparagraph (F) duplicates other data required to be submitted under subparagraph (C), the submission of such data under subparagraph (F) shall be in lieu of the submission of such data under subparagraph (C). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.''.

(4) SKILLED NURSING FACILITIES.—

(A) IN GENERAL.—Paragraph (6) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended to read as follows:

''(6) REPORTING OF ASSESSMENT AND QUALITY DATA.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

''(i) IN GENERAL.—For fiscal years beginning with fiscal year 2018, in the case of a skilled nursing facility that does not submit data, as applicable, in accordance with subclauses (II) and (III) of subparagraph (B)(i) with respect to such a fiscal year, after determining the percentage described in paragraph (5)(B)(i), and after application of paragraph (5)(B)(ii), the Secretary shall reduce such percentage for payment rates during such fiscal year by 2 percentage points.

''(ii) SPECIAL RULE.—The application of this subparagraph may result in the percentage described in paragraph (5)(B)(i), after application of paragraph (5)(B)(ii), being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

''(iii) NONCUMULATIVE APPLICATION.—Any reduction under clause (i) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

''(B) ASSESSMENT AND MEASURE DATA.—

''(i) IN GENERAL.—A skilled nursing facility, or a facility (other than a critical access hospital) described in paragraph (7)(B), shall submit to the Secretary, in a manner and within the timeframes prescribed by the Secretary—

''(I) subject to clause (iii), the resident assessment data necessary to develop and implement the rates under this subsection;

''(II) for fiscal years beginning on or after the specified application date (as defined in subsection (a)(2)(E) of section 1899B), as applicable with respect to skilled nursing facilities and quality measures under subsection (c)(1) of such section and measures under subsection (d)(1) of such section, data on such quality measures under such subsection (c)(1) and any necessary data specified by the Secretary under such subsection (d)(1); and

''(III) for fiscal years beginning on or after October 1, 2018, standardized patient assessment data required under subsection (b)(1) of section 1899B.

''(ii) USE OF STANDARD INSTRUMENT.—For purposes of meeting the requirement under clause (i), a skilled nursing facility, or a facility (other than a critical access hospital) described in paragraph (7)(B), may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

''(iii) NON-DUPLICATION.—To the extent data submitted under subclause (II) or (III) of clause (i) duplicates other data required to be submitted under clause (i)(I), the submission of such data under such a subclause shall be in lieu of the submission of such data under clause (i)(I). The previous sentence shall not apply insofar as the Secretary determines it is necessary to avoid a delay in the implementation of section 1899B, taking into account the different specified application dates under subsection (a)(2)(E) of such section.''.

(B) FUNDING FOR NURSING HOME COMPARE WEBSITE.—Section 1819(i) of the Social Security Act (42 U.S.C. 1395i–3(i)) is amended by adding at the end the following new paragraph:

''(3) FUNDING.—The Secretary shall transfer to the Centers for Medicare & Medicaid Services Program Management Account, from the Federal Hospital Insurance Trust Fund under section 1817 a one-time allocation of $11,000,000. The amount shall be available on the date of the enactment of this paragraph. Such sums shall remain available until expended. Such sums shall be used to implement section 1128I(g).''.

(d) IMPROVING PAYMENT ACCURACY UNDER THE PAC PAYMENT SYSTEMS AND OTHER MEDICARE PAYMENT SYSTEMS.—

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

(A) STUDY USING EXISTING MEDICARE DATA.—

(i) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study that examines the effect of individuals' socioeconomic status on quality measures and resource use and other measures for individuals under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (such as to recognize that less healthy individuals may require more intensive interventions). The study shall use information collected on such individuals in carrying out such program, such as urban and rural location, eligibility for Medicaid under title XIX of such Act (42 U.S.C. 1396 et seq.) (recognizing and accounting for varying Medicaid eligibility across States), and eligibility for benefits under the supplemental security income (SSI) program. The Secretary shall carry out this paragraph acting through the Assistant Secretary for Planning and Evaluation.

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

(B) STUDY USING OTHER DATA.—

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

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

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

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

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

(ii) account for such factors—

(I) in quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (including such measures specified under subsections (c) and (d) of section 1899B of such Act, as added by subsection (a)); and

(II) in determining payment adjustments based on such measures in other applicable provisions of such title.

(E) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined appropriate by the Secretary) to carry out this paragraph $6,000,000, to remain available until expended.

(2) CMS ACTIVITIES.—

(A) IN GENERAL.—Taking into account the relevant studies conducted and recommendations made in reports under paragraph (1) and, as appropriate, other information, including information collected before completion of such studies and recommendations, the Secretary, on an ongoing basis, shall, as the Secretary determines appropriate and based on an individual's health status and other factors—

(i) assess appropriate adjustments to quality measures, resource use measures, and other measures under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) (including measures specified in subsections (c) and (d) of section 1899B of such Act, as added by subsection (a)); and

(ii) assess and implement appropriate adjustments to payments under such title based on measures described in clause (i).

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

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

(D) FUNDING.—There are hereby appropriated to the Secretary from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) (in proportions determined appropriate by the Secretary) to carry out this paragraph $10,000,000, to remain available until expended.

(3) STRATEGIC PLAN FOR ACCESSING RACE AND ETHNICITY DATA.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall develop and report to Congress on a strategic plan for collecting or otherwise accessing data on race and ethnicity for purposes of specifying quality measures and resource use and other measures under subsections (c) and (d) of section 1899B of the Social Security Act, as added by subsection (a), and, as the Secretary determines appropriate, other similar provisions of, including payment adjustments under, title XVIII of such Act (42 U.S.C. 1395 et seq.).

SEC. 3. HOSPICE CARE.

(a) HOSPICE SURVEY REQUIREMENT.—

(1) IN GENERAL.—Section 1861(dd)(4) of the Social Security Act (42 U.S.C. 1395x(dd)(4)) is amended by adding at the end the following new subparagraph:

''(C) Any entity that is certified as a hospice program shall be subject to a standard survey by an appropriate State or local survey agency, or an approved accreditation agency, as determined by the Secretary, not less frequently than once every 36 months beginning 6 months after the date of the enactment of this subparagraph and ending September 30, 2025.''.

(2) FUNDING.—For purposes of carrying out subparagraph (C) of section 1861(dd)(4) of the Social Security Act (42 U.S.C. 1395x(dd)(4)), as added by paragraph (1), there shall be transferred from the Federal Hospital Insurance Trust Fund under section 1817 of such Act (42 U.S.C. 1395i) to the Centers for Medicare & Medicaid Services Program Management Account—

(A) $25,000,000 for fiscal years 2015 through 2017, to be made available for such purposes in equal parts for each such fiscal year; and

(B) $45,000,000 for fiscal years 2018 through 2025, to be made available for such purposes in equal parts for each such fiscal year.

(b) HOSPICE PROGRAM ELIGIBILITY RECERTIFICATION TECHNICAL CORRECTION TO APPLY LIMITATION ON LIABILITY OF BENEFICIARY RULES.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended by adding at the end the following new subsection:

''(i) The provisions of this section shall apply with respect to a denial of a payment under this title by reason of section 1814(a)(7)(E) in the same manner as such provisions apply with respect to a denial of a payment under this title by reason of section 1862(a)(1).''.

(c) REVISION TO REQUIREMENT FOR MEDICAL REVIEW OF CERTAIN HOSPICE CARE.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (C), by striking ''and'' at the end;

(2) in subparagraph (D), in the matter preceding clause (i), by inserting ''(and, in the case of clause (ii), before the date of enactment of subparagraph (E))'' after ''2011''; and

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

''(E) on and after the date of enactment of this subparagraph, in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of all cases of

individuals provided hospice care by the program under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary); and''.

(d) UPDATE OF HOSPICE AGGREGATE PAYMENT CAP.—Section 1814(i)(2)(B) of the Social Security Act (42 U.S.C. 1395f(i)(2)(B)) is amended—

(1) by striking ''(B) For purposes'' and inserting ''(B)(i) Except as provided in clause (ii), for purposes''; and

(2) by adding at the end the following:

''(ii) For purposes of subparagraph (A) for accounting years that end after September 30, 2016, and before October 1, 2025, the 'cap amount' is the cap amount under this subparagraph for the preceding accounting year updated by the percentage update to payment rates for hospice care under paragraph (1)(C) for services furnished during the fiscal year beginning on the October 1 preceding the beginning of the accounting year (including the application of any productivity or other adjustment under clause (iv) of that paragraph).

''(iii) For accounting years that end after September 30, 2025, the cap amount shall be computed under clause (i) as if clause (ii) had never applied.''.

(e) MEDICARE IMPROVEMENT FUND.—Section 1898 of the Social Security Act (42 U.S.C. 1395iii) is amended—

(1) by amending the heading to read as follows: ''**MEDICARE IMPROVEMENT FUND**'';

(2) by amending subsection (a) to read as follows:

''(a) ESTABLISHMENT.—The Secretary shall establish under this title a Medicare Improvement Fund (in this section referred to as the 'Fund') which shall be available to the Secretary to make improvements under the original Medicare fee-for-service program under parts A and B for individuals entitled to, or enrolled for, benefits under part or enrolled under part B including adjustments to payments for items and services furnished by providers of services and suppliers under such original Medicare fee-for-service program.'';

(3) in subsection (b)(1), by striking ''during'' and all that follows and inserting ''during and after fiscal year 2020, $195,000,000.''; and

(4) in subsection (b)(2), by striking ''from the Federal'' and all that follows and inserting ''from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines appropriate.''.

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

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BRADY of Texas. 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 the subject of the bill under consideration.

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

There was no objection.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, today I rise in support of the IMPACT Act. This bill has a clever name and it will do what it says; it will have a positive impact on the Medicare program.

Much work has been done to investigate how to improve care for seniors, and last June, the Ways and Means Health Subcommittee held a hearing on care delivery after a hospitalization, or what we call post-acute care. Much like the IMPACT Act, the hearing was bipartisan and focused on post-acute reforms that the President advanced in his annual budget.

It has been over a decade since meaningful changes have been made in the care of Medicare patients after hospitalization is paid.

We have recently made progress. Site-neutral payments for long-term care hospitals and a value-based readmission program for nursing homes have been signed into law. These changes are a positive step in the right direction.

Talks of broader reform have been ongoing as concerns of the impact of the solvency of the major source of funding for this care, the Medicare hospital insurance ''HI'' trust fund, persist.

The Medicare trustees have explicitly told us the trajectory of spending from the HI trust fund is unsustainable. The trustees' current estimate is that the HI trust fund will be insolvent by 2030.

Since 2008, the trust fund has been spending more money than it has been taking in. No wonder the HI trust fund has not met the trustees' formal test of short-range adequacy since 2003.

This is a major problem. The HI trust fund is a ticking time bomb.

The IMPACT Act is not the full solution, but it is a vital step on the path toward the solution. The IMPACT Act lays the foundation for future reform.

The act establishes standard data and metrics across all of Medicare's post-hospitalization settings, including nursing homes and rehabilitation facilities. This important information will allow Congress to make future reforms armed with the facts.

We all owe it to the seniors across America to catapult the Medicare program into the 21st century, and that is exactly what this bill does.

Caring for our seniors after they are in the hospital is important, and we need to ensure the trust fund is solvent to allow us to continue to provide this care to our children and grandchildren.

This is just plain, good, commonsense policy. I am voting in favor of the IMPACT Act, and I urge my colleagues to do the same.

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair understands that this bill is being considered as amended.

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

This legislation is truly a bipartisan effort. I congratulate Mr. BRADY and all of my colleagues on both sides of the aisle on the committee who worked on this. And I think Mr. BRADY would like to join me, I am sure, in thanking the staff for their very considerable work on this.

The Affordable Care Act is making major strides towards improving our health care system, including moving toward accountable, quality-driven care. This legislation furthers this quality effort in the post-acute care space.

It is also the first step towards modernizing post-acute care payments to Medicare providers. The current lack of apples-to-apples quality and patient assessment data in post-acute settings makes it difficult to evaluate the quality and cost effectiveness of these providers.

This bipartisan, bicameral legislation, crafted with my colleagues on the Ways and Means and Senate Finance Committees, requires post-acute providers to report common data elements across settings, including patient assessments of function and mobility and quality and resource use measures. Over time, this data will enable health care providers, patients, and their families to determine the best post-acute setting for that patient's particular condition and preferences.

The legislation also asks the Secretary and MEDPAC to provide suggestions and models for how Congress may reform post-acute care payments in the future.

As we continue to strive for quality and value in the Medicare program, it is important we do not discourage providers from caring for complex patient populations. That is why this legislation directs the Secretary to study the effect of individual socioeconomic status, health literacy, English language proficiency, and other factors on quality and research use measurement, and then incorporate those findings into value-based performance programs.

Lastly, the IMPACT Act ensures quality within the hospice benefit by requiring that providers are surveyed by an appropriate accrediting agency at least once every 3 years.

Overall, the IMPACT Act is supported by a multitude of stakeholder organizations. So I encourage my colleagues to vote ''yes'' and to take this important step—and I want to underline that—this important step towards modernizing vital post-acute care.

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

Mr. BRADY of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. REED), a key member of the Ways and Means Committee and a champion for affordable health care.

Mr. REED. I thank the gentleman from Texas for yielding.

Mr. Speaker, I rise tonight in strong support of the IMPACT Act, H.R. 4994. In particular, I would direct my comments tonight in regards to the provisions that deal with hospice care in America. I thank the ranking member, Mr. LEVIN, a friend who has stood with

us in regards to this act, and I echo his support and request for support for its passage this evening.

When we drafted the Hospice Opportunities for Supporting Patients with Integrity and Care Evaluations, otherwise known as the HOSPICE, Act, I was glad to bring those issues to the forefront in the debate that has been incorporated in the IMPACT Act tonight.

To me, hospice care is the right thing to do for our fellow Americans that face those hard decisions as we deal with health care at the end of our lives.

To me, the HOSPICE Act and the provisions in the IMPACT Act go to ensure that there is quality care when it comes to hospice care for our fellow Americans.

These reforms are necessary. They are the right thing to do, and they will ensure that hospice in America is done in a quality, well-conducted manner for all of our fellow Americans.

I would like to thank my coauthor on this, Mr. MIKE THOMPSON from California, with his bipartisan support, and with my colleague on the other side joining us in regards to these reforms to hospice care across America.

Mr. Speaker, I ask my colleagues to support this legislation.

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

I will close just briefly to reiterate, this is a product of months and months of work across the aisle, our staffs working together many, many hours, I think, probably at various hours of the day and night, maybe even as late as it is tonight on other days. So I think we should be proud of this product, and I hope all of us will support it.

I thank Mr. BRADY for his work on this.

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

Mr. BRADY of Texas. Mr. Speaker, I yield myself as much time as I may consume to close.

The bill began with an open letter to stakeholders, as Ranking Member LEVIN said. Following our bipartisan call to action, we received over 70 comments in response to our letter asking for specific recommendations to improve care for seniors.

□ 2145

There were three central themes that stakeholders urged us to pursue, and they are very simple:

One, create a common measure set with standardized data to assess the quality of health care, the way it is delivered;

Two, carefully research and study Medicare's post-acute settings to inform future payment and delivery system reform;

And then third, place an emphasis on informing the patient and team of caregivers during the discharge planning process in order to more effectively coordinate care.

The IMPACT Act achieves these important objectives.

Support for IMPACT comes from hospitals, nursing homes, home health care providers, leading quality groups like the National Quality Forum, and leading beneficiary advocates. I would like to highlight a few:

From the National Home Care and Hospice Association:

''We are very supportive of the goals behind the IMPACT Act and fully support the development of a uniform patient assessment and discharge planning process.''

From the American Academy of Physical Medicine and Rehabilitation, which represents rehab physicians:

''The presence of these quality measures will ensure that patients are receiving the best possible care in the most appropriate setting.''

Finally, from the National Coalition on Health Care, which represents many Medicare beneficiary organizations:

''With this information, payers, providers, consumers, and family caregivers can work together to identify the best care setting for each individual, and policymakers can begin the challenging work of implementing broader reform to Medicare's post-acute system.''

On behalf of Chairman DAVE CAMP, I want to thank the ranking member, Mr. LEVIN, and his staff for all of their good work and thank Senator WYDEN and Senator HATCH in joining us in this bipartisan, bicameral effort.

It is time to support our seniors and improve the Medicare program on which they rely. I urge my colleagues to join me and vote ''yes.''

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

Mr. WAXMAN. Mr. Speaker, there is an old saying, "you get what you pay for." This is true in medicine as in many other fields, and it is why federal healthcare payment policies are so important.

The Affordable Care Act made important reforms in this area. We established many new programs to move us away from a healthcare system that rewards volume over value, such as the Hospital Value Based Purchasing program, the Physician Value-Based Payment Modifier, the Medicare Shared Savings Program or ACOs, and the many new payment models being tested under the Center for Medicare and Medicaid Innovation (CMMI).

Although we have yet to pass final legislation, the bipartisan, bicameral Sustainable Growth Rate (SGR) physician payment reform policies we adopted in the House earlier this year would make valuable additional reforms.

And the bill before us, the Improving Medicare Post-Acute Care Transformation Act of 2014, would take another crucial step toward the modernization of Medicare payments to healthcare providers.

Post-acute care providers, such as nursing homes, long-term care hospitals, and home health agencies are the logical next providers to undergo payment and delivery system transformations. There is tremendous variation in healthcare spending across post-acute care settings. And there is only inconclusive evidence to support which patients should receive which services in which settings of care.

Before we revamp how providers are paid in these settings, we must ensure we have the information we need to make informed decisions. Comprehensive and reliable quality and outcomes data must be collected and analyzed before we can implement payment reforms, such as equalized payments across settings or bundled payments.

And that is exactly what this bill does. It gathers the data we need to compare quality across different post-acute care providers, improve hospital and post-acute care discharge planning, and understand how to appropriately account for socio-economic status in payment and quality performance. This information will help us improve the payment and delivery systems for post-acute care, thereby ensuring Medicare beneficiaries receive the right high-quality care, in the right setting, at the right time.

I am pleased to see this important bipartisan effort to reform post-acute care move forward, which will lead to improved quality, improved outcomes, and lower healthcare costs. I urge my colleagues to vote for its swift passage.

Mr. McDERMOTT. Mr. Speaker, I rise today in support of H.R. 4994, the IMPACT Act. This bipartisan, bicameral legislation makes several small changes to improve post-acute care quality measures and reporting systems in Medicare.

This bill will lay the groundwork for future changes that will reform how Medicare pays for post-acute care.

This bill has support across the post-acute care community, including providers and beneficiaries.

This bill is budget neutral. In short, this is an innocuous bill.

Yet, the bottom line is this:

Congress must do more than pass small, innocuous bills. My constituents in Seattle—and constituents from coast to coast—are coping with a list of growing challenges.

Yet, this Congress is content to push the urgent work of tackling these challenges to another day.

Seniors, patients and doctors need Congress to find a permanent fix for the flawed Sustainable Growth Rate formula in Medicare.

American seniors deserve greater safety and security, but Congress' most recent SGR patch—thrown together last Spring—expires in March.

By then, Congress—just like the 17 times before—will be up against an urgent deadline and flailing to find a permanent solution.

American families need Congress to reauthorize the Children's Health Insurance Program.

More than 8 million children and pregnant women access affordable health coverage through CHIP.

But federal funding faces a cliff next year, and this Congress isn't doing anything about it.

America needs a reenergized primary care workforce.

By 2020, our nation's health system will be staggered by a shortage of 45,000 primary care doctors.

But this Congress isn't talking about extending Medicaid payment parity before it expires in December.

This Congress isn't talking about reauthorizing the National Health Service Corps.

And this Congress certainly isn't talking about new ideas like R–DOCS—a program, modeled on our military's ROTC program, to train and place new primary care doctors where they are needed most.

Yes, we might pass legislation like the IMPACT Act this week. But the American people demand and deserve bolder action and bigger results from their Congress.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BRADY) that the House suspend the rules and pass the bill, H.R. 4994, as amended.

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

A motion to reconsider was laid on the table.

AIR PASSENGER FEE LIMITATIONS

Mr. HUDSON. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 5462) to amend title 49, United States Code, to provide for limitations on the fees charged to passengers of air carriers.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 5462

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

SECTION 1. LIMITATION ON FEES CHARGED TO PASSENGERS OF AIR CARRIERS.

(a) IN GENERAL.—Subsection (c) of section 44940 of title 49, United States Code, is amended to read as follows:

''(c) LIMITATION ON FEE.—

''(1) AMOUNT.—Fees imposed under subsection (a)(1) shall be $5.60 per one-way trip in air transportation or intrastate air transportation that originates at an airport in the United States, except that the fee imposed per round trip shall not exceed $11.20.

''(2) DEFINITION OF ROUND TRIP.—In this subsection, the term 'round trip' means a trip on an air travel itinerary that terminates or has a stopover at the origin point (or co-terminal).''.

(b) APPLICABILITY.—The amendment made by subsection (a) shall apply with respect to a trip in air transportation or intrastate air transportation that is purchased on or after the date of the enactment of this Act.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from North Carolina (Mr. HUDSON) and the gentlewoman from Texas (Ms. JACKSON LEE) each will control 20 minutes.

The Chair recognizes the gentleman from North Carolina.

GENERAL LEAVE

Mr. HUDSON. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days within which to revise and extend their remarks and include any extraneous material on the bill under consideration.

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

There was no objection.

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

I rise in strong support of H.R. 5462, a bill I introduced to address executive overreach affecting the traveling public.

Specifically, this bill would lower fees for certain airline passengers by clarifying congressional intent and setting a mandatory cap on the fees that TSA collects for round trips.

Since 9/11, aviation user fees have helped to defray security costs and ensure that our vital transportation network remains safe. However, when the Bipartisan Budget Act increased these fees, TSA took the language to mean that it was authorized to collect an even higher amount than Congress intended, and it eliminated its own long-standing cap on round trip fees.

Bipartisan Members of the House and Senate, including the authors of the Bipartisan Budget Act, agree that TSA is not authorized to collect these higher fees from travelers, which will add $60 to $70 million annually to the cost of air travel.

H.R. 5462 looks to correct this overreach and save American taxpayers from having to shell out millions of dollars in extra fees. Reducing the burden on airline passengers benefits everyone—from helping families save money when taking a vacation to cutting costs for our small businesses whose employees travel for work.

I urge my colleagues to support the bill, and I reserve the balance of my time.

Ms. JACKSON LEE. Mr. Speaker, I yield myself such time as I may consume.

I rise in strong support of H.R. 5462.

At the outset, I would like to commend the chairman of the Subcommittee on Transportation Security, Representative HUDSON, for the bipartisan approach he has taken with this legislation. I know that Mr. THOMPSON and Mr. RICHMOND have joined him on this legislation, and I have as well.

H.R. 5462 seeks to remove any confusion about a key provision of the Bipartisan Budget Act of 2013 as enacted into law in December 2013. Section 601 of that law provided for the aviation security fee that the Transportation Security Administration collects to increase to $5.60 per one-way trip.

We know that since 9/11 this department was created, and the fees have been utilized to continue to protect the homeland, fees that are assessed on the airlines and utilized by the Transportation Security Administration, but we are attempting to make sure that the process is fair. The language did not specifically cap the fee for a round trip ticket, but common sense would tell us that Congress intended the passenger fee for a round trip to be twice that of a one-way trip, or $11.20.

Regrettably, TSA has missed this intent, resulting in some passengers being assessed excessive fees.

We have the responsibility here in the United States Congress to provide the kind of oversight that treats the Transportation Security Administration fairly: providing them with resources; ensuring that they are protecting the traveling public; ensuring that their TSOs are trained; and, as well, acknowledging the important work that they do. But we have, likewise, a responsibility to the traveling public, and we must balance that with making sure that the fees that are assessed are not excessive.

The legislation before us today clarifies that the passenger security fee should be capped for a round trip at twice the rate assessed for a one-way trip.

Mr. Speaker, for the better part of 5 months, the Committee on Homeland Security and others in Congress have been engaged in a back-and-forth with TSA on this issue. It is my sincere hope that, with this guidance and the enactment of this legislation, this will resolve this issue, once and for all, for the American flying public. Again, as I indicated, it is important to be balanced and fair.

Simply put, this straightforward, bipartisan legislation will ensure that passengers are no longer charged air transportation fees above and beyond what Congress envisioned and intended.

Let me again thank Chairman HUDSON for his leadership on this issue and for the give-and-take that has gone on.

I do want to add two points to my closing remarks as I urge my colleagues to support H.R. 5462 so that TSA can no longer charge passenger security fees above and beyond what is reasonable and what Congress has intended.

I think it is important—and I know Mr. HUDSON will agree with me—the work of the Transportation Security Administration and the improvement of training that we have seen in TSO officers in the line of defense, if you will, that they serve in the Nation's airports.

I want to acknowledge an incident that allegedly occurred, or occurred, with a FAM officer in Nigeria. I want to express to the Federal Air Marshals my concern for that issue and that incident. To the particular air marshal who was in the line of duty and his having been attacked with a hypodermic needle, we express our concern, and we are pleased that there are continued negotiations regarding the process of those FAMs going through international airports.

Lastly, I would say—and I hope that we will engage in this discussion—I know Chairman HUDSON is having a number of meetings. We are all aware, on the backdrop on the debate we will have tomorrow on ISIL, of the potential of the impact on the homeland. We know that we have about 100 American passport individuals who have left for the foreign fighters.

I am looking to introduce in very short order legislation that indicates No Fly for Foreign Fighters Act of 2014, which gives greater details and assessment of the No Fly List, the watch list, to make sure that those with American passports who have gone to the fight cannot be on our airlines; so I am looking forward to working with the committee on this issue.

I only offer that, Mr. Speaker, because of the important work of the Transportation Security Subcommittee, and the responsibility that we have here on the securing of the