OPEN EXECUTIVE SESSION TO CONSIDER AN ORIGINAL BILL TO REPEAL THE SUSTAINABLE GROWTH RATE SYSTEM AND TO CONSIDER HEALTH CARE EXTENDERS; AND TO CONSIDER THE SUPPORTING AT-RISK CHILDREN ACT

THURSDAY, DECEMBER 12, 2013

U.S. Senate,

Committee on Finance,

Washington, DC.

The hearing was convened, pursuant to notice, at 10:13 a.m., in Room 215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Cardin, Brown, Bennet, Casey, Hatch, Grassley, Crapo, Roberts, Enzi, Cornyn, Thune, Burr, Isakson, Portman, and Toomey.

Also present: Douglas Elmendorf, Ph.D., Director, Congressional Budget Office; Thomas Bradley, Chief, Medicare Cost Estimates, Congressional Budget Office. Democratic Staff: Dan Todd, Health Policy Advisor; Karen Fisher, Professional Staff; Josh Levasseur, Chief Clerk; Athena Schritz, Office Manager; and Becky Shipp, Health Policy Advisor. Democratic Staff: Amber Cottle, Staff Director; Mac Campbell, General Counsel; David Schwartz, Chief Health Counsel; and Diedra Henry-Spires, Professional Staff. Republican Staff: Chris Campbell,

Staff Director; Mark Prater, Deputy Chief of Staff and Chief Tax Counsel; and Jay Khosla, Chief Health Counsel Policy Director.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The Chairman. The Committee will come to order. The Committee will come to order. That means come to order.

Before we start this morning, Senator Hatch and I want to recognize a member of the Senate Finance Committee's professional staff who recently marked a major milestone. That is Mark Blair. Mark, stand up.

[Applause.]

The Chairman. Mark serves as systems administrator for the Committee. We are celebrating 30 years of service in the Senate this past September. Thirty years is quite an achievement. But more impressive, those 3 decades have all been with the Senate Finance Committee.

Mark is a true public servant and I know I can speak for all members of the Committee when I say thank you. Thank you so much, Mark, for all that you have done.

I must tell you, also, that one of my staff today said, "Mark is the best computer systems person I have ever, ever worked with in my life, and I have worked with a lot of them." You are number one.

I will not go the next step and say where you should have been the last few months.

[Laughter.]

The Chairman. But anyway, thank you so much, Mark, for your service. And I would like to present this award to you.

[Applause.]

The Chairman. I also want to welcome Mark's family who are here with us today: daughters Sharell, Nicole, and Nyah, as well as your son Aaron, your sister Cindy, your mother, Arlene Prince, and your mother-in-law, Carolyn Boose. Will you all please stand? We want to recognize all of you too.

[Applause.]

The Chairman. The Committee meets today to consider two items; first, the original bill to repeal the sustainable growth rate system and consider health care extenders; and, second, an original bill, known as the Supporting At-Risk Children Act.

The American industrialist Henry Ford once said, and I quote, "Most people spend more time and energy going around problems rather than in trying to solve them."

The Medicare payment system for doctors is a testament to Henry Ford's words. For more than a decade, Medicare has used a broken formula, known as the sustainable growth rate, or SGR, to determine physician payments.

Since 2002, the SGR has threatened to make draconian cuts to physician payments, cuts that cause seniors to lose access to their doctors, and every year Congress has had to spend more time and money to pass temporary fixes.

Congress has spent $150 billion on these temporary patches, which is more than the current cost of repealing SGR over the 10-year number. 2014 is no different. Doctors are facing a payment cut of nearly 24 percent.

Enough is enough. After a decade of Band-Aid solutions, it is time for this Committee to act. And I am very proud to say that today we are taking the first step. Senator Hatch and I are bringing forth a bill that repeals the SGR.

Just think of that, those of us who have been involved in the SGR world. Repealing the SGR, finally.

[Laughter.]

The Chairman. Not a 1-year patch. One more time.

[Laughter.]

The Chairman. And give certainty to seniors and physicians, and approves the Medicare physician payment system toward value over volume.

Our comprehensive bill reflects input we received from the entire health community. Over the past several years, we have heard from stakeholders, numerous roundtable discussions and hearings, and our counterparts

in the House have engaged in a similar effort.

As we began to develop our proposal, we realized that we all share the same goal -- improved fee-for-service system; reward value over volume; encourage physicians to transition to alternative payment models, such as medical homes and accountable care organizations.

The House Energy and Commerce Committee acted first. In July, it unanimously approved a bipartisan bill to repeal and replace the SGR. Together with the House Ways and Means Committee, we built on that document to produce a bipartisan, bicameral proposal.

We shared that proposal with the health care community in October and asked for their input. Our draft reflects the feedback received from hundreds of letters and dozens of meetings.

The mark before us accomplishes four goals. First, it repeals the SGR and ties payments to quality and efficiency.

Second, it improves the fee-for-service system by streamlining Medicare's existing web of quality programs into one value-based performance program. It ensures accurate payments for services and encourages physicians to adopt proven practices.

Third, the mark incentivizes movement to alternative payment models. What does that mean? It means doctors

and providers will focus more on coordination and prevention to improve quality and reduce costs.

Finally, the mark makes Medicare data more transparent. Patients will have access to the information they need to make informed choices. Doctors will use data to improve the care they deliver.

Dr. Michael Brown of the Montana Medical Association applauded the Committee's work to repeal the SGR, and here is his quote: "This bill moves Medicare to a viable payment formula. It will bring stability to physician practices and help maintain access for our senior citizens," end quote.

While it is critical to finally solve the SGR problem, it is just as important that we address other health policies that Congress extends temporarily year-by-year.

The mark addresses these so-called extenders. Much like with SGR, it is time to put an end to the cycle of relying on short-term fixes for long-term problems. Doctors, seniors need and deserve certainty and our mark gives it to them.

The mark reflects hard work by both parties and both chambers of Congress.

I especially want to thank Senator Hatch and our Ways and Means colleagues, Dave Camp and Sandy Levin, for

their leadership.

Today we are also considered important legislation to protect our Nation's children. The mark reauthorizes the adoption incentives program. In 2011, more than 400,000 children were living in foster care, 3,000 of them in my home State of Montana.

The mark provides funds to help strengthen struggling families, reunite foster children with loved ones, and give States greater flexibility to create new ways to support families.

The mark also takes action to protect America's youth from sex trafficking. According to the Department of Health and Human Services, children are the victims of sexual exploitation nearly 200,000 times a year in the United States.

The mark makes State child welfare departments a part of the solution by giving them greater power and legal authority to protect youth from sex trafficking.

Current law blocks State child welfare departments from helping victims sold by someone other than a legal guardian. That makes no sense. It must change.

Every witness at our hearing on sex trafficking in July told this Committee that there were not enough safe housing options for victims. We heard that constantly.

The mark addresses that. It requires the

identification of existing Federal housing resources that can be repurposed for trafficking victims.

Lastly, the mark minimizes the red tape involved in creating and sharing best practices in serving victims of trafficking.

It creates a Federal Advisory Committee to determine which policies protect kids and which do not. That means State leaders will soon have a one-stop-shop where they can learn what other States are doing to combat trafficking.

Kids need everyone involved in their lives to be responsible for them, both financially and socially.

The mark also strengthens child support enforcement to help kids get the resources they need to grow and to thrive. A long list of my colleagues pitched in to build and strengthen this legislation, Senators Hatch, Wyden, Bennet, Senator Brown, Senators Cantwell, Casey, Senators Cornyn, Grassley, Menendez, Portman, Rockefeller, and Stabenow. I want to thank them all very, very much for their very, very hard work to make this happen.

As Henry Ford said, most people spend more time and energy going around problems than trying to solve them. It is time for us to stop going around some of these problems and it is time for us to tackle it head on.

So let us get to work and pass these vital reforms

for our Nation's doctors, seniors, and our children.

Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator Hatch. Thank you, Mr. Chairman.

I, too, want to take a moment to recognize Mark Blair for his 30 years of service to this Finance Committee. That really is an achievement. In fact, it is my understanding that Mark is only one of two staffers in the history of the Committee to reach that milestone. So that is a real tribute to him.

He served under seven different chairmen, including Chairmen Dole, Packwood, Bentsen, Moynihan, Roth, Grassley, and, of course, our own Chairman Baucus.

Needless to say, that is pretty impressive. Mark is a true professional. His work here on the Committee is greatly appreciated, and I want to thank him for his dedicated public service and for all he does for us here on this Committee.

Thank you, Mark. And thank you to all of his family members who are here today, that have joined him here today.

Now, Mr. Chairman, today the Committee will hopefully report our legislation to repeal the sustainable growth rate, or SGR, system. This legislation represents almost a year of hard work from

people on both sides of the aisle and both sides of the Capitol. This is truly a bipartisan, bicameral event and effort.

The House Energy and Commerce Committee has already reported a bill to repeal the SGR. And today the House Ways and Means Committee will report a bill similar to ours. In these partisan times, it is truly a testament to our commitment to our seniors and physicians that we can come together on a policy that has all three committees of jurisdiction moving forward in a bipartisan way.

I think this process can serve as an example of how things can and should be done here in Congress. The SGR is a problem that has plagued us for over a decade. Virtually every year, there is a mad dash to find billions of dollars in Medicare provider cuts to pay for a doc fix.

Since 2003, we have had to patch the SGR 15 times at a total cost of $150 billion.

If enacted, our bill will put an end to all of this. In drafting this proposal, we have had almost a year's worth of hearings, roundtables, and countless meetings to get feedback from everyone involved, including physician and other health care provider groups, as well as policy experts, and the legislation has been shaped and altered

in response to that feedback.

Consequently, a number of these organizations have already publicly expressed their support for this legislation, including the American Medical Association, the American Osteopathic Association, the American Academy of Family Physicians, the American College of Radiology, the American College of Cardiology, just to mention a few.

The timing of this legislation is fortunate, thanks to a recent Congressional Budget Office estimate that put the cost of permanently repealing the SGR at $116 billion over 10 years. Previous CBO estimates were more than double that amount.

Now, I know there is some trepidation out there when it comes to the cost and current lack of offsets. Let me say it in no uncertain terms -- this bill will be offset, period, or it is not going to go through both houses.

I have had extensive discussions with Chairmen Camp and Upton in the House on this matter, and Chairman Baucus and I have agreed that once the bill is out of Committee, we will sit down to find suitable offsets.

Now, let me repeat myself just so it is clear. This bill will be paid for. Like many policy efforts, repealing the SGR is a process. Reporting the bill out of the Finance Committee is an important step in that

process, but we are still only at the beginning.

I urge my colleagues to take this step with us. It is my hope that we will get a strong bipartisan vote in favor of reporting this bill today.

Now, this is an historic opportunity for our Committee. But a policy change of this magnitude needs to have the input of the entire Senate, and I know both Senator Baucus and I are committed to a robust regular order process on the floor, just like we have had here in this Committee.

Our members have great ideas and we will continue to work through the process, but it is essential that we accomplish this first step today.

In addition to the SGR bill, we will also be marking up a package of Medicare and Medicaid extenders that have been carefully negotiated to move the process forward. For the first time, we have taken a thorough and complete look at each of these extenders.

For those we believe are still justified, we will make them permanent. For others, we will extend for a period of time so we can continue to assess them.

Finally, we will report the Supporting At-Risk Children Act, another piece of bipartisan, bicameral legislation that is long overdue. If enacted, this bill will make important reforms by promoting adoption,

addressing the domestic sex trafficking of children and youth, and improving the collection and dissemination of child support.

The bill draws from a number of proposals from several members of this Committee. I would particularly like to thank the Chairman for including a number of key provisions in the trafficking title from the legislation I introduced this year, the Improving Outcomes for Youth At Risk for Sex Trafficking, otherwise known as I O Youth.

This is another important bill. I hope all of my colleagues will support it.

Mr. Chairman, it appears that we are going to get a lot done today. I commend you for your work on these bills and I am glad I have had the opportunity to work with you on these efforts.

I want to thank you, once again, Mr. Chairman, and all members of this Committee, as well.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

I would like to note that I think there will be a series of votes today. My understanding is they tend to be in pairs in about an hour, hour-and-a-half intervals, but we will just have to see and do the best we can here, which means a couple of things.

Number one, I urge all of us to be efficient and concise in our statements, whether opening statements or amendments or whatnot.

Second, I want to thank everybody for their cooperation in allowing us to meet and mark up this bill. It means a lot to me. More importantly, it means a lot to a lot of seniors and people in the physician community and hospitals that we are acting on this quite important legislation.

So at this point, I am going to ask if any Senator wishes to make any statements. To the degree we do, I am just going to go back and forth on the basis of seniority until everyone has a chance to speak. Again, I encourage you to get to the point, say what you want to say.

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator Grassley. I commend Senators Baucus and Hatch on working together to find common ground on the replacement of our broken Medicare physician payment system and the child welfare issues that we will take up later today.

It is an important step forward. There is no question we must replace the SGR. I accept the Chairman and Ranking Member's commitment to pay for this bill. I want to support this bill today and on final passage on the floor.

I have concerns about the uncertainty of the policy impact of this bill and the delegation of authority to the Secretary and to CMS. I will express those further later.

However, I do congratulate the leaders of this Committee on the progress they have made.

On another bill, the Supporting Act-Risk Child Act continues the tradition of bipartisanship on child welfare issues. The three titles will go a long ways to help our most vulnerable children and families. Helping foster youth, especially older children who are less likely to find a permanent family, is so critically

important today. We must do what we can to help families stay strong.

I am grateful that the mark includes provisions from the Menendez-Grassley child support enforcement bill that has been introduced for the last several years. I also thank them for including other modifications that I have suggested that improve the mark.

I yield the floor.

The Chairman. Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator Rockefeller. Thank you, Mr. Chairman.

I am here today to continue work on what I have done for nearly 50 years -- protecting the most vulnerable amongst us. It is something I take very, very seriously.

Medicare and Medicaid and the people who rely on these vital programs and, in many ways, it is all about my life's work really, are a reason for being in public service. So I will report this legislation, Mr. Chairman.

In recent weeks, my staff has worked tirelessly with yours. David Schwartz and others have been fantastic.

Some changes made it into the text. Others, like a fix that would level the playing field for West Virginia hospitals with regard to the Medicare wage index could not be agreed on at this time, and I understand that.

I thank you and your staff, as well as my own, for their dedicated effort. Protecting low income Medicaid and Medicare beneficiaries, again, is so important. Tens of thousands of West Virginians rely on these programs for their health care coverage, and we know that entire communities benefit when their populations can access the health services they need.

In conclusion, I deeply regret the one critically important item that benefits the population that has not changed in this mark. That item is the Medicaid managed care bill or the Medicaid MLR, medical loss ratio.

Currently, some states, like California, are moving their entire Medicaid population into managed care, but without the same protections insurers must abide by in Medicare Advantage and in the new health care marketplace.

So I look forward to voting for this bill, which is not perfect, but which you and your staff have done everything possible.

The Chairman. Thank you, Senator, very, very much.

Senator Cornyn?

Senator Cornyn. I will defer.

The Chairman. Senator Roberts?

OPENING STATEMENT OF HON. PAT ROBERTS, A U.S. SENATOR FROM KANSAS

Senator Roberts. Well, thank you, Mr. Chairman. I will try to be brief.

Thank you so much, to you and the Ranking Member, Senator Hatch, for holding this markup. This is the first real health care markup we have had in a long time and I really appreciate that.

I want to thank you and the entire Committee for working toward a solution to the SGR problem and the commitment to the rural extender programs, and I speak from the standpoint that I still believe I am the co-chair of the Rural Health Care Caucus. We may not have 27 in the posse, but we have a considerable number.

This has been a long and arduous process. I appreciate the briefings, the meetings, all of the hard work and your willingness to work with us on this issue, and more especially with the amendments that I have offered, along with many other members.

This is something that absolutely needed to happen. I appreciate that this can pass through regular order. I have said regular order probably 150 times a day during the climate that we live in, and not at the 11th hour and 59th minute. It is probably the 11th hour and the 57th

minute. But at any rate, this is no small accomplishment given the current legislative environment that we operate in today.

I want to stress, I support your efforts and the Committee efforts. I believe that you have come up with reasonable solutions. As has been stated by Senator Rockefeller and others, it may not be perfect. There are still things that can be improved, but that is what regular order is all about.

The bottom line, perhaps not the best possible bill, but the best bill possible.

I have an outstanding concern. This markup does not address offsets for the underlying package. I think I can support it and many of the amendments that have been filed and may be offered today. Some of that I have personally supported for many years. But we have to take the difficult votes for the cuts and taking the hard votes to get our fiscal house in order.

Unfortunately, if the package is not paid for today, I do not think I will be able to support it. I believe Senator Hatch that that will come and I hope that time will come. Hopefully, in the future, if we are able to fully offset the package and it is paid for, this very comprehensive and most needed reform will have my enthusiastic support.

I thank the Chairman.

The Chairman. Senator Schumer?

OPENING STATEMENT OF HON. CHARLES E. SCHUMER, A U.S. SENATOR FROM NEW YORK

Senator Schumer. Thank you, Mr. Chairman.

First, I want to thank you for convening this markup. There is great support for replacing the flawed medical sustainable growth rate physician payment formula.

For more than a decade, we have passed short-term fixes necessary so that American doctors can continue to take care of seniors, but penny wise and pound foolish.

And you are to be applauded, Mr. Chairman, you and Senator Hatch, for taking this on and doing this in the right way, and very much appreciate it. It will take us off the rollercoaster of doc fixes and greatly improve how Medicare pays for essential services.

We have talked about incentivizing values. In my State, we have some hospitals and medical organizations that do it. Montefiore Medical Center in the Bronx is a pioneer accountable organization, new payment innovation, delivering high quality care to among the poorest people in America.

In Upstate New York, in the Hudson Headwaters, North Country created an Adirondack Regional Medical Home pilot; 60,000 poor rural New Yorkers receive high

quality.

So this is the general direction you are moving and I think that is great.

A couple of things I wanted to mention specifically. I thank you and the Ranking Member for including the 5-year extension of ambulant payment increase, critical for ambulance providers, particularly in rural areas.

Senator Grassley and I will offer an amendment on the Medicare dependent hospital and low volume hospital program. You have made it permanent, but the way it is done, it cuts of 116 hospitals in the country that could not do without this money, all rural, all struggling, and we are going to offer an amendment to that.

I also hope to offer amendments -- I filed amendments on fixing the Medicare DSH cut, and Senator Nelson, Senator Reed and I on GME slots, adding slots, as well.

So there is a lot of good in this bill. Obviously, it is a framework that we can add some other things onto. And I hope that we can make this happen. I really hope we can make this happen when the 3-month short-term fix expires. It is a great thing to do.

The Chairman. Thank you, Senator.

Senator Enzi?

OPENING STATEMENT OF HON. MIKE ENZI, A U.S. SENATOR FROM WYOMING

Senator Enzi. Mr. Chairman, I think that it is past time that we quit holding the docs hostage a year at a time and I hope this will be honestly paid for, and hoping to start a trend.

I would submit the rest of my statement for the record.

[The prepared statement of Senator Enzi appears in the appendix.]

The Chairman. Senator Stabenow?

OPENING STATEMENT OF HON. DEBBIE STABENOW, A U.S. SENATOR FROM MICHGAN

Senator Stabenow. Mr. Chairman, I just want to say a quick thank you to you and Senator Hatch. This has been a long time coming.

A lot of us who have cared very deeply about changing and eliminating this flawed payment system are celebrating the fact that we could actually get this done.

So congratulations, and look forward to working with you on it.

The Chairman. Thank you, Senator, very much.

Senator Cornyn?

OPENING STATEMENT OF HON. JOHN CORNYN, A U.S. SENATOR FROM TEXAS

Senator Cornyn. Mr. Chairman, thanks for holding this markup.

This is a challenging issue that Congress has struggled with for more than 10 years, although if we have learned one thing, it seems to be arbitrarily cutting provider payments can be counterproductive, because it will deny people access when they cannot find doctors who will see them at that price.

I do appreciate all the hard work that you and the committee have put toward addressing full repeal and replacement of the SGR.

And I want to join Senator Roberts in expressing my gratitude for a health care markup, in the first one in 4 years. It is about time and I am glad we are doing this.

Today's markup indicates bipartisan recognition that there are real issues in health care that need to be addressed, but I do respectfully suggest that my concerns that the offsets are not under consideration today and I am relying on the commitments that I am hearing from you and the Ranking Member that all members of the Committee will be fully involved in the offset discussion and the bill will be fully offset.

The only way we can have a truly transparent and bipartisan product is for everyone to have a seat at the table when we are discussing those offsets. Before I conclude, let me raise a concern I have about how physicians and small practices in rural areas will fare under this package.

In order to make certain that these providers are able to continue to participate in the Medicare program, we need to ensure they have they have the ability to transition to alternative payment models or possess the tools necessary to succeed in the VBP program.

I thank the Chairman and Ranking Member for including two studies that Senator Cardin and I have asked for that will help us assess how this bill affects our physicians in rural areas.

It is critical we solve the SGR problem in order to provide stability for both Medicare providers and beneficiaries, and I look forward to working with the Committee toward that end.

Thank you.

The Chairman. Thank you, Senator.

Senator Cantwell?

OPENING STATEMENT OF HON. MARIA CANTWELL, A U.S. SENATOR FROM WASHINGTON

Senator Cantwell. Thank you, Mr. Chairman.

I agree with my colleagues here today that we need to find a bipartisan solution to the Medicare sustainable growth rate and that we need to promote certainty and stability for Medicare providers and patients.

I want to speak about the efforts within this bill to promote efficiency and quality outcomes. We have a saying in Washington State that we like to innovate, and I know we are here today to legislate, but I need to make sure that innovation is preserved.

The Everett Clinic launched a quality outcome program with Boeing employees recently that called for the intensive outpatient care with 230 employees. They coordinated the wellness for these employees that resulted in a 20 percent savings in health care due to fewer hospitalizations, emergency room visits, and, over the last 2.5 years, developed medical homes that focused on 750 employees with complex health care issues.

All of this coordination between the patient and providers and all of these programs, including the family resources, the Boeing Company said was a return on investment not only of quality care and outcomes, but

better performance by the employees and their productivity.

So this is what happens when we focus on quality outcomes. Providers in Washington State, like Group Health Cooperative, the Everett Clinic and many others, are providing efficient, high quality care and we have been doing so for decades.

Under the Medicare fee-for-service system, they were actually penalized for this. In fact, the Dartmouth Atlas of Health Care estimated that Washington State providers were paid, on average, $1,200 less than the national average and approximately 34 States having a higher per individual Medicare cost.

That is why I championed the value-based modifier that we passed in the health care bill. Just last week, Swedish Hospital, which employees over 1,000 physicians in hospitals and clinics in my State, announced that it would be switching to an outcome-based model that would have 25 percent of its physicians paid directly, determined by patient outcomes instead of fee-for-service.

As the Swedish medical director said, quote, "The structure of payment drives the structure of health care system and it determines the way we deliver care."

At a previous hearing, CMS Administrator Don Berwick

called the value-based modifier a large piece of the component of reducing Medicare costs.

So strong outcomes in an outcome-based system will promote savings through the entire Medicare system. This bill sunsets the value-based modifier and creates a value-based program for performance, consolidating many of the incentive programs that were previously in existence.

I have expressed my concerns on making sure that the alternative payment model that my colleague just referred to, the previous colleague, is also fully included in an incentive program, because so much of the major investments and reaping of cost savings are happening in alternative payment models. We need to make sure that we are not only getting off of fee-for-service, but moving toward alternative payment models that are going to give us our biggest incentives and savings.

That is why I worked closely with Karen Fisher, David Schwartz, Deputy Staff Director Matt Campbell and others to make sure that we had a full understanding of these goals and amendments that were offered in this legislation.

So my main objective is to make sure that our providers stay ahead of the curve, because we want to keep moving forward. We do not want to miss the

opportunity to keep the leaders and innovators on the forward march, because they are the ones who are delivering the best cost savings to us as the rest of the system catches up.

So, Mr. Chairman, thank you, your office and your staff for working with us to improve this legislation.

The Chairman. Thank you, Senator. I will also compliment you and your work, innovative work in this area, because you, more than any other Senator, have pushed in the direction which I think is the right one to go. Thank you very much.

Senator Thune?

OPENING STATEMENT OF HON. JOHN THUNE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator Thune. Mr. Chairman, thank you and to Ranking Member Hatch, for your good work on this.

We have known for a long time we have got to do this. We have been passing these short-term fixes -- I was here in 1997 when Congress passed the current SGR formula and ever since that time, we have been trying to come up with a better solution and, in lieu of that, consistently passing what have become very expensive temporary fixes.

So I think this is moving us in the right direction. The private sector has, obviously, recognized the importance of shifting this paradigm, and I am hopeful that we, as we start focusing on reimbursing for quality instead of quantity, that we can move the Medicare program toward quality and in a better direction.

As I have evaluated how I look at the legislation before us, there are really two issues at the forefront of my mind. One is how we pay for it, and I think that is something we have got to have. Fortunately, CBO has put a fire sale on SGR fix and I think that is, from a timing standpoint, important that we get this done now.

But I think that we should not be adding it to the

debt and we should not be raising taxes to pay for it. We have to figure out how to offset it.

The second question I will ask is how does this proposal impact providers and beneficiaries in my home State of South Dakota. And in terms of how this program affects providers in my State, I am concerned about some of the unresolved questions that I have, particularly about the distribution of providers in the value-based program or performance incentive program. And I am also concerned about possible disincentives for providers in our very rural areas to continue to provide high quality care to people in those very rural areas.

But I look forward to working with the Committee as we address these concerns and hopefully get a opportunity to do something meaningful in terms of a long-term solution to this very serious problem that, if we do not fix, is going to continue to be enormously expensive.

I would like, at some point, too, to hear from the folks at CBO and Mr. Elmendorf about how they score tele-health legislation; generally, about how the CBO views the use of tele-health technology both with respect to projects like remote patient monitoring and a modification to Section 1834(m) of the Social Security Act, which essentially limits Medicare tele-health to rural areas for CMS-approved codes.

So those are some questions I would like to get answered, and I have got an amendment that I will offer later that hopefully will give us an opportunity to discuss that.

So, Mr. Chairman, thank you very much.

The Chairman. Thank you, Senator.

Do other Senators wish to speak?

Senator Wyden?

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator Wyden. Thank you, Mr. Chairman. I am going to be very brief.

To me, what is beginning today is the effort to modernize Medicare, to make this a more transparent program and to ensure that it really reflects the biggest challenges in terms of the health problems presented by the elderly population.

I am very pleased, Mr. Chairman, that you included two areas that were of great importance to me. First, Senator Grassley and I have been prosecuting this transparency cause for a number of years, by opening up the Medicare claims database. This is, colleagues, really the treasure trove of information that is going to be enormously helpful to seniors.

It will also be very helpful if you have an employer plan or an HSA, because, depending on what the Medicare reimbursement rate is in a given community, you are going to want to know why is your employer plan or your HSA is not able to get it.

So I thank you very much for including that.

The second area where there is enormous interest in this Committee -- Senator Isakson and I have teamed up,

Senator Bennet, Senator Toomey have expressed real interest -- is the focus on chronic disease. This, in my view, is what Medicare is all about.

Today, the prevalence of cancer, stroke, diabetes, heart problems, is responsible for 80 percent-plus of the spending in the Medicare program. Medicare in 2013 is real different than Medicare in 1965. And I am very appreciative of Senator Isakson and our colleagues who want to work on this in a bipartisan way.

Mr. Chairman, you have allowed us to get in the mark some improvements to the C-SNP program -- that is the chronic special needs plan. That is going to be very helpful. And then, when we get to amendments, Senator Isakson and I will discuss our proposal, to hopefully be joined by Senator Bennet and Senator Toomey.

But I am very appreciative of the efforts that you have made in this significant step toward modernizing Medicare, particularly to make the program more transparent and to ensure that it really reflects the big challenges, like chronic disease.

The Chairman. Thank you, Senator.

Do other Senators wish to be recognized?

Senator Isakson?

OPENING STATEMENT OF HON. JOHNNY ISAKSON, A U.S. SENATOR FROM GEORGIA

Senator Isakson. I just want to thank the Chairman and the Ranking Member and their staff, in particular, for the cooperation over the last week or so leading up to this markup. We have had tremendous help.

I share the enthusiasm of everybody here. I would just admonish everyone to sustain that enthusiasm. This is the first step of a journey that we are going to have to be enthusiastically committed to to get this job done in the first quarter of next year by paying for it and seeing to it we finish the task.

But I commend the Chairman and the Ranking Member for great work, and I thank you for the time.

The Chairman. Thank you, Senator. Wise words.

Senator Wyden. Mr. Chairman, for 5 seconds, let me just acknowledge my omission. It is really the Bennet-Warner discussion on chronic disease, and I apologize to my friend from Colorado.

The Chairman. Senator Nelson, do you seek recognition?

OPENING STATEMENT OF HON. BILL NELSON, A U.S. SENATOR FROM FLORIDA

Senator Nelson. Mr. Chairman, I have a Christmas present for you. I will not offer an opening statement, but instead will insert it in the record.

[Laughter.]

Senator Nelson. And I want to thank you for including three of our amendments, several Senators joined, and our Aging Committee wants to work with you in the future on seniors having the right of appeal on extremely expensive specialty drugs.

Thank you.

[The prepared statement of Senator Nelson appears at the end of the transcript.]

The Chairman. Thank you.

Other Senators?

Senator Carper?

OPENING STATEMENT OF HON. THOMAS R. CARPER, A U.S. SENATOR FROM DELAWARE

Senator Carper. A statement, no present.

I want to again thank you and Orrin, and your staffs are just doing great work on this, really setting an example.

The folks back home say to me all the time, "Why can't you work together down there," and I think this Committee is going to demonstrate that we are able to do that and I am very, very proud to be one of you.

I have argued for a long time about the need to move away from fee-for-service toward performance-based payments in Medicare expeditiously and with this proposal, that is what we are going to do.

And it does that, in part, by encouraging our country's health care providers to participate in the affordable care organizations and accountable care organizations, patient-centered medical homes, and other innovative payments and delivery models.

And instead of paying physicians and other health care providers for the number of services they provide, this legislation actually encourages our country's health care providers to improve health outcomes and drive down the costs by keeping patients as healthy as possible.

Imagine that.

I also want to thank the Chairman and his staff, Senator Hatch and his staff for including in the revised mark a number of amendments that my staff have worked on with probably half the Democrats and Republicans in this Committee.

Compared with our markup on the Affordable Care Act, when we had so few bipartisan amendments, almost every one of these is bipartisan and I am just delighted to see that.

Among the amendments that I am joining my colleagues in offering is one that focuses on -- a lot of them focus on curbing waste and fraud in Medicare and Medicaid. One of them, in particular, I want to mention, Mr. Chairman, is the adoption of most of the provisions of the PRIME Act, something that Dr. Coburn and I have coauthored, cosponsored by 25 of our colleagues, including, on this Committee, Senator Bennet, Senator Enzi, Senator Isakson, Senator Nelson, and Senator Thune. We look forward to working with our Committee on measures to save taxpayers money through stronger program integrity efforts.

The other thing I would say is there are a couple of other waste and fraud ideas that I may raise in this morning's discussion, including an amendment by Senator Toomey and Senator Brown, Sherrod Brown of Ohio, to

address the fraudulent diversion of controlled substances, drugs, such as pain killers, from Medicare's prescription drug program.

Finally, I would just take a moment to note the importance of the Commission on Patient-Directed Health Care to help us advance our national conversation on how to ensure that each individual's care preferences are fully respected in the course of their health care treatment.

I believe this commission will provide a tremendous service to our country by giving Americans the opportunity to have an honest discussion about our individual health care choices and expectations and how to ensure that these choices are respected at every stage of our life.

Thank you for including that commission in this bill.

The Chairman. Senator Crapo?

OPENING STATEMENT OF HON. MIKE CRAPO, A U.S. SENATOR FROM IDAHO

Senator Crapo. Thank you, Mr. Chairman. I want to commend you and Senator Hatch for taking the effort to launch a longer-term look at the Medicare physician payment rates issue and policy extenders.

For too long, the Medicare sustainable growth rate system and short-term policy extenders have hung over doctors, hospitals, patients, and Congress as a perennial threat that always gets a last-minute fix, but only at least in the most transparent manner possible we need.

On June 8, the Committee asked us that we restore regular order to the process of considering Medicare reform proposals, and the public will be best served, I think, for specific reforms to be developed in a transparent way, but, also, with the opportunity for full debate and consideration.

If we are ever to establish some semblance of a responsible Medicare program, getting a handle on its finances and benefits is a must. The Medicare trustees remind us that absent reform, Medicare will be insolvent in 2026, if not sooner.

So I appreciate our markup today and, again, I congratulate on taking this action.

However, I would be remiss if I did not express my

serious concerns about the fact that we continue not to give the strong attention needed to full Medicare reform.

As I indicated, the Medicare system is headed for insolvency soon, and we need to take, I believe, much broader and more aggressive action.

Earlier this year -- and I would like to put my full statement in the record, Mr. Chairman. But earlier this year and for some time now, the Committee has paid very serious attention to the issue of tax reform, which also is critically important and needed in terms of dealing with our fiscal crisis. And I would encourage you to do the same thing now, to initiate the same kind of process now with regard to Medicare reform.

Let us have the meetings. Let us have the roundtables. Let us have the discussions and delve into the specific kinds of issues of the needed reforms that are important that we make to our Medicare system to help it avoid insolvency.

If we do that, I think that can actually become a part of a much broader and larger resolution of our fiscal policy and even in conjunction with our reform of the tax code.

These are items that I believe are critically absent right now in Congress deliberations. So although, again, I commend you for this progress and moving forward in a

very positive way on the SGR.

I encourage you to take the same approach to resolving the broader issues of Medicare reform that you have done with regard to tax reform and help us, as a Committee, to lead in this effort to take the major steps that are needed in this area to help us deal with our fiscal policy, as well as this specific program.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

That, obviously, prompts a couple of thoughts. One is I do believe that the pending budget agreement is a good first step. It is not sweeping scope in scope. It did not address a lot of the major issues that need to be addressed, but it is a start and it is an agreement.

We here are starting to reform SGR and it is becoming an agreement, and I just think -- my view is that anything that is durable and sustainable has to be agreed upon and has to be bipartisan. Otherwise, it tends not to have a long life.

But thanks for that. I appreciate that comment.

Senator Crapo. I agree with you. Thank you.

The Chairman. Senator Cardin?

OPENING STATEMENT OF HON. BENJAMIN L. CARDIN, A U.S. SENATOR FROM MARYLAND

Senator Cardin. Thank you, Mr. Chairman. And I also want to thank --

The Chairman. I might suggest, Senator, before you begin, apparently another vote has just begun. So maybe we can wrap up all our statements and vote quickly and come back.

Senator Cardin. Absolutely, Mr. Chairman. I just really want to thank you and Senator Hatch for coming forward with this proposal.

It was 16 years ago that the Balanced Budget Act of 1997 was passed that set up the SGR system. It has been 20 years since the RBRVS. And every year we have acknowledged it does not work and we have used patches, yet no one has come forward with a fix or a substitute.

So I applaud the leadership of this Committee for doing something that is real and substituting the SGR formula with a payment structure that makes sense.

I particularly thank you for how you handled the RUC issue so that we can try to encourage more primary care and understanding of primary care and better incentives for coordinated care, which is in the Chairman's mark and I congratulate you on that.

I also want to acknowledge how important it is that you have come forward with a permanent fix for the therapy caps. This is another policy that was enacted in 1997, and, Mr. Chairman, I was part of the Ways and Means Committee at that time and remember asking, what is the policy for these therapy caps, and they said, there is no policy, it is strictly a target for budget money.

It makes no sense for quality care. It penalizes those that have the most challenging needs, and your mark fixes that permanently, also, and I thank you very much for doing that.

I thank you for incorporating some amendments that I had suggested that will provide outreach for those with multiple chronic conditions so that we can better coordinate their care and setting up a demonstration for at-risk seniors who are in danger of going into nursing homes and then spending down and being qualified for Medicaid, which will not only save the Federal Government tax dollars and the State tax dollars, but better care for our senior population.

Then, lastly, I look forward to discussing with the Committee an amendment that Senator Portman and I have introduced that deals with dispensing fees in long-term care facilities to avoid wastage in drugs. We believe it will save money and we look forward to that discussion.

The Chairman. Thank you, Senator.

Senator Brown?

OPENING STATEMENT OF HON. SHERROD BROWN, A U.S. SENATOR FROM OHIO

Senator Brown. Thank you, Mr. Chairman.

Since Senator Cardin mentioned it has been more than a decade-and-a-half since the first doc fix, I wrote with -- my staff and I wrote with then Chairman Bilirakis on the House Subcommittee on Health -- he was the Chair, I was the Ranking Member for the first, unfortunately, temporary doc fix, and I am so pleased that Chairman Baucus and Senator Hatch are working on this.

I am particularly pleased to see the mark this morning includes an extension of traditional medical assistance. It is a crucial work support initiative, because it protects families from burdensome health care expenses when a parent works toward making the family financially self-sufficient by getting a job or getting a better job.

I am also pleased that Senator Rockefeller said that we found a way to give -- to incentivize Medicare providers.

I do have some remaining concerns, however, that this mark does not adequately address the needs of everyday Ohioans and Americans who are in economic straits and depend on Medicare and Medicaid for their

health and wellbeing and that of their families.

I believe many of the amendments we will raise today would do a lot to continue helping these Americans.

One of my amendments would give a 1-year extension of the health care tax credit. I know Senator Portman is working on something similar for workers and retirees who lose their jobs and benefits due to no fault of their own.

Extending HCTC for just 1 year would help preserve a program that people in Ohio know and understand and do it in a fiscally responsible way.

My improving access to Medicare coverage amendment would correct a Medicare billing discrepancy that occurs when a hospital stay is coded under observation status. Under this confusion policy, two people can be hospitalized for the same problem, but how their hospital stay is coded affects what Medicare will pay.

The amendment would help ensure that seniors receive the care they need without incurring unexpected and unfair costs.

My third amendment would extend the existing 2-year parity in payment between Medicare and Medicaid providers for an additional year. It is wrong that Medicaid providers are paid less than Medicare providers, despite the fact that Medicaid providers tend to work with more

complex patients and more complex situations.

I will not be seeking votes on these amendments, but I hope that the Chair and the Ranking Member can work to support these comments and initiatives in the coming year, and I thank you both.

The Chairman. Thank you, Senator.

Senator Portman?

OPENING STATEMENT OF HON. ROB PORTMAN, A U.S. SENATOR FROM OHIO

Senator Portman. Mr. Chairman, thank you. And as you can tell from the pent-up demand here in this room, it is great that we are having a hearing on health care, because there is a lot of interest and, obviously, a lot of important things to be done today.

I do hope that we can continue this progress, because we are not hitting the big issues, which includes Obamacare and its effect on our constituents, and, of course, what Senator Crapo said with regard to the unsustainability of Medicare.

We have got to deal with these issues in order to ensure that those programs are there for our constituents.

So I hold a tele-town hall, as many of the members of this Committee do frequently, and over the last couple of years, the top issue has always been jobs and the economy.

It is no longer jobs and economy. The last two tele-town halls, it was health care. And, obviously, what is happening with Obamacare is part of it, but it is a broader issue now with so many families being concerned about whether they are going to be able to pay for their

health care needs and what kind of choices they are going to have.

So, again, I hope we will take these issues up not just today, but continue this progress.

I do commend you for your effort and the efforts of the Ranking Member to fix the broken sustainable growth rate formula. This does create a more certain and, I think, sustainable way to reimburse.

Obviously, I join my colleagues in saying that we are not going to be able to support this at the end of the day unless it has a pay-for.

So my commitment to my constituents is a commitment that Senator Hatch and you have made, which is that we are going to find a pay-for for this on the floor. But it is important that we address this issue and I thank you for it.

I was able to work with several of my colleagues on both sides of the aisle today on a crucial change that ensures seniors can continue to have access to quality durable medical equipment. This proposal contains language that will require companies to prove that they have appropriate state licensure before they are able to bid to become durable medical equipment suppliers in that State.

This is a critical protection that was lacking in

the current bidding system. And I appreciate your work, Mr. Chairman, and the Ranking Member on this; also, Senator Roberts, Senators Cardin, Grassley, Stabenow, Thune and Casey for their work on this.

I am also pleased to have an opportunity to take up several child welfare bills today, including key provisions of the Child Sex Trafficking Data and Response Act. Senator Wyden and I introduced this bill in June and there is strong bipartisan backing, of course, from members of this Committee on this issue, but specifically on this legislation.

I think it is really important we consider these measures today, because we know there are many instances when State child welfare systems fail to properly identify and assist trafficked and exploited children.

So this is an issue where we are able to streamline data collection, reporting on sex trafficking, and ensure that exploited children qualify for and receive services through the child welfare system.

It also enhances data collection on children who have been identified as victims on sex trafficking.

Senator Brown mentioned the health care tax credit issue and I look forward to working with him and others with an amendment that I will be offering to have a 2-year extension to that program. I think that is

critically important given, again, the uncertainty we have and specifically some uncertainty that is related, frankly, to Obamacare and how it has been implemented for many people who are affected by it.

So, Mr. Chairman, I look forward to working with you on this and other amendments over the next couple of hours and, again, commend you for holding this hearing.

The Chairman. Thank you, Senator.

Does anyone else wish to speak?

Senator Bennet?

OPENING STATEMENT OF HON. MICHAEL F. BENNET, A U.S. SENATOR FROM COLORADO

Senator Bennet. Thank you, Mr. Chairman. I want to thank you and the Ranking Member for having this markup today and for setting such a worthy example of bipartisanship in this Congress. I hope it is something that other committees will follow.

I deeply appreciate it. And I am going to be brief, because I know Senator Casey probably wants to speak before we have to vote.

We have all voted on temporary fixes to the SGR countless time, and our Nation's providers and seniors should be pleased that finally we are moving forward to try to get this done permanently.

And I thank you, Mr. Chairman, for getting us to this place, because what my Colorado providers have told me is that they are ready to move forward with innovative payment systems, but need some stability and a pathway to get there.

This bill, I think, is a huge step forward in this direction and we look forward to working with both of you to help this process ultimately pass into law.

So I thank you, again, and I thank my colleagues on both sides of the aisle for their work on some very

important amendments to bring transparency to our Medicare system.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Senator Casey?

OPENING STATEMENT OF HON. ROBERT P. CASEY, JR., A U.S. SENATOR FROM PENNSYLVANIA

Senator Casey. Mr. Chairman, thank you very much, and the Ranking Member. We are grateful for the work.

I will talk about my amendments a little bit later and what is behind them, the reason for them, but make two or three points.

Number one is it is rare when we can make progress on legislation that helps our seniors, our kids, and, in this case, physicians. So we are grateful to be able to do that.

Secondly, a lot of what animates the discussion and the work here is the focus on quality of care versus quantity. That is one of the reasons why the effort made to focus, for example, on imaging, the criteria for imaging, so that we are not having an overutilization of services like that.

Then, finally, the work that is going to happen as part of this effort on supporting at-risk children. Not many people, I guess, when they think of the Finance Committee, think in terms of helping at-risk children. So we are grateful to be part of that and we will be talking about the amendments as we go forward.

Thank you very much.

The Chairman. Thank you, Senator.

A couple of observations here. Number one, two votes. Since we are near the end of the first vote, we can back here within 15 minutes and start the second vote.

Second, I encourage staffs to work together during this 15-minute period to try to work out any differences that may still prevent some resolution here.

So let us be efficient, make the best use of our time.

The Committee stands in recess until the call of the Chair.

[Whereupon, at 11:07 a.m., the Committee was recessed and resumed back on the record at 11:42 a.m.]

AFTER RECESS

[11:42 a.m.]

The Chairman. The Committee will come to order. While we were voting, the Ways and Means Committee voted out its SGR bill just a few moments ago by a committee vote of 39-0. It was unanimous. And their SGR bill is not identical, but it is very, very similar to what we are working on today.

I want to thank Mr. Elmendorf for being here, as well as Mr. Bradley with CBO. And I would like now to bring the Committee bill before us.

We have before us the Chairman's mark on the bill to repeal the sustainable growth rate system and consider health care extenders and any modification to the mark.

The modification is deemed incorporated in the Chairman's mark.

Senators have had the Chairman's mark since Tuesday and a walkthrough of the mark for staffs conducted that same day.

Now, I ask Karen Fisher to very briefly explain the modification to the Chairman's mark. When she is finished, I will also ask Dan Todd -- Mr. Todd if he has any additions that he would like to make.

At that point, then the mark will be open for amendments.

Ms. Fisher?

Ms. Fisher. Thank you, Mr. Chairman. Mr. Todd and I are going to walk through the modifications, and I will go through the first half and he will go through the second half.

You should all have these modifications at your chair.

On page 7 of the mark, we are going to strike the number 1 after Section 1861(r). This will allow more additional physicians to participate in the VBP, including oral surgeons, podiatrists, optometrists, and chiropractors.

On page 17 of the mark, we are going to strike "is paid based on quality measures compared to the VBP quality performance category, bears financial risk for monetary losses that are in excess of a nominal amount, and for whom the Secretary determines and uses certified EHR technology" and insert that with a similar, but slightly different language to say "uses certified EHR technology, is paid based on quality measures comparable to the VBP quality performance category, and bears more than nominal risk, as defined by if aggregate expenditures exceed expected aggregate expenditures.

On page 18 of the mark, this will be a similar change for the years 2020 and 2021. So I will not read

it.

On page 8 of the mark, in terms of examples of clinical practice activities that would be included in the legislation, it would be to add patients and other providers after the timely exchange of clinical information.

On page 9 of the bullet, there is a clarification to define small practices to be those that consist of 10 or fewer professionals.

The correct a drafting error in Section 103, the date will be 2014 rather than 2013 for the secretarial draft for major development.

On page 25, we are going to modify the definition of a measure of overuse to say a measure of appropriate use of all services, parenthetical, "(including measures of overuse)."

In the section involving the promoting of evidence-based care on page 32, we will add the word "only" after "November 15, 2015." In the first sentence of the second paragraph, we will add "provider-led" after "other" in the first sentence of the second paragraph, and the following sentence will be added to the mark after the first sentence in the second paragraph, "The Secretary shall only choose appropriate use criteria developed or endorsed by national professional medical specialty

societies.

On page 33 of the mark, regarding expansion of the appropriate use criteria, the mark would add "only provider-developed or endorsed" after "with the use of" in the first sentence of the fourth paragraph. And in the expansion after the first sentence of the fourth paragraph, the mark adds "any additional adoption of appropriate use criteria for other par fee services would be required to replicate only the provider-developed or endorsed criteria framework of advanced imaging appropriate use criteria."

On expanded claims data availability to improve care, the mark would add "and retirees" after the section that talks about providing health insurance to its employees, so that it would also include retirees.

The mark would do that, also, again, on line 11 of the third paragraph of that same page.

The technical correction on Medicare special needs plans, on page 47 of the mark, to add after "to the extent current state law under the State's Medicaid plan permitted capitated payments for long-term care services or behavioral health services" the sentence "However, for purposes of the integration requirements beginning in 2018, the definition of an FIDE-SNP does not include the requirement that the D-SNPs enrollment have similar

average levels of frailty as the programs of all-inclusive care for the elderly, the PACE program."

Also, in the special needs plans program, on page 48 of the mark, to replace "below a minimum threshold, as determined by the Secretary" with "of not more than 2.5 stars."

In the quality measure and endorsement and selection section, on page 52 of the mark, we will say in the last paragraph, we are going to strike -- the mark will strike "used under payment systems operating on a fiscal year basis" and replace with "received from the Secretary by October 1."

On page 53 of the mark, in the fifth line of the third full paragraph, strike "with respect to measures for use under payment systems that operate on a fiscal year basis" and, also, strike "with respect to all other quality and efficiency measures."

On the seventh line of the third full paragraph, before "However, the Secretary," add "the Secretary would provide for an appropriate balance of the number of measures made available by each date."

To correct a drafting error in the heading of subtitle B, the mark would add an "and" between "Medicaid" and "other extensions".

To correct another drafting error in Section 214, on

page 58, to add "at least" before "15 million" in line four of the second paragraph.

In the Title 1 amendments, to accept Grassley-Rockefeller number 15, as modified accordingly on page 17 of the mark, in paragraph 2B2i, after "Tricare," insert "or Title 19 in the case where no medical home or alternative payment model is available under such title." And after "exceeds expected aggregate expenditures" insert "or is a Title 19 medical home meeting criteria comparable to medical homes expanded under Section 1115(a)(c).

Similar changes would be made on page 18 of the mark regarding for periods 20, 21, and beyond.

On page 19 of the mark, regarding encouraging CMMI in testing of models, we would add "to encourage development and testing of additional APMs," add "and models that focus primarily on Medicaid working in conjunction with the CMCS."

To accept Menendez No. 3, as modified, so that in the first full paragraph of page 14, "in medically underserved areas would be included in the technical assistance" after "in health professional shortage areas."

To accept the Thune-Wyden-Roberts-Rockefeller-Enzi-Stabenow No. 5 amendment, to add in between the fourth

and fifth full paragraphs the following paragraph: "This mark would ensure that professionals who move into an APM are free to use tele-health technology to enhance patient outcomes and improve quality, regardless of the statutory restrictions in Section 1834(m). This would mean that accountable care organizations, bundled payments, medical homes, or any other models developed to be in APM could use tele-health technology not paid under Section 1834(m)."

To accept Cardin-Bennet-Brown Amendment No. 2, the following paragraph would be added after the last paragraph of Title 1, Section 104: "The Secretary would conduct an education and outreach campaign to inform providers and seniors of the benefits of chronic care coordination and encourage participation by seniors with multiple chronic conditions. The Secretary would work with the HHS Office of Rural Health Policy and the CMS Office of Minority Health to encourage participation by underserved rural populations and racial and ethnic minority populations. The Secretary would report to Congress by December 31, 2017 on the representation of beneficiaries living in rural areas and of racial" --

[Laughter.]

Ms. Fisher. Keep going? Where is my phone? I cannot see it? Do you have a phone? Does someone have a

phone with a flashlight?

Hang on -- "racial and ethnic minority populations in the chronic care management program, identify any barriers to participation, and make recommendations for increasing participation."

To accept Bennet-Thune No. 5, as modified, to add to Section 108 "to allow a qualified entity to provide, via an alternative method, the same data that would be made available via in an enclave. To do so, the Secretary must certify that the method would be as secure as the data enclave. If another secure method is used, the Secretary should enforce additional protections of the data between the qualified entities and its users, such as data use agreements or monetary penalties."

Finally, my section, before turning to Mr. Todd, to accept Cornyn-Cardin Amendments 9 and 10, the following language on page 15 to say that after "concerning the GAO two studies," to include after "geographic location and patient mix" the following language: "No. 2, provide recommendations for improving the program; 3, evaluate the impact of technical assistance funding on the ability of providers (especially providers in rural areas or HPSAs and physicians treating other underserved populations) to improve within the VBP or successfully transition to APM."

The Chairman. Ms. Fisher, I wonder if you could -- we have another vote at 12:45. If you could just kind of hit the highlights.

Ms. Fisher. You did not think those were all highlights?

The Chairman. Those are very high.

[Laughter.]

The Chairman. Hit the higher highlights.

[Laughter.]

Ms. Fisher: We can do that. We can do that, Mr. Chairman.

No. 5, we are adding additional information under Cornyn-Cardin.

No. 6, Dan, you have been following that. Do you want to do the highlights for those?

Mr. Todd. Thank you, Karen.

Mr. Chairman, now we have the Title 2 amendments.

To accept Wyden No. 5, which adds to Title 2, Section 206, a requirement that the Secretary of HHS consider applying unified Medicare and Medicare appeals procedures to other types of special needs plans, including duly eligible special needs plans.

To accept Wyden-Grassley Amendment No. 6, with modifications. It adds a new Section 233 to improve and modernize the Medicaid data systems and reporting. The

mark requires CMS to implement a strategic plan to address redundancies and gaps in Medicaid data systems.

To accept Nelson-Grassley-Rockefeller-Enzi No. 4, it adds a new Section 234, a special needs trust fairness. The mark amends the Social Security Act by inserting "the individual" after "for the benefit of such individual in that section."

To accept Nelson-Rockefeller-Casey No. 5, it adds a new Section 235, an annual Medicaid disproportionate share report. The mark requires the Secretary of HHS to report to Congress on an annual basis, beginning on January 1, 2015, an annual DSH report which would contain changes in the numbers of uninsured individuals, hospitals that continue to incur uncompensated costs, hospitals that continue to provide charity care, a methodology for estimating the amount of unpaid co-pays and deductibles, and a study on administrative burden; and, for each State, the difference between the aggregate amount of hospital uncompensated care costs and the States DSH allotment.

Moving down to subsection D, Mr. Chairman, to accept Nelson-Grassley No. 2. It adds to Title 2, subtitle D, an expansion of the scope of Medicaid fraud control units and activities that are for a full Federal financial partnership to include the cost of investigating and

prosecuting allegations of abuse.

To accept, with modifications, Menendez-Brown No. 1 and to add to Title 2, subtitle D, Section 232, a requirement that CMS seek advice and consultation from hospitals, physicians, and other expert stakeholders to determine appropriate criteria to account for medically necessary inpatient admissions that last less than two midnights.

To accept, with modification, Carper-Bennet-Enzi-Isakson-Thune-Nelson No. 1, amend Title 2, subsection D, to add a section on preventing and reducing Medicare and Medicaid expenditures to help maintain the solvency of the Medicare Trust Fund, and help to moderate the growth in Medicaid expenditures, including the following provisions: requiring a valid prescriber national provider identifier on pharmacy claims; reforming how CMS tracks and corrects the vulnerabilities identified by recovery audit contractors; strengthening Medicaid program integrity through flexibility; access to national directory of new hires; and, improving the sharing of data between the Federal Government and State Medicaid programs.

To accept Carper-Toomey-Bennet No. 2, add to Title 2, subtitle D, Section 233 "The ability for CMS or the Centers for Medicare and Medicaid Innovation to allow the

programs of all-inclusive care for the elderly, the PACE program, to participate in demonstration programs under Section 1115, research and development projects at CMS."

To accept, with modification, Cardin-Grassley No. 5, add to Title 2, subtitle D, Section 234 "a community-based institutional special needs plan demonstration program conducted outside of the Centers for Medicare and Medicaid Innovation, consisting of not more than five plans, and to preventing or delaying institutionalization and spend-down among the at-risk Medicare population.

To accept Grassley No. 16, add to Title 2, subtitle D of Section 236, to allow the Inspector General of the Department of Health and Human Services to receive and retain 3 percent of all collection, pursuant to civil debt collection actions related to false claims or fraud involving the Medicare program. These funds would then be available for oversight and enforcement activities of the IG in order to provide the resources to pursue its mission in fighting fraud, waste and abuse.

The Chairman. Mr. Todd, we have this document before us. You need not read descriptions of each amendment.

Why do you not just list the amendments without reading the description.

Mr. Todd: Yes, Mr. Chairman.

The Chairman. And if Senators have questions, they can ask.

Mr. Todd. We also accept Toomey-Carper No. 2, as modified.

We accept Portman-Cardin-Stabenow-Casey Amendment No. 2.

Wyden-Crapo Amendment No. 7.

The Chairman. You could mention the titles.

[Laughter.]

The Chairman. Like repeal SGR, repeal where Medicare Beneficiary Act says Improvement Act.

Mr. Todd. Yes, Mr. Chairman.

To accept Roberts No. 4, and, unfortunately, on our list, we do not have the title on this one.

[Laughter.]

The Chairman. Do not worry.

Mr. Todd. To accept Enzi-Carper No. 1. To accept Carper-Isakson-Rockefeller-Wyden-Cardin No. 3, as modified.

To accept Thune-Bennet-Enzi-Roberts No. 1, as modified. To accept Cantwell No. 2, as modified. And to accept Cantwell No. 4, with modification.

The Chairman. Thank you very much.

Do any Senators have questions of the mark?

Senator Isakson?

Senator Isakson. Thank you, Mr. Chairman.

I would like to ask Dan and Karen a question, if I can.

I have heard from a lot of pathologists and physicians in the State of Georgia and the southeast. They have expressed concern about CMS requirements for quality reporting and meaningful use are unworkable for them because they do not have face-to-face interaction with their client. In particular, an example would be a pathologist.

What does the Chairman's mark do to ensure that there is flexibility in the value-based performance standards so that physicians are not unduly disadvantaged?

Mr. Todd. Senator Isakson, we have worked pretty extensively with the specialty community, including the pathologists. One area for those physicians that do not have face-to-face is we have provided an ability for them to use or adopt hospital-based measures.

Sixty percent of pathologists are employed by the hospital, and so they could adopt those within the PQRS system.

In the modification of the Ways and Means mark that just got voted through, they have made additional measures and we have committed to your staff that we are

going to work with them following.

Ms. Fisher. I would add, Senator, too, that in the clinical practice improvement activities, the Chairman's mark has specific language that says talk to the various physician groups, specialty societies, find out what activities are appropriate for each category.

For those physicians that are not eligible for certain programs, for example, meaningful use, they would not be penalized because they are not in that program. Their score would be based on the other activities.

Senator Isakson. Mr. Chairman, I understand that the Ways and Means mark, which passed unanimously 39-0, does incorporate a provision that directs CMS to make this consideration. Is that correct?

Ms. Fisher. We have not seen the exact language, but it is something comparable to that, I think.

Senator Isakson. It is my understanding that is the case.

I would just like to ask the Chair if the staff and the Chair will work with me as we go through this process to try and incorporate those provisions in the Chairman's mark, as well.

The Chairman. We will, Senator. Appreciate you raising that.

Other questions of the staff about the mark?

[No Response.]

The Chairman. Seeing none, the -- Senator Cantwell?

Senator Cantwell. Is that for anybody at the table or just for the --

The Chairman. I have a question for Mr. Elmendorf about the language that basically says that this value-based modifier program is budget neutral. And so why is that?

Mr. Elmendorf. Senator, I will say, to start, that I am joined today by a number of colleagues with expertise in the particular policies that you all are discussing today.

At the table with me right now is Tom Bradley, who leads our analysis of changes to the Medicare program. I think it would be more efficient for me to let Tom answer that question for you.

Mr. Bradley. The fundamental element that makes that budget neutral is that there is a reduction in payment rate of a specified percentage, where that percentage varies by year.

There is a mechanism by which providers are distributed in terms of their eligibility for a payment adjustment and the payment adjustment for each category of providers the Secretary determines gets either no

change or an increase in their payments, such that that change is calculated to be budget neutral.

Because of the mechanism of figuring out how to distribute providers as to what the criteria are to determine whether a provider gets a larger or smaller increase off that base is a process that can actually be done in the rate-setting process and will be effectively budget neutral.

Senator Cantwell. So you are talking about a CBO analysis of the provision or you are saying that was in the original value-based index and just carried over and you are just saying how it will work?

Mr. Bradley. The design of the mechanism for figuring out how to distribute the pool that is basically created by the reduction that applied is a mechanism that works in terms of ensuring budget neutrality.

Mr. Elmendorf. So it is not just neutral by our estimate, Senator. It is constructed in a way that we think -- it was intended to be budget neutral and we think will, in fact, be budget neutral, but it is the construction of the payments, not just an estimate by us, that makes it budget neutral.

Senator Cantwell. Well, Mr. Chairman, the reason I am bringing up this point is I think this is a key area for this Committee to continue to work on.

The fact that we focus on an outcome-based health care delivery system, as I mentioned in my opening statement, in the Everett Clinic case, ended up saving 20 percent on the health care costs. Obviously, if we are going to look at sustainability of Medicare in the long run, focusing on getting off of fee for service and getting an outcome-based delivery system will save us money.

And the sooner we get around scoring that, I think the better we are going to do in having our discussions about how we reform Medicare.

The Chairman. Senator Thune?

Senator Thune. Mr. Chairman, I would like to ask Ms. Fisher and Mr. Todd if they have any data or analysis that would give us any indication of how a value-based model might affect rural providers. That is something that is of grave concern to us, if there is any distributional impact analysis, because, obviously, this is something that those of us who represent a lot of the rural hospitals and rural providers are very concerned about as we move forward.

Mr. Todd. Senator Thune, thank you for the question. In terms of explicit distributional analysis, we do not.

What we could say is that a rural physician, really,

any physician, but a rural physician would be better in the VBP program than where they are in current law today, and I do not just mean in a repeal of the SGR, though certainly getting rid of that uncertainty is helpful.

Under current law, you have penalties for the value-based modifier, the electronic health record, and the physician quality reporting program that total, in current law, minus 7 percent.

The challenge is they are in different parts of the statute and physicians are not aware of them. But what we have done is collapsed these programs into one program, that is an overall quality program, that, one, will be easier for them to understand, will reduce administrative -- some of the administrative burdens on them, but, also, in the beginning part, the payment implication is capped at 4 percent, whereas in current law it is 7 percent.

So we actually think it is pretty good for all physicians, but that is also good for rural docs.

Senator Thune. Go ahead.

Ms. Fisher. I would just say, I might add, in consideration of that, it is part of the reason in the clinical improvement activities that the mark says let us look and talk to physicians and see where they are and see what they are capable of doing and pushing and

challenging them forward to do.

I should also point out that in the Chairman's mark, there is an inclusion of the ability of physicians in small practices to group together to become a virtual group so that their data are looked at together.

We heard a lot about that from rural physicians in Maryland under CareFirst, who, by themselves, their numbers, because they may have a patient who is an outlier, the quality scores, the resource use scores may not be really reflective of their practices.

This allows them to come together and perform better under the system.

The Chairman's mark also includes additional funds for technical assistance to help physicians in rural areas and small practices.

But I would also say, Senator, that I think Dan has taken meetings and I certainly have taken meetings from a number of practices in rural areas in Montana and talked to physicians who are providing very high quality constrained resource care coordination for their patients, who believe and that we believe will do very well in this program.

Senator Thune. One of the components, significant component, I think it is 25 percent of the value-based payment, however, is EHR meaningful use, and that is

something that, in rural areas, we are probably not going to get there as quickly, obviously, as you might in other areas.

So any thoughts about how you address that?

Mr. Todd. Senator, one of the things about the mark's concept here and the value-based program is that it is budget neutral. And so the weights and the construct of what that funding is, to the extent that it does not work -- and we believe it will and we are hopeful it will -- but if it does not, it is very easy for Congress to go back, because it is not going to cost anything to redirect.

Senator Thune. Thanks. Thanks, Mr. Chairman.

The Chairman. Other questions?

Senator Cantwell. Mr. Chairman, I would just point out that the original value-based modifier had language saying that the Secretary shall give consideration to small practices in rural areas and hard-to-serve areas so that they would be specially considered and evaluated to help them meet these requirements.

That language is preserved in this Act, as well. So I think it is a good protection. We do not know the final outcome, but it is a good indication that they do have to be protected.

The Chairman. Thank you. I appreciate you adding

that.

Seeing no Senators seeking recognition for more questions, the mark is now open for amendment. A quorum is present.

You may all have before you, at least I have before me, a sheet indicating the first of 17 amendments to be offered. They are listed. The first would be Wyden 1. No. 17 is Casey 1.

Unless Senators have objections, I am going to proceed according to the basis of amendments listed on this sheet of paper.

So Senator Wyden is now recognized.

Senator Wyden. Thank you very much, Mr. Chairman.

I touched on it earlier, colleagues. Medicare, in the future, is basically about chronic disease. That is the ballgame. Eight percent-plus of the money is going to focus on cancer and strokes and diabetes and heart problems.

We have a bipartisan effort here in this Committee. Senator Isakson, I am going to yield to him very briefly, and I also want to commend Senator Bennet and Senator Toomey. They have been very interested. So the four of us are going to partner on it.

We have the good fortunate of having a bipartisan coalition in the House of Representatives with

Congressman Peter Welch and, also, Erik Paulsen.

So, colleagues, understand where we are. Chairman Baucus and Senator Hatch have agreed to put in place the first real steps to an improved approach for handling those with chronic disease, and it involves what is called C-SNP, the chronic special needs plan.

And the reality today is it does not much work for anybody and it is little used. It does not work for the seniors, it does not work for the providers, it does not work for the plans.

So what Chairman Baucus and Senator Hatch have been willing to do, and I am very appreciative, is they have put in place a number of reforms that I think are going to make this much more attractive to seniors and to high performing plans.

That is the heart of what is in the bill now. For example, Chairman Baucus and Senator Hatch have added, for example, a measure to ensure that those seniors, those very vulnerable people are able to get individual care plans.

So I am very appreciative of that, Senator Baucus and Senator Hatch. That is in the bill, colleagues.

What this amendment that I offer with my colleague and friend from Georgia, Senator Isakson, would do would be to ensure that we go beyond what is in the bill. We

keep the senior protections, but we make it more attractive to providers to get into this effort to put a new focus on chronic disease.

The reality is we need a team approach, an integrated, coordinated team, not something that just is sort of layered on top of a convoluted, volume-driven fee-for-service model.

That is what this legislation -- this particular amendment does. This program would not, for example, have what is known as the attribution rule that keeps, for example, organizations from being able to specialize, to only enroll patients with multiple chronic conditions.

The reason this is so important -- and Senator Isakson deserves the credit for framing it this way -- this would give us a chance in the area that is going to drive Medicare for decades to come to give seniors the opportunity to get better care at a lower cost.

So I think with that, if Senator Isakson or Senator Bennet or Senator Toomey want to chime in, I am happy to stop the speechifying.

But I want to thank all of them. This, in my view, not only is it bipartisan -- I heard Senator Crapo talk about the future of the Medicare program and Chairman Baucus has been very interested in this, as well.

This is the future of the Medicare program,

colleagues. Chronic disease is what it is going to be all about.

I would be happy to yield to any of my colleagues, starting with Senator Isakson, for any comments they may have. Senator Isakson, Senator Bennet, and Senator Toomey.

The Chairman. Senator Isakson?

Senator Isakson. I will be very brief. I want to thank Senator Wyden for the recognition, but point out his last statement.

All of us want to improve quality and reduce costs. I mean, that is the magic bullet. Two or more chronic diseases are the rule, not the exception, in terms of our seniors, and, more often than not, individual treatment of each chronic care without coordination causes cost to go up and, actually, quality to go down.

So if you have an incentive that coordinates the care of these seniors, their quality of care will improve and the cost of Medicare on the taxpayer will go down.

So I want to commend Senator Wyden on his effort. This makes as lot of sense. I hope as we move forward in the process, we can adopt this as the way we want to move forward with the care for our seniors with multiple chronic diseases.

Senator Wyden. Mr. Chairman, if Senator Bennet and

Senator Toomey can chime in on this, we will be happy to say this is a chronic debate for now.

Senator Bennet?

The Chairman. Senator Bennet?

Senator Bennet. Thank you, Mr. Chairman. I would just like to weigh in just for a moment to support Senator Wyden and Senator Isakson on this amendment.

Senator Wyden, in particular, has been such a longtime leader of addressing high cost beneficiaries and has championed helping those with chronic conditions, beneficiaries who need specialized care the most.

I filed an amendment with Senator Toomey. I deeply appreciate his leadership in a similar vein, trying to focus on the highest cost Medicare beneficiaries.

Just knowing that 5 percent of the most complex Medicare beneficiaries consume 43 percent of our Medicare dollars tells us that we need to focus here. It makes this an issue worth exploring further.

It is not going to be an easy issue. We know that. But I appreciate the hard work that has gone in by all my colleagues and hope we can work together to get this resolved with the House.

Thank you, Mr. Chairman.

The Chairman. Senator Toomey?

Senator Toomey. Thank you, Mr. Chairman.

I will just say, very briefly, Senators Bennet, Wyden, and Isakson have put it well: The costs and the burdens of caring for chronic illnesses are plaguing our health care system.

I am looking forward to the days when we cure these diseases, which we will, but in the meantime, they are going to continue to be enormously costly.

So I thank the leadership of my colleagues for addressing this issue in a very substantive and thoughtful way.

Senator Wyden. Mr. Chairman, you have been kind to get us get the first step toward a chronic care policy with the reforms that you have added with respect to C-SNPs. It is clear we are going to work with you and Senator Hatch in terms of the next steps.

And with that, I would withdraw the amendment.

The Chairman. The amendment is withdrawn.

I might say I think the amendment is a major step forward, but we want to make sure that it does not trump other alternative payment models and the criteria to develop the bill to assure that those alternative payment models work.

So, basically, I am just saying I think it is a good idea, your amendment, but it needs a little work to make sure that it fits in with what we are trying to do as we

address the chronically ill -- providing quality care for the chronically ill.

Thank you. The amendment is withdrawn.

Next on my list is Roberts No. 1.

Senator Roberts. Yes, Mr. Chairman. If, in fact, Senator Wyden and others are driving the stagecoach in behalf of chronic care policy, Senator Casey and I are riding shotgun.

Medication therapy management has been shown to be an incredibly successful program for multiple chronic conditions. You can have a chronic condition, you can have two chronic conditions, or, for goodness sakes, even more than that, but if you do not have the proper therapy, you are just really treading water. And it is proven to increase patient quality and save the system money.

I want to thank Senator Casey for his support. I know your staff was working with ours until early this morning to find a reasonable solution to this amendment.

Our amendment would expand this therapy to patients that have a single chronic condition, but to which the condition requires additional counseling to management that condition.

It is drafted to be budget neutral. Mr. President (sic), I think this would receive a strong bipartisan

vote, but I know our staff worked closely to try to perfect the policy until late last night. They apparently were not able to come to agreement, but I would hope that I could get a commitment from you, Mr. Chairman, to continue to work to get the policy addressed as we move to the floor.

If I have that commitment, I certainly will withdraw the amendment, with your promise.

The Chairman. You have my commitment.

Senator Roberts. Thank you, sir. I withdraw the amendment.

Senator Casey. Excuse me. Mr. Chairman?

The Chairman. Senator Casey?

Senator Casey. I just want to offer a couple of comments. I want to thank my colleague, Senator Roberts, for his work on this and the work of others. Our staffs were meeting, as many staffs were, until late in the evening last night.

One of the concerns that we all have about not just fixing a number of these problems that have arisen, but in a particular way, to focus on better ways to treat people that have sometimes complex and multiple chronic conditions, but even someone with one chronic condition, obviously, has a heavy burden to bear.

So we are trying to, with this amendment, making a

change that involves medication therapy management, to speak to that concern that one individual with one chronic condition and the difficulties they have.

So I want to thank Senator Roberts for his work and thank the Chair for his working with us on this.

The Chairman. Thank you, Senator.

I might say to Senator Roberts, too, I am a little concerned about the provision in the amendment which its effectiveness depends upon the actuary estimates. I am always a little nervous about those kinds of triggers.

I certainly want to work with the Senator to get a good CBO score on this, but the triggers are a little bit difficult. So we have to work out some other alternative.

Senator Roberts. I understand that, Mr. Chairman. I share your concern. But if you do not have therapy with regard to chronic conditions, you are just going -- as I say, that patient will be in purgatory until you get the proper therapy to get them to a point where we are saving money and we are improving the quality of life.

I am confident we can work this out.

The Chairman. I am, too. Thank you very much.

Next, I have Nelson 1. I do not see Senator Nelson here.

We will go down next to Thune No. 3. No. 4 on my

list is Senator Thune No. 3.

Senator Thune. I think CMS has spent somewhere on the order of $17 billion of the $30 billion that has been appropriated to the meaningful use program on incentive payments to eligible providers as of October of 2014.

I think it is imperative to send the message that this program cannot spend every cent appropriated to it without achieving the goals that were set out for it.

HHS ought to adopt standards by 2017 that ensure that electronic health record systems are interoperable across vendor platforms. Placing this clear standard on the Administration is what needs to be done to ensure the meaningful use program is successful.

Technology to share data across vendor platforms exists. I believe it is necessary to put pressure in the meaningful use program to continue to address barriers to interoperability.

Ensuring ease of data flow across platforms is necessary for the success of the value-based performance model and the alternative payment model in the underlying bill.

2017 is the best year to require interoperability, because it lines up with the recently announced modifications in the timing of stage three of the meaningful use program. Stage three now begins in 2017

and stage three, which is the last scheduled stage, should require interoperability.

I believe a significant barrier to ultimate interoperability are the EHR systems that block the sharing of data across vendor platforms, and I do not believe that is what Congress intended when it created this program.

This Committee, in conjunction with the Health Committee, should take time over the next year to ensure the meaningful use program is effective.

I had an amendment that would require that to happen by 2017. In consultation with Senator Hatch and Senator Baucus and members of their staff, I will withdraw that amendment, but hope that we can get a commitment to make that not only a goal, but something that actually is achievable by the year 2017.

So I hope we can get that done. I look forward to working with my colleagues on this Committee to see that happens.

Mr. Chairman, I would withdraw that amendment.

The Chairman. Thank you, Senator. You have raised a good point. Frankly, I am a little bit concerned that HHS is a little slow. They could be pushing more quickly for interoperability. 2017 might be a good date.

I appreciate your efforts here and I think we will

find a way to address it.

The amendment is withdrawn.

Next, Senator Menendez, No. 9.

Senator Menendez. Thank you, Mr. Chairman.

Mr. Chairman, before I speak to this amendment, since I was not here for the opening statements because of an Iran hearing in Banking, I just want to take a moment to preface my remarks.

This is the only amendment that I will offer and actually withdraw. So I will ask for the indulgence of the Chair.

I want to thank you and Senator Hatch for the hard work that has led up to the markup and for getting us out of the habit of short-term fixes, and I am glad we are living up to that goal.

And I want to thank you, Mr. Chairman, for accepting two of my amendments to the mark, one to recognize that providers in areas defined as medically underserved areas should be eligible for technical assistance funding, just like those in rural areas and health professional shortage areas. That is a critical distinction for providers in New Jersey, and I want to thank you for accepting it.

And, also, for accepting a provision of mine that calls on CMS to consult closely with hospitals,

physicians and other stakeholders when they are devising new criteria for how Medicare classifies certain 1-day inpatient treatments. And I look forward to working closely with you to continue making progress on these issues.

I want to discuss a couple of the amendments which I feel are extremely important, but considering the task before us, might be better addressed at another time.

First is an issue resulting from drafting error in the high tech health information technology law. That error resulted in hospitals in Puerto Rico being unable to participate in the health information technology meaningful use program.

I filed an amendment with Senator Nelson that would make a correction to the underlying statute to add Puerto Rico hospitals to the list of eligible providers. I understand, however, the Chairman is planning on addressing the issue of health information technology in a comprehensive way in the new year, and I look forward to working with him at that time to address this issue, which I think is generally agreed was a drafting error.

Additionally, I want to raise an issue that is fundamental to the practice of medicine, which is clinical laboratory tests. Those clinical labs are responsible for assisting physicians in 70 percent of all

clinical decisions, but represent only about 2 percent of Medicare total spending.

After we finish the underlying policy debate here today and move toward a discussion about offsets, I hope we can continue to work toward a policy that both protects and advances clinical laboratories.

Finally, I want to thank the Chairman for his cooperation and working with Senator Grassley and me on child support provisions, which have been included in the Supporting At-Risk Children Act that is being marked on later.

With reference to Amendment 9, which is the only amendment I am going to call up, Mr. Chairman, and withdraw, this amendment is very straightforward. It provides for a permanent extension of two of the most important policies in this mark for children and their families.

The Family-to-Family health information centers are organizations that are designed to help families with children with special health care needs navigate a difficult landscape of health care, education, housing, and other challenging issues.

The centers are run by a dedicated group of similarly situated parents who know firsthand the struggles associated with raising a special needs child.

And the mark provides for a 5-year extension of the Family-to-Family program, and, for that, I am very grateful, as are these families. However, as many of the extenders in the mark are made permanent, I felt that there is no reason that this cannot also be made permanent.

Some of the extensions in this mark cost in excess of billions of dollars. The Family-to-Family program is literally an asterisk on the CBO score.

Providing the funding to ensure families of children with special care needs are able to receive the support and services they need I think is not too much to ask.

Additionally, this amendment would permanently extend the maternal, infant and early childhood visitation program at its current funding levels. It is a program that has an evidence-based reality and success that pairs vulnerable and high-risk women and young children with health care and social workers to provide them with the life skills they need to thrive.

The mark does not provide for an extension of this program, meaning States, territories and tribes could face significant cuts in services. However, the program does not expire until the end of 2014. And so I will continue working with the Chair and the Committee to ensure it is extended hopefully before then.

With that Mr. Chairman, I withdraw this amendment.

The Chairman. The amendment is withdrawn.

Next, I have Isakson No. 1.

Senator Isakson. Thank you, Mr. Chairman. I want to discuss Isakson No. 1 for just a minute, and I understand there are some concerns with the amendment, but I do want to make a point that I think we should all pay close attention to.

As the Committee members know, there is a current prohibition against doctors who contract directly with Medicare beneficiaries for services have to opt out of Medicare for 2 years.

That used to not be a big problem, but in 2012, 10,000 physicians who had previously provided Medicare services dropped out of Medicare because they were privately contracting to deliver Medicare services to their patients.

This was a reduction of 10,000 physicians who would have otherwise been providing Medicare services to their beneficiaries.

This amendment would have created a demonstration project in up to 5 States to try and remove that prohibition and see if it did not increase the accessibility of physicians, qualified physicians, to Medicare beneficiaries.

I understand there are a lot of people who object to private contracting with Medicare beneficiaries by physicians, something that has become known as concierge services in many areas.

But the unintended consequence of the rule that is applied by CMS has taken 10,000 doctors who were otherwise serving Medicare beneficiaries out of the system.

Because of the objection of members of the Committee and the staff, I am going to withdraw the amendment, but I hope during the course of the next year, we can study this phenomenon and this concern and recognize that the unintended consequence of our rule is denying care to many seniors.

And I withdraw the amendment.

The Chairman. The amendment is withdrawn.

Senator Carper. Mr. Chairman?

The Chairman. Senator Carper?

Senator Carper. I have spoken with Stabenow and asked if she would mind that I just slipped ahead of her, and Rob Portman is not here yet, and just take 60 seconds to speak on the amendment. I think it is listed as No. 9. It is my Amendment No. 4.

The Chairman. Right.

Senator Carper. I want to thank you, Senator

Stabenow.

The Chairman. Thank you, Senator Stabenow.

Senator Carper. Thank you very much.

I have joined Senator Toomey and Senator Brown on an amendment that requires CMS to establish some important preventive steps to curb the fraudulent diversion of prescription drugs, something we have held extensive hearings on in Homeland Security and Government Affairs Committee.

Our amendment requires better sharing of anti-waste and fraud data between CMS and the prescription drug plans. It also would take a key action to curb fraudulent activity when that activity is identified.

And we do not plan on calling for a vote on our amendment. However, it is our hope that Senator Toomey, Senator Brown and myself, along with our staffs, can work, again, with your staff, Mr. Chairman, and that of Senator Hatch on these issues. They are important issues.

I think we can find some common ground. I think we are pretty close on what steps ought to be taken. It includes the modified version of this amendment as the bill proceeds to the Senate floor.

And the only other thing I would say, there is going to be a voice vote on the Stabenow amendment and while I

will not be here to say "aye," I would say "aye" right now.

Thank you very much for yielding to me.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

Senator Toomey. Mr. Chairman?

The Chairman. Senator Toomey?

Senator Toomey. Thank you, Mr. Chairman. I would also like to thank Senator Stabenow for yielding to Senator Carper, and Senators Carper and Coburn for their terrific work on this subject.

I would just say briefly that rarely a day goes by in Pennsylvania without a story about the bust of a prescription drug ring or a fatal overdose of a person who is much too young. Many of these individuals get addicted to prescription drugs first, and then slide down the path to less expensive alternatives such as heroin, all too often ending in their death by overdose.

It is an absolutely horrendous tragedy of a scale that is shocking. This legislation, or some similar variation thereon, will help curb the abuse of prescription drugs.

Therefore, I am very grateful for everybody who is helping. I certainly hope we will have broad support within the Committee and be able to find a solution on

the Senate floor, as this is a really important problem in Pennsylvania and across the country.

But this is a really important problem in Pennsylvania and across the country.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator. The amendment is withdrawn.

Senator Stabenow?

Senator Stabenow. Thank you very much, Mr. Chairman. I want to thank you, your staff, and Senator Hatch's staff for working with us on this amendment.

First, I would ask unanimous consent that Senator Grassley be added as a cosponsor of the amendment.

The Chairman. Without objection.

Senator Stabenow. Thank you very much.

Also, I would like to submit a list. We have over 50 organizations supporting demonstration projects based on the Excellence in Mental Health Act, which Senator Blunt and I have introduced, and we appreciate very much the support we have received for the demonstration projects.

We have a list of organizations. I will not read all of them, of course, but the National Sheriffs Association, National Association of Police Officers, Police Organizations, Iraq-Afghanistan Veterans of

America, American Medical Association, a whole range of organizations that are supportive, and I would appreciate putting it in the record.

The Chairman. Without objection.

[The list referred to appears at the end of the transcript.]

Senator Stabenow. And if I might just explain, just for a brief moment, what we are doing. We have a wonderful model for community care called Federally-qualified health centers.

What we are doing is creating a model for Federally-qualified behavioral health clinics, where we are giving the voluntary opportunity for folks in the community to create higher standards, including 24-hour emergency psychiatric help, where our police officers, instead of housing people in jails, will be able to get them to the treatment that they need in emergency psychiatric care rather than going to the emergency room or going to the jail.

We are basically saying if you meet high standards, you will be able to qualify for reimbursement, such as we do for health centers.

I, finally, will say that we all know the cost of inaction. The majority of people that have a mental illness, if they receive the treatment and support they

need, will be able to live long, successful lives.

We do know, though, that about over half of those with serious mental illnesses get no treatment at all during a year and even though most of those individuals will be more likely to be a victim of crime than a perpetrator, we also know what has happened at Newtown, the tragedy, or the Navy Yard or the woman very close to this building and the tragedy of what happened to her with her child in the back of the car.

We can do better than that. Our Iraq and Afghanistan Veterans are deeply concerned. We have 22 Veterans committing suicide every day in this country.

These demonstration projects will partner with outpatient clinics for the VA, will create opportunities for people to get the support they need. So that we are really saying we are going to treat illnesses above the neck equal to those below the neck and provide people hope and opportunity to live successful lives.

So I would urge support and thank all the colleagues that have been involved with this.

Senator Wyden. Would the gentlelady yield just briefly?

Senator Stabenow. I will.

Senator Wyden. And I will be very short. I think this is an exceptionally important amendment, because it

affects so many Americans. We are talking about the families, we are talking about the Veterans, we are talking about the employer-employee relationship.

We understand that this is a key part of an effective strategy against gun violence.

So I strongly support the Stabenow amendment, like the fact that it is bipartisan, note that Senator Grassley is involved, and really encourage colleagues to support it.

Senator Hatch. Mr. Chairman?

The Chairman. Senator Hatch?

Senator Hatch. Mr. Chairman, I just want to tell Senator Stabenow I appreciate her efforts in this area and it is an important policy that she is concerned about. I commend your hard work on this and I appreciate your willingness to take a voice vote on it.

But it is your hard work and I think it absolutely needs to be addressed. I look forward to working with you to support this policy. So I think we can bring this to an effective conclusion in the end.

Senator Nelson. And I support it, too, Mr. Chairman.

Senator Grassley. Mr. Chairman?

The Chairman. Thank you.

Senator Grassley?

Senator Grassley. Obviously, we know how relentless Senator Stabenow has been on this subject, as well as a lot of others. The provision of mental health services is a critical issue for this Committee and we have primary jurisdiction over two very significant payers for mental health services.

We should use our authority and our jurisdiction to improve access and quality in the provision of mental health services. So I am very supportive of it. And I also would like to say that on the Republican side, Senator Blunt has been very active in helping Senator Stabenow, as well.

Senator Burr. Mr. Chairman?

The Chairman. Senator Burr?

Senator Burr. Mr. Chairman, I applaud the efforts of my colleague from Michigan. I think every American knows that we need comprehensive review of mental health services in this country.

The unfortunate thing is this is not comprehensive. This is a pilot program. And I do not think that any of us have stopped, except for possibly the author of the bill, and asked ourselves does this present challenges for State Medicaid programs, does this present challenges for the VA.

Now, as the Ranking Member of the Veterans' Affairs

Committee, I can assure you that we are -- we own 55 percent of the available clinical staff for mental health in America. They are on contract or employees of the VA.

We are beginning to make progress at the services we provide our Veterans on mental health. You notice I came up short of saying we are solving the mental health challenge. I am not sure any of us know how to solve it.

And I would probably support this piece of legislation, but I am going to vote against it, because it is $1.6 billion. It is important, but it is not funded. Correct me if I am wrong, there is not an offset for it.

Senator Stabenow. There is not an offset for anything we are doing today, Senator, and there will be when we complete the process.

Senator Burr. Well, I appreciate -- I am not one that goes on faith alone, but I have been told that by the Chairman and the Ranking Member, and I have never marked a bill up in concept or amendments up in concept. So this is a new thing for me. So consider my skepticism to be in concept.

I think it is important when legislation, especially health care legislation, is marked up, that you get to read the language. I am not sure how to interpret that we leave it up to the Secretary to make determinations as

to how they structure in consultation with SAMSHA the issues of regulation and certifying community behavioral health clinics.

I see the criteria that you have set. But without understanding with great texture, it is impossible for me to then understand how that might be integrated into a Medicaid system versus layered on top.

I guess what I am saying is I do not think the answer to our problem is to layer more services on top. It is to figure out what is broken and fix it.

So I applaud you for your willingness and your determination to fix it. I am not sure this accomplishes that. Therefore, I will oppose the amendment, but I look forward to working with the sponsor to see if, in fact, it becomes a little more appetizing to me.

Senator Stabenow. Mr. Chairman, if I might just respond. I appreciate and look forward to working with my colleague as we go through this. We have been extensively working on this. This is an area for me of extensive work for 30 years and very, very aware of what is happening and not happening as it relates to the community.

We have purposely pulled back from the total bill, the Excellence in Mental Health Act, which would require every State to be involved to make this a voluntary

demonstration project. Up to 10 States could voluntarily decide they wanted to create this new model with higher standards.

We have the model now. It is called Federally-qualified health centers. They do an excellent job. It is interesting. They can be reimbursed for physical health services, but not mental health services at the same level.

And we today know that about a third of those that have mood disorders, which is imminently treatable with medication and treatment, just as someone has insulin if they have diabetes and they have it monitored and they are able to take medicine and live a long, productive life, we know the same thing is true for someone that is bipolar or has depression if they get the treatment they need. They are just not getting it.

We also know, for those who have even more serious mental illnesses, that over half of them get no treatment in a year. And we have literally seen what happens in the rare case when one of those individuals is committing violent acts and we have had loss of life.

I would urge that we work together to do something that, in the context of this bill, is an extremely modest investment in saving lives and creating hope and opportunity for people and eliminating what is an

artificial stigma between diseases in the brain and diseases in every other part of our body.

This is a real opportunity to come together and do something extremely positive. And I will finally say that in talking -- we are working closely with our Veterans' organizations, the outpatient clinics. There are places in rural America and certainly in Michigan where they do not have ready access to the kinds of services they need every day.

Well, we can partner to make that happen, as you know, and I appreciate your leadership on this.

So I look forward to working with you. But I would argue we absolutely know what to do. We just need to make sure that the quality standards and resources are there to do it.

Senator Cantwell. Mr. Chairman?

The Chairman. Senator Cantwell?

Senator Cantwell. If I could just add, quickly. We are talking about how we are going to change our delivery system to make it more efficient and focus on outcomes, and, obviously, delivering continuity of care. And the larger issue that Senator Stabenow is trying to address is as we have deinstitutionalized mental health, we have left a system where oftentimes patients cannot get care or the reason why the Sheriffs Association

nationally is supporting this legislation is our jails have become our mental health clinics.

And, unfortunately, that cost our local government, not only in the cost of housing and servicing these individuals, but actually in the cost of their medication, as well. So this is a huge expenditure.

In fact, my county of the Seattle area has said that this costs the United States something like $8 billion a year in uncovered costs for crime and mental health issues.

So we are spending billions of dollars a year on these issues because we are not properly medicating and giving the continuity of care.

So having a small pilot to demonstrate that we have a hole in our system and being able to get people off of the street and not make our jails pay for this, to me, is very in line with the efficiency that we are trying to drive through the entire Medicare system.

So I hope my colleagues will support this.

The Chairman. Thank you, Senators.

I join in all the strong words praising Senator Stabenow. You have worked very hard at this, Senator, and I deeply appreciate your work as the right thing to do. It is a huge challenge and I think demonstration projects are a good start. We have to work a lot more,

too, but thank you very much for your work on the amendment.

Senator Stabenow, it is going to be voiced, right?

Senator Stabenow. I am happy to take a voice vote.

The Chairman. All those in favor of the Stabenow amendment, say aye.

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[A Chorus of Nays.]

The Chairman. The ayes have it. The amendment is agreed to.

Next is Senator Nelson.

Senator Nelson. Mr. Chairman, please call up Nelson Amendment No. 1.

The Chairman. Yes. We just did.

Senator Nelson. I am not going to ask for a vote, but I need to say that this is critical and we are going to have to face it. We are providing -- in this reform, we are helping the doctors.

Now, we are going to have to provide the number of doctors that is necessary for an elderly population, and that is all of the universities are educating the doctors, but then the doctors have got to go to residencies, and we still face a shortage in this country of 91,000 doctors and it is going to get worse.

Of course, as you know, with primary physicians being so important through Medicare as gatekeepers, now, with the baby boom generation retiring, more folks are going to be on Medicare and physicians are retiring, as well.

So the medical schools have expanded their enrollments, but then they get out of medical school and we do not have enough residency slots. I can tell you most of your growth States, which would include Texas, it would include Arizona, it would include Florida, of course, and New York, Nevada, these States are way behind in the number of residency slots.

So the ACA freed up some of the available slots to be redistributed, but now we are going to be in a situation -- we are going to have to provide more residency slots through graduate medical education.

That includes Utah, too, Senator Hatch.

So I have this amendment with a bunch of Senators here and we are going to have to face this graduate medical education program. It costs money. So we are going to have to face the music.

Thank you.

Senator Schumer. Mr. Chairman?

The Chairman. Senator Schumer?

Senator Schumer. I just want to say a brief word

as cosponsors and supporter.

We are going to have a great shortage of physicians. One of the best ways to both deliver good health care and save money is have the most capable, competent physicians around. The fewer mistakes they make, the quicker they treat people, the better off it is. And this program does just that.

It is a very good program. We are going to need to expand it, and I hope my colleagues will be mindful of it.

The Chairman. Thank you, Senators.

Senator Cardin?

Senator Cardin. Thank you, Mr. Chairman.

I would offer a --

The Chairman. Let me just say, on the last amendment, as I understand it, the amendment is offered and withdrawn. Is that correct?

Senator Nelson. Yes.

The Chairman. It is. I might also say that I agree about the GME slots. A major area of need, I think, tends to be family practice. So we must make sure there are enough family practice slots, to the degree there are additional slots in total.

Who is next here?

Senator Cardin. Mr. Chairman, I would offer Cardin

Amendment No. 4.

The Chairman. Senator Cardin?

Senator Cardin. Thank you. Mr. Chairman, this amendment would affect the dispensing fees paid to long-term care pharmacies.

And here is the problem. Congress has directed CMS to reduce the amount of wastage in the Part D prescriptions that are issued in long-term care facilities, and the dispensing fee is a critical tool in getting that done.

The challenge is that a CMS rule allows up to 14 days of a drug to be dispensed in long-term care facilities, and, if a prescription is dispensed that is of shorter duration, the fee is prorated.

Therefore, the incentive is to give 14 days, whether it is needed or not, because you get the larger dispensing fee. When you talk to people who are in the industry, they tell you the cost of dispensing is not much different if it is 1 day or 14 days. So the rule really encourages the wastage of prescription drugs.

We have long-term care pharmacies that know how to do daily doses, and, therefore, the amount of wastage is actually reduced to zero, which will save us money under the system.

This amendment recognizes that, to allow the most

efficient dispensing fee to reduce the amount of wastage.

Mr. Chairman, you and I have talked about this. I have talked about it with the staff. We do not have a CBO score. I believe that this may very well come in as a cost saver.

I would ask two things: one, that we can get a CBO score, and I understand the people who can do that are at the table here. So I would hope that we could get a commitment to get the scoring on it; and, that if I withdraw this amendment, it would be without prejudice to be able to get this into the package once we get the readied information.

I might tell you that it is supported by the nursing home industry, because they recognize it is a cost saver, one that they can support.

Senator Portman has joined me in this. This is bipartisan. There is broad support for this. It is the right way to reduce the amount of unnecessary doses of medicine that are given out in long-term care facilities, and it will save us money.

I would urge that we get a score and that once we have that, I would be able to proceed with this without bias if I withdraw the amendment.

The Chairman. I appreciate that, Senator. You and I have spoken on this subject. I might ask Mr. Elmendorf

if he could commit to getting a score very quickly.

Mr. Elmendorf. And I am sorry, Senator. We have not had an opportunity to focus on the amendments that you all are bringing. We have been very engaged with the Chairman's staff and Senator Hatch's staff in analyzing the mark and, also, working separately on the very short-term extension that you and the House will be voting on.

So we just have not had a chance to turn to this, but we are happy to work with the Committee staff and with the member staffs to evaluate the amendments that are most important to all of you.

The Chairman. Thank you. And if there is not a savings here, I would commit to the Senator to work with the Senator without prejudice to try to find a resolution, because I think he is making a good point.

Senator Cardin. Thank you.

The Chairman. Thank you.

Senator Schumer. Mr. Chairman?

The Chairman. The amendment is withdrawn.

Senator Schumer?

Senator Schumer. Thank you, Mr. Chairman. I am going to ask for a vote on a bipartisan amendment with Senator Grassley. He and I have worked as a team on this to protect our rural hospitals.

It is a permanent extension of the 1988 Medicare-

dependent hospital program, the low volume hospital program. It is a permanent version of the bipartisan bill, 842, the Rural Hospital Access Act, which has 27 cosponsors.

And I particularly want to thank Senator Grassley for his leadership on this issue. This is a bill where the two Charles Es of the U.S. Senate are working together.

Also, what am I doing sponsoring a rural hospital bill? Well, New York has the third largest rural population in America. It is not just downstate. Forty-five percent of our population is outside the New York Metropolitan Area. And there are major centers of population, but a huge amount of rural people, and they depend on their hospitals.

And I am very familiar with the difficulties that rural hospitals have. They want to give topnotch medical care, but they do not have the same volume that our urban hospitals have. Yet, if you ask people to drive 50 or 75 or 100 miles, it could be life and death.

So Congress, in its wisdom, has always tried to help the rural hospitals and I am glad we have, and I am grateful to Chairman Baucus and Ranking Member Hatch for including in the mark a permanent provision for these rural hospitals.

The provision does, though, as drawn, eliminate payments to 116 low volume hospitals in the U.S., in many of your States. And without that money, many of them would go under.

So I hope we can pass our amendment here to keep those hospitals in the low volume program. In New York State, hospitals in rural areas are essential. They provide lifesaving care. Facilities like Jones Memorial and St. James Mercy in sparsely populated Allegheny County are changing the standards of rural health care.

Under the mark, these two hospitals are eliminated from the low volume payment program and would have a hard time continuing.

And the 116 hospitals stretch across the Nation. Most of my colleagues here come from areas that are affected.

I know we have a vote coming up, so I will be quick, but I would remind people that the hospitals serve a high percentage of Medicare beneficiaries. We have a lot of Medicare people in our rural areas. They are located in smaller, more isolated communities. So it is harder for providers to reach people. And because they do not have such a large volume of patients, it is harder for them to buy the modern machines and equipment that every patient, whether they live in an urban area, suburban area, or

rural area, is entitled to.

So I am going to ask unanimous consent that my entire remarks be read into the record.

I would just mention that five hospitals in New York are so desperately affected: Alice Hyde in Franklin County, Nicholas Noyes in Livingston County, Claxton-Hepburn in St. Lawrence County, Oneida Health in Madison County, and Canton-Potsdam in St. Lawrence County.

With that, I would just mention Michigan loses 7 of their 19; Ohio loses 4 of its 16; Georgia loses 4 of its 16. This is not a program that just affects Iowa or New York. It affects the whole country.

[The prepared statement of Senator Schumer appears in the appendix.]

Senator Schumer. And with that, I would yield to my colleague from Iowa, Senator Grassley.

Senator Grassley. I thank you, Senator Schumer, for your cooperation on this issue and for our being able to work together. And I would urge my colleagues to support the amendment.

Hospitals in rural areas are particularly vulnerable to changes in Medicare payments because of a very high percentage of Medicare beneficiaries living in those areas that they do not -- in these rural areas, do not have high enough population of third-party pay or private

pay to offset the deficiencies in the Federal Government reimbursement.

Rural residents tend to be older, have lower incomes, and suffer from higher rates of chronic illness than those who live in urban areas.

Medicare-dependent hospitals see a high volume of Medicare patients and are less able to rely on private payers to offset losses of Medicare dollars.

Low volume hospitals or, in my State, we call these tweener hospitals, are critical to the community and may not serve high volume of patients. These two programs help support rural hospitals and maintain a high level of quality health care for rural residents.

I have serious concerns that the cuts proposed by the Chairman's mark will negatively impact low volume and Medicare-dependent hospitals and ultimately end up leading to a lack of access to health care for rural beneficiaries.

I ask my colleagues to join Senator Schumer and this Senator in supporting this amendment to ensure quality access for rural providers and beneficiaries.

Thank you. I yield.

The Chairman. Is there anymore discussion?

[No Response.]

The Chairman. All those in favor of the amendment,

signify by saying aye?

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[No Response.]

The Chairman. The ayes have it.

Senator Schumer. Let the record show not a nay was heard.

[Laughter.]

The Chairman. The record will so show.

Next on the list here, we have Cornyn.

Senator Cornyn, you are next.

Senator Cornyn. Thank you, Mr. Chairman. I would like to offer Cornyn Amendment No. 1 for consideration. I will withdraw the amendment. But this has to do with an organization that we have all come to know and loathe, called the Independent Payment Advisory Board, 15 unaccountable bureaucrats that would make substantial changes to Medicare based on arbitrary global budget targets without full transparency and accountability.

Obamacare prohibits recommendations that raise revenues or Medicare beneficiary premiums, increasing beneficiary cost-sharing or modifying eligibility criteria. So there is little left for IPAB to recommend other than cutting providers.

The intent of the SGR repeal is to stabilize

Medicare physician reimbursement. In order to accomplish that goal, we need to repeal IPAB and ensure Medicare providers will not be subject to arbitrary reimbursement cuts.

Additional provider cuts will further exacerbate the problem of beneficiary access. The AMA estimates that 1 in 3 primary care doctors limits their Medicare patients they see. Access to Medicare coverage will do a beneficiary little good if they cannot find a doctor to treat them.

IPAB takes decision-making authority away from elected officials and gives it to the President's political appointments. These decisions do not belong in the hands of a new unaccountable board.

We should repeal IPAB and instead working together on reforms that will put Medicare on a sound financial ground and preserve it for future beneficiaries.

Mr. Chairman, I know that there has been a lot of consideration about IPAB on a bipartisan basis in both houses and while I will withdraw this amendment today, I want to raise the visibility of this, particularly as the Committee moves forward to try to reform the way that providers are reimbursed.

And the need, if there ever was a need for IPAB, is fading as a result of the reforms that are contemplated

in this underlying legislation.

Thank you, Mr. Chairman.

The Chairman. Thank you, Senator. The amendment is withdrawn.

Senator Bennet?

Senator Bennet. Thank you, Mr. Chairman. I would like to call up Bennet-Cornyn-Isakson Amendment No. 1.

I will not ask for a vote on this amendment, but I wanted to speak to it briefly. This amendment seeks to incentivize States to achieve reductions in future health care cost growth while improving quality.

I would also like to thank Senator Alexander for his help on this issue over the last year.

The amendment would set up a shared savings model where States could enter into agreements with the Federal Government to have more flexibility over their Medicare and Medicaid populations and working with the private sector, bring everyone to the table to reduce health care costs.

Our intent is also to ensure that if States pursue this agreement, Medicare and Medicaid beneficiaries are protected from unfair cost shifts.

Many of us come from States, Mr. Chairman, that are finding ways, despite these tough fiscal times, to innovate across the private sector, as well as the public

sector. In fact, I would argue that they are innovating, in part, because the times are so tough.

Many of us come from States where when the conversation can be held outside of Washington, people can sit down together and come to reasonable, innovative, bipartisan solutions.

It seems to me that for those well intentioned States, CMS ought to be able to enter into agreements with them. We need to continue to be open to ways in which not everything has to be run from Washington, DC, so long as we can keep the right beneficiary protections in place.

So while I will not seek a vote on this amendment at this time, I would ask that the Chairman would continue to work with us, as he has, on this issue moving forward.

And I would yield to my colleague, Senator Cornyn, if if he has got anything he would like to add, and I would like to thank him very much for his leadership on this issue.

Senator Cornyn. Mr. Chairman, I will be brief and just offer a big bipartisan bravo to Senator Bennet and it is a pleasure to work with him on it. I think it is an important amendment and I hope we can work with the Chairman and the Ranking Member.

The Chairman. I appreciate both. This is a big

question, big issue. The Dartmouth study got this kicked off a decade or 12 years ago or so, and I am glad that you are following up.

Thanks very much. The amendment is withdrawn.

Senator Toomey?

Senator Toomey. Thank you, Mr. Chairman. I am going to just briefly discuss an amendment. First, let me ask unanimous consent to have Senator Cornyn added as a cosponsor.

The Chairman. Without objection.

Senator Toomey. Thank you. I will withdraw this amendment, but I do hope we will be able to work to advance this cause in the underlying legislation.

As you know very well, Mr. Chairman, over the last decade or so, the Federal Government has been gradually moving to tie Federal payments to providers, in part, to their compliance with measures that are designed to improve efficiency and quality.

I think our legislation today contributes to that trend.

The purpose of the amendment is to make it clear that a lawsuit could not be litigated against a health care provider solely on the basis of whether or not the medical provider followed, implemented or otherwise successfully achieved the Federal guidelines, practice

standards, or other quality measures.

The simple idea is that these quality standards and guidelines should not, by themselves, be misconstrued to create a new cause of action for litigation.

We know that doctors already struggle with extremely high costs of litigation and malpractice insurance. Physicians in Pennsylvania face some of the highest malpractice premiums in the country.

My amendment would ensure that this problem would not get worse by virtue of the progress we are making in tying payments to quality outcomes. It does not amend or change Medicare or Medicaid rules, nor does it change the rules of evidence. It does not -- and this is an important point -- preclude an individual from bringing a cause of action for other reasons and citing among their arguments the adherence or lack thereof to quality control measures.

So I think this is a very, very important measure. I want to thank Senator Carper for working with me on this, as well.

This provision was included in both the House Ways and Means and Energy and Commerce proposals, so I know there is broad support in the other body. I hope we will have that here, and I would be most grateful if Senators Baucus and Hatch would work with us to get some version

of this measure enacted.

Thank you, Mr. Chairman. I withdraw the amendment.

The Chairman. Thank you, Senator. We certainly will work with you. You have that commitment. The amendment is withdrawn.

I see no other Senators here except Senator Casey.

Do you have an amendment, Senator?

Senator Casey. I will offer and ask to call up -- it would be Casey No. 1. Casey-Rockefeller-Brown-Wyden.

The Chairman. Here it is.

Senator Casey. The amendment is a straight 2-year extension of the performance bonus payment. This is involving the children's health insurance program, which I know the Chairman has done such good work over many years to support it and to perpetuate a critically important program. The Ranking Member and others have worked on this, as well.

But this is a performance bonus payment that 25 States have received since fiscal year 2009. The data indicates that there has been significant progress in covering more eligible children. Children that are eligible for the children's health insurance program are sometimes not enrolled unless there is a determined effort to get them enrolled.

The so-called eligible, but uninsured children

category, fortunately, has dropped by some 18 percent from 4.9 million children who were eligible, but not enrolled, down to 4 million. But 4 million is still too high.

So this is an effort to continue that performance bonus payment. We know that among other health care outcomes, one adverse outcome for children is that uninsured children are 5 times more likely to use an emergency room for routine care. So when they are insured, obviously, they are not only better off, but our economy is, as well.

I, for a variety of reasons, am offering this, but will withdraw it, but look for further consideration down the road and we will discuss it.

Thank you.

The Chairman. Thank you, Senator. I do not know anyone who is a greater champion for children than you. Thanks so much for what you are doing.

Senator Casey. Thank you.

The Chairman. You are just constantly there. The amendment is withdrawn.

The Committee will stand in recess until 1:30.

[Whereupon, at 1:04 p.m., the Committee was recessed and resumed back on the record at 1:42 p.m.]

AFTER RECESS

[1:42 p.m.]

The Chairman. Many of the amendments that are going to be offered will be withdrawn, and, therefore, we do not need a quorum. A quorum to vote on amendments is eight, whether it is voice or recorded vote, but a quorum is not necessary for an amendment to be offered, discussed, and withdrawn.

There are several Senators here who have amendments that fit that last category. We have, I mentioned earlier, a list of 17 amendments and we are going to offer those in order.

On this next page are the amendments -- there are about 11 on that page. Ordinarily, they would be offered in order, but because many of these can be offered and withdrawn or may not require a lot of discussion, I am going to recognize Senators first who are wish to offer and withdraw amendments, irrespective whether on page 1 or page 2 and irrespective of the order they might be listed here.

I will recognize those Senators because they are here. You are here to do business. And so I will go down the list, and the first one I have is yours, Senator Enzi. I have Enzi No. 3, if you want to bring that amendment up.

Senator Enzi. Yes. Thank you, Mr. Chairman. I would call up Enzi Amendment No. 3. It is intended to draw attention to an issue of growing concern.

More and more media reports identify physicians selling their practices to hospitals and hospital systems merging together, while health care prices and costs continue to increase.

At a time when buzzwords like care coordination and integrated system are continually tossed around, it is important to understand the long-term consequences for access to health care for consumers, as well as the economy as a whole, of the policies we enact today.

Medicare, as the largest single purchaser of health care in this country, can have a significant impact on those issues with how it sets its payment rates.

The fact that so many rules and regulations are released by CMS after the stock markets close for the day illustrates that point.

We need to understand how Medicare payment policies will or will not increase the current trends of this consolidation of medical -- of doctors into hospitals and hospitals merging.

I understand from my staff that the Chairman and his staff have agreed to work with me to explore this issue further. I look forward to working with the Chair and

other members of the Committee on this important question. And I will withdraw the amendment.

The Chairman. Is there further discussion?

[No Response.]

The Chairman. The amendment is withdrawn.

I might say, Senator, I think you are addressing an extremely important point. I think consolidation is something that needs to be addressed. There are a lot of factors, obviously. Consolidation of hospitals, consolidation of the insurance industry, and who knows the degree to which all of that is helping consumers, and I appreciate you offering this amendment.

Senator Enzi. Thank you.

The Chairman. The amendment is withdrawn.

Senator Grassley, do you have an amendment?

Senator Grassley. Yes. This is an amendment that you would have to vote on after you get a quorum here, but I would like to explain it.

This would be --

The Chairman. Which one is this?

Senator Grassley. My Amendment No. 13. And it makes permanent the existing 1.0 floor on the physician work index under the Medicare physician's fee schedule.

I will ask for a vote on the amendment and encourage my colleagues to support it.

There are some technical terms I would like to touch on. Under current law, the Medicare fee schedule is adjusted geographically for three factors to reflect differences in the cost of resources needed to produce physician services. One would be physician work; number two would be practice expense; and, number three would be medical malpractice insurance.

Rural practices, like those in my State of Iowa, serve patients who are, on average, older and more Medicare-dependent, have lower incomes, and suffer from higher rates of chronic illness than urban counterparts.

Medicare pays rural providers less than their urban counterparts. Doctors in rural areas have greater on-call time and travel costs, and it is harder for rural practices to recruit young doctors replacing those retiring.

At a time when we are asking doctors to do more with less, it is critical that we not cut funding that we have historically provided to physicians in rural areas. Maintaining the existing floor on physician work index is an important step in ensuring access to physicians in rural areas.

Given the uncertainty of the outcomes under this bill's new structure, I believe we should fight to preserve every dollar going into the rural areas.

Further, it is no secret that the House of Representatives wants to cut rural policies even further. I do not want to agree to a painful compromise now knowing that there are more compromises to come.

We need to speak strongly in favor of rural providers right now.

Finally, I know this amendment costs money. However, the Ways and Means Committee just added 3 years of positive updates to their bill. Unless the Chairman and Ranking Member commit not to give up on updates, we all know that additional money will be going to doctors as this bill moves forward.

So should we be doing it broadly or using the targeted mechanism that we call GPCI? To me, the answer is easy. We should use a proven rural mechanism.

I would, again, encourage my colleagues to support this amendment and I would ask for a vote, if there are no further comments or questions.

The Chairman. Is there any further discussion?

[No Response.]

The Chairman. I appreciate, Senator, you offering this amendment. I will set aside that amendment until the proper time and we have a quorum so we can vote on it. But there may be further discussion at that point. But I appreciate you bringing it up.

Senator, you have another amendment.

Senator Grassley. Yes. This is one that I will withdraw, and it is kind of central to some of the stuff that you have heard me discuss in our private meetings we have had.

This is Grassley No. 5, cosponsored by Senators Bennet, Casey, Toomey, Nelson, Portman, Rockefeller, Brown and Cantwell.

As I said, I will offer it and withdraw it. I look forward to comments from other Senators, as well.

The Medicaid program can and should help drive better outcomes. We need the attention of the Committee moving forward and with SGR off the table, I hope we can do more to improve the quality of care provided through Medicaid.

This amendment is one of those ideas that we need to be discussing for the future. Medicaid provides coverage for millions of children, many of them with complex medical conditions. Approximately 3 million children in the country suffer from medically complex conditions and 2 million of these children are covered by Medicaid.

Approximately 6 percent of children enrolled in Medicaid account for 40 percent of the Medicaid spending on children. So let me repeat that. Six percent of the children on Medicaid account for 40 percent of the

spending on children.

This amendment suggests using some of the principles in the underlying bill related to accountable care organizations to coverage of those medically complex children. The complexity of the Medicaid program does produce impediments to creating multistate collaboratives, such as the proposal here.

So I would ask the Chairman and Ranking Member to work with us once SGR is behind us to see if an idea like this can be made reality.

Further, we need more help from the Congressional Budget Office. Better outcomes for these medically complex children should be lower cost outcomes. So we need the Congressional Budget Office expertise in reviewing policies and determining the value of those policies in lowering the cost of care. I believe it is possible, but CBO is the ultimate arbiter.

So I ask for your commitment to work with us going forward, Dr. Elmendorf.

I defer to my colleagues from Colorado and anybody else, but I guess nobody else is here right now. When they come, maybe you would let them speak on it. But I could maybe ask Dr. Elmendorf if he thinks I have got a reasonable request.

Mr. Elmendorf. Yes, Senator. Of course, .that is

a quite reasonable request and, as I said earlier, we look forward to having an opportunity to work with the members of the Committee and your staffs and the Committee staff on whatever issues you think are the highest priority for us to be doing as you move ahead in this process.

Senator Grassley. Thank you for now, but I hope you will give other people, when they come back, maybe an opportunity. I have said all I need to say on it, but I think some of my colleagues wanted to speak, as well.

So I withdraw it, if that does not prevent my other colleagues from speaking.

The Chairman. Withdrawing never prevents somebody from speaking. But you are addressing a very important issue. I think it is important. We want to make sure that both urban and rural medically complex kids are --

Senator Grassley. I have to go now and will not be back until 2:30. Is that all right?

[Laughter.]

The Chairman. You are excused.

Senator Thune?

Senator Thune. Mr. Chairman, I have got an amendment that I would like to get voted on, and I think that can happen when we get a quorum. But I would like to speak to it, and it deals with this issue of tele-

health.

The costs and burden of caring for seniors is steadily increasing and, if given the choice, we know a lo t of seniors would prefer to live independently with minimum intervention from the caregiver. And there are a lot of important innovative technologies that are rapidly emerging that offer seniors the option of living at home without jeopardizing their health or safety.

Unfortunately, the Medicare program is not keeping up with advances in technology. By providing a demonstration project on remote patient monitoring, we can start Medicare down the path of leveraging technology to help ensure that seniors remain in their homes longer.

This technology can help prevent costly hospital admissions and readmissions. A recent study performed by the Common Wealth Fund shows that using remote patient monitoring can reduce hospital readmissions and increase patient satisfaction.

This amendment would create a pilot program to provide incentives for home health agencies and other entitles across the country to use home monitoring and communications technologies, giving seniors greater access to the care they need and the ability to stay in their homes.

Home health agencies or other entities participating

in the pilot program will receive incentive payments based on a percentage of the Medicare savings achieved as a result of the pilot project.

This remote patient monitoring amendment is designed to be budget neutral in its payments to home health agencies or other entities.

So I would also ask for HHS to establish a more formal mechanism to determine how remote monitoring services can further enhance the value-based performance program.

The VHA, Veterans' Health Administration, is the most notable example of home tele-health service taken to scale. The VHA piloted, evaluated, and deployed home tele-health and found that it can lead to cost-effective quality outcomes for chronic care patients.

So, Mr. Chairman, I would ask -- it is Amendment No. 2 -- that at the appropriate time, when we have a sufficient number of Senators here to have this voted on and I would like to ask, as long as we have the folks from CBO here, if perhaps they could give us a little bit of insight about how they score these types technologies and the contribution they make to reducing some of the payments made out under Medicare.

The CMS data that I have shows that for 2011, CMS paid under $ 7 million on tele-health claims. The number

is quite different than what CBO estimated when the current Medicare tele-health structure was created in 2000.

At that time, the CBO said tele-health policy that is now in law would cost about $30 million a year. And I would note that this is not additional reimbursement. As we know, tele-health encounters and reimbursements are just the same as in person reimbursements, but just through a different medium.

And I raise the issue because I think that the assumptions that are made about tele-health by CBO may not be accurate, and there have been a lot of studies done recently suggesting that using tele-health can actually achieve savings, and I want to make sure that CBO is considering the latest data when it considers tele-health programs, proposals, and how those might be scored.

So I would ask you to perhaps comment on how you look at those issues and commit to working with my staff to talk in greater depth about how you currently view tele-health and ways to approach this issue going forward.

Mr. Elmendorf. So, Senator, as I mentioned earlier, we have not had time to look at the amendments. Specifically, we have not had time to look at your

amendment, but we are happy to do so.

As a general matter, when we think about provisions regarding tele-health, we try to look at the number, try to assess, as best we can, the extent to which the particular services would be used, the cost -- the price that would be set for those services, and then, also, the effects on the use of other health care services that might arise from the use of other health care services that might arise from the use of tele-health.

We will certainly take on board whatever information is available and we look forward to talking with you and your staff if you have information that you have seen that we have not seen.

I cannot speak to the particular projection from 2000. I was not there. I have not learned about it since then. So I do not know what may have changed over time in the way the health care system evolved or the way the laws were changed that apparently made the costs come in much less than we had expected.

But we try very hard to learn from errors in our projections previously and to take on board the best available information at any point we make an estimate, and we will do that in this case for you, Senator.

Senator Thune. I appreciate that.

With that, Mr. Chairman, I will, when the

appropriate time comes, ask that this amendment be voted on, and yield back. Thanks.

The Chairman. Yes.

Senator Thune. I am sorry. Mr. Chairman? Mr. Chairman, if I might ask that that be voice voted.

The Chairman. Yes. Senators, we now have a quorum for the purpose of voting.

For the information of Senators present, this is -- Senator, why do you not describe it. This is Thune No. 2 on your sheet. It is on the second sheet, Senator Thune No. 2, cosponsored by Senators Casey and Enzi.

Do you want to describe the amendment again?

Senator Thune. I, very quickly, Mr. Chairman, can say it is the short title, basically, provide a demonstration project on remote patient monitoring in the Medicare program to ensure seniors can remain in their homes longer and to prevent hospital readmissions.

It is designed to be budget neutral in its payments to home health agencies or other entities. But something that I think in terms of the ways in which we treat people, allow them to live more independently and be taken care of in their homes, with the technologies that are available today, this is something that I think we not only are seeing a lot of providers proceed with, but we need to make sure that the Medicare rules for

reimbursement keep up with that technology.

The Chairman. The question is on the amendment offered by the Senator from South Dakota, Amendment No. 2.

All those in favor, say aye?

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[No Response.]

The Chairman. The ayes have it. The amendment is agreed to.

I have on my list -- Senator Enzi, do you have another amendment you wish to offer and withdraw?

Senator Enzi. I do, Mr. Chairman.

The Chairman. Let us do that.

Senator Enzi. Yes. I would call up Enzi Amendment No. 6.

The Chairman. Thank you.

Senator Enzi. And my amendment would introduce a number of bipartisan comments on its reforms to the Medicare benefit. These changes will help protect seniors from medical bankruptcy and make their health care expenses more predictable.

The bill would simplify the basic structure of Parts A and B, reduce the distortions, as well as higher costs that many seniors pay that result from first dollar in

Medigap coverage.

It would protect low income seniors from catastrophic medical costs and it would better align Medicare premiums with the seniors' ability to pay.

These bipartisan reforms include proposals from the National Commission on Fiscal Responsibility and Reform, the President's Fiscal Commission, the Lieberman-Coburn bipartisan proposal to save Medicare, and they have enjoyed the support of a wide range of stakeholders, think tanks, and members of Congress.

As the moment of truth project co-chairs, Erskin Bowles and Alan Simpson recently highlighted, roughly 80 percent of Medigap enrollees would see a reduction in out-of-pocket spending under a combination of cost-sharing benefit design and supplemental coverage reforms, with an average debt reduction of $415 per person.

As I said in my opening statement, this legislation has to be offset, and I look forward to working with members of this Committee on ways to responsibly offset the cost of this bill.

The proposals in my amendment represent a good starting point for determining our path forward on offsets, and it also makes it equal for seniors, as with other insurance holders on some of the limits.

Thank you, Mr. Chairman. If there isn't any further

discussion, I would withdraw the amendment.

The Chairman. Thank you, Senator. The amendment is withdrawn.

While we are here, we could vote on Grassley No. 13. Oh, the sponsor is not here. He cannot be back for a short while, but let us go ahead anyway and I will call it up. It is Grassley No. 13. He spoke on it earlier.

All those in favor of Grassley 13, say aye?

[A Chorus of ayes.]

The Chairman. Opposed, no?

[No Response.]

The Chairman. The ayes have it and the amendment is agreed to. That is Grassley No. 13.

Do other Senators present wish to offer amendments? Senator Wyden, do you have one?

Senator Wyden. Thank you, Mr. Chairman. I think we can do two at once. We have talked with your staff about it.

Amendment 3, which I offer with Senator Isakson, Senator Carper, and Senator Grassley, is designed to modernize the system of risk adjustment in America.

Today, about 30 percent of all seniors and more than 40 percent in my home State are in Medicare Advantage programs that get a risk-adjusted payment for each enrollee, and making sure that these payments accurately

reflect the cost of providing care to those who are enrolled is essential to getting Medicare reform right.

Obviously, you do not want to overpay for healthy patients and underpay for the sick ones. So this amendment that I have offered with colleagues, in effect, seeks to offer some of the recommendations made by MedPAC so we can modernize the risk adjustment process.

I am not intending to offer this at this time, Mr. Chairman, but I would hope that we could work together and for purposes at least of the floor see if we can begin the process of getting risk adjustment right.

We started talking about this a long time ago and this is an area where -- not through anybody's fault. I just do not think risk adjustment has kept up with the times.

The Chairman. Thank you. Yes, we will work with you and try to find a solution.

Senator Wyden. Very good. And I will do the other one in really the same way, Mr. Chairman. That is Amendment 9 that I have developed with Senator Portman, Senator Carper, and Senator Enzi.

What this is about, and something that I think clearly ought to be a priority for the future, is we now pay something like $4 billion for free physicals for seniors under Medicare. That is a very good thing. That

is something that starts the program toward an ethic of prevention.

It is not just sick care. It is not just Part A, the hospital part, but it is a focus on prevention. But as far as I can tell, after we make that $4 billion investment, with millions of these physicals each year, nothing much happens in terms of our having a system of trying to ensure that seniors can maximize the value of prevention, and this is enormously important.

You look, for example, at older women and the screens that are now available. If older women can have access to these screens, you have 30 percent less incidence of hip fractures.

So this amendment that I have developed that is bipartisan is, in effect, designed to say that when seniors and their providers save Medicare money, they should be able to share in the savings.

It is a voluntary program, but -- I see Senator Brown is here -- the Cleveland Clinic has done a lot of good work in this area, the Oregon Health Sciences Center has done a lot of good work in this area.

It is one thing to start a brand new program, colleagues. It is quite another to not wring every bit of value out of a major Federal expenditure. We are now spending $4 billion on these physicals. And I guess, Mr.

Chairman, I have tried to track it with senior friends from Gray Panther days.

I guess if you get one of these free physicals and your doctor tells you what is going on, you feel good about, I guess afterwards, you can go to the Dairy Queen and you can have three hot fudge sundaes. If the doctor tells you it did not go so well, I guess you go to the tavern and drink something else.

But the point is what folks at the Oregon Health Sciences Center and the Cleveland Clinic have done is made this a science of rewarding people, and I think there is an opportunity to reward seniors and providers and taxpayers, and I would hope that we could continue to work on that in a bipartisan way.

Senator Hatch has had a great interest in prevention over the years, as well.

And with that, I would withdraw.

The Chairman. The amendment is withdrawn.

Next on the list, I have Senator Brown No. 4. It is otherwise known as Rockefeller 4.

Senator Brown. Mr. Chairman, yes, thank you. This listed as No. 18, Rockefeller No. 4.

It did make it into the amended mark this morning. I am offering this on behalf of Senator Rockefeller and me. I also ask that Senator Casey -- I do not know if I

need consent, but that Senator Casey be added as a cosponsor to the amendment.

Since 1974, for 40 years, transitional medical assistance provided extended Medicaid coverage to members of low income families who otherwise would lose Medicaid and potentially become uninsured because of something we want them to do, an increase in hours worked or an increase in income or increased income from employment, usually sometimes increased income from child or spousal support.

Either way, they are moving in the direction we want them to, but we cannot -- stripping away their Medicaid makes no sense. The GAO found that TMA helps families transition to self-sufficiency. It estimates that TMA extended vital coverage to almost 4 million Americans in 2011, the last year we have full numbers.

The NGA, the Governors Association, called it a, quote, "crucial work support initiative," because it protects those families who are getting ahead, getting jobs, getting pay increases, getting promotions from incurring burdensome health care expenses.

It periodically is scheduled to expire. It has been around, as I said, since 1974. Congress has always extended it on a bipartisan basis, most recently as part of the December 12, 2012 budget agreement. It expires at

the end of this month. That is the importance of it.

Ohio is expanding Medicaid. Many of our States are. Many of them are not. But for those States that do not expand, TMA is even more important. Without TMA, many parents whose earnings increase, but who remain relatively low income and, thus, ineligible for exchange subsidies -- so they would get Medicaid if they were in, say, Ohio, but would not get it if they were in Texas.

But TMA is especially important, because they will end up being uninsured in these cases. In the typical State, the income level which a working parent loses eligibility is just 61 percent of the poverty level, $11,900 for a family of three.

It is designed to help those Americans so they do not have to choose between a job and health care. We do not want somebody to turn down a better job, to turn down a raise because they might lose Medicaid. That makes no sense for any of the values that Republicans and Democrats alike share.

As I said, this has historically enjoyed bipartisan support. I ask for support for the Rockefeller-Brown-Casey amendment, Mr. Chairman.

The Chairman. Senator Casey?

Senator Casey. Mr. Chairman, very briefly. I would incorporate by reference what Senator Brown said.

But just to reemphasize what he said, these folks are working. They are working. And this is one way to provide a measure of work support that would not be there otherwise.

So I urge support for the amendment, as well.

The Chairman. Senator Cardin?

Senator Cardin. Mr. Chairman, I also want to add my voice in support of this amendment. This is one of the fundamental provisions behind the philosophy of rewarding work.

If a person moves off of assistance to work, gives up health care, it makes it more challenging for them to be able to survive, and that is why this transitional assistance program was first developed.

It acts as a way to help encourage people to work and make work pay, and I would urge support of the amendment.

The Chairman. All right. Does anyone else wish to speak on this amendment?

[No Response.]

The Chairman. If not, all those favor of the amendment, say aye?

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[A Chorus of Nays.]

The Chairman. The ayes have it. The amendment passes.

My understanding is that, Senator Portman, you have got a couple of amendments.

Senator Portman. Yes, Mr. Chairman. Thank you.

The first one I am going to offer, and maybe the only one now, is the health care tax credit amendment. This is something we have talked about in this Committee quite a bit because it relates to our --

The Chairman. Is that Portman No. 1?

Senator Portman. -- trade policies.

The Chairman. Is that Portman No. 1?

Senator Portman. Yes, Portman No. 1. Before I start, Mr. Chairman, I would like, with his permission, to ask unanimous consent that my colleague, Senator Brown, be added as a cosponsor to the amendment.

The Chairman. Without objection.

Senator Portman. And I thank Senator Brown.

This health care tax credit is a vital tool for struggling Americans to pay for their health insurance.

The amendment would extend the tax credit for 2 years. As, again, many of you know, this tax credit helps Americans who have experienced job loss and received TAA, trade adjustment assistance, or have had their defined benefit pension plans taken over by the

PBGC, the Pension Benefit Guaranty Corporation.

Often, the health coverage tax credit serves as an important bridge for Americans until they become eligible for Medicare benefits.

This amendment extends this tax credit at the current level to cover 72.5 percent of health insurance premiums, which was reached after some intense bipartisan negotiations in 2011.

It expires on January 1, 2014.

For a lot of users of this program, including about 20,000 families of the Delphi salaried retirees who nearly lost everything during the GM bankruptcy, they very much depend on this health care tax credit for their health insurance. In this case, those pensions were turned over to the PBGC.

However, for a lot of these folks, like the Delphi retirees, they do not fit well under the Obamacare premiums. In other words, even with the subsidies under Obamacare, their premiums are going to be higher than what they are paying under their group plan. And they have got very little margin in their family budgets based on what happened during the takeover and during the auto bailout where they were left behind, and they had their pensions terminated.

So GAO has looked at this. They have determined

that 69 percent of the people who currently receive the health care tax credit would be worse off under Obamacare. So they would agree with us on that. Certainly, that is the anecdotal information that we have from particularly these Delphi retirees.

There is bipartisan support for the health coverage tax credit, always has been, and I believe this belongs as part of the package we have before us today, which also deals with the health care issues.

I think extending this coverage is fair to these workers and I hope, Mr. Chairman, that we can have it added to this package today.

The Chairman. Are you offering or withdrawing?

Senator Portman. Well, I would like to have it offered as part of this package today that is moving forward.

The Chairman. I do not know that we can do it. I would encourage the Senator to offer and withdraw so we can keep working on it. It is not germane to the subject before us.

Senator Brown. Mr. Chairman, could I speak for it before withdrawal?

The Chairman. We can figure out some way to work this out without forcing the issue.

Senator Brown?

Senator Brown. Thank you, Mr. Chairman.

I wanted to offer support and if Senator Portman is withdrawing, I want to continue to work with him and with this Committee on that.

But we know that TAA and the trade adjustment in HCTC, the health care tax credit, are not substitute for a job, yet it is essential for many displaced workers.

We know what happens when there are -- no matter your position on trade, we know there are some number of winners and some number of losers. Quantify them how you will.

But those who are losers to trade policy need something like -- or other kinds of upheaval in their economic lives need something like HCTC.

It is important that we extend these benefits for workers and retirees who lose their jobs and benefits primarily through no fault of their own, and extending the tax credit makes sense. Extending the -- to provide health care for a number of workers.

So I would offer my support for the amendment that Senator Portman and I and others are offering.

Senator Stabenow. Mr. Chairman?

The Chairman. Senator Stabenow?

Senator Stabenow. Mr. Chairman, I just simply wanted to ask unanimous consent to be added to Senator

Portman's amendment. I have also joined with Senator Brown.

I commend both of them and just indicate this is very, very important for displaced workers and retirees. And in the middle of what was a positive outcome in terms of the automobile industry, people who were left behind were the Delphi retirees, which should not have happened. And this is incredibly important for them, as well as others.

So I commend colleagues and I want very much to continue to work with you.

Senator Portman. I appreciate, Mr. Chairman, and I agree with Senator Stabenow.

I wonder, Mr. Chairman, if it is not germane today, would we be able to get a commitment that this could be included in whatever short-term patch goes into effect on January 1 and that this health care coverage does end on January 1.

Normally, perhaps it would be dealt with as part of TAA or some other trade discussion. That is likely to be put off, as I understand it, until at least the spring and there would be a gap here.

So if we could get a commitment today, since this is a bipartisan issue where there is a lot of agreement, to have it included in whatever patch is put forward January

1 on, we would appreciate that commitment today.

The Chairman. Senator, I think it is a bit much. I do not think we can put it in the patch. The patch would be just an extension of current SGR policy, and if it is not germane to this, it is not germane to that.

I very much appreciate the concern, but I think the appropriate process here, frankly, is for us to sit down and work out some way to accommodate your wishes and your intention.

But I cannot make a commitment now that this is going to be part of the patch. I can certainly commit to working with you, and I mean it. That is not an idle statement. But it is not germane. All other amendments have been germane and one could make the same argument for other non-germane amendments that Senators may want to bring up, that are brought up not here, but in the context of the patch, and I just do not know that it is appropriate to do that at this point.

Senator Portman. Well, I appreciate your consideration and your willingness to work with us. This is unusual, as you know, because it does end January 1 and these families are going to find themselves with a real gap in their coverage.

I suppose, Mr. Chairman, as a backup, I would ask that you work with us on the TAA extension, which, as you

know, is likely --

The Chairman. Absolutely.

Senator Portman. -- to come up later in the spring.

The Chairman. TAA is a necessary component of any potential TPA and I don't say potential, we are going to pass TPA. Therefore, we have got to pass TAA, and when we pass TAA, this is probably a very important component of the tax credit.

Senator Portman. We would appreciate you working with us on that.

The Chairman. Thank you. And I thank the Senator for withdrawing.

Senator Schumer. Mr. Chairman?

The Chairman. Senator Schumer?

Senator Schumer. Mr. Chairman, I am offering another amendment, again, with Senator Grassley. He is not here right now.

This involves podiatry.

The Chairman. Do you have a number there, Senator?

Senator Schumer. It is No. 4, Schumer Amendment 4.

The Chairman. All right.

Senator Schumer. And Senator Grassley, as well as Senators Cardin and Stabenow are cosponsors of this.

We all know podiatry is important. Podiatry --

podiatrists have been defined as physicians under Medicare, but not Medicaid. Now, with diabetes, dramatically increasing particularly among poor people, the need for podiatric services is very, very real, very important to helping deal with diabetes.

And so the amendment would enhance patient access to podiatrists and improve health care quality, recognizes podiatrists as physicians under Medicaid, and strengthens coordination of care among providers under Medicare's therapeutic shoe program.

The Chairman. There is a little bit too much conversation going on here. Let us give the Senator our full attention.

Senator Schumer. Thank you, Mr. Chairman. It would not mandate any new Medicaid services or benefits nor would it require any Medicaid patient to seek care from a podiatric physician.

So I hope we can vote on this by voice. It has bipartisan support.

The Chairman. Any further discussion?

[No Response.]

The Chairman. If not, all those in favor of the amendment, signify their agreement by voting aye.

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[A Chorus of Nays.]

The Chairman. The ayes have it. The amendment is agreed to.

Senator Stabenow. I believe I was next, I believe, on the list.

The Chairman. Senator Stabenow?

Senator Stabenow. Thank you, Chairman Baucus.

First of all, I would call up amendment -- it is Stabenow-Casey No. 2 Amendment regarding payment for cancer drugs, and ask that Senator Brown be added as a cosponsor.

I also want to thank, in addition to Senator Casey, Senator Roberts for working on this issue with me.

We have introduced this amendment to protect access to cancer treatment at community cancer clinics. More than half of all cancer patients are treated in community-based cancer clinics.

However, since 2008, more than 1,300 community cancer centers have been closed, consolidated, or reported financial problems. And in my home State, there are 38 clinics who either closed, opened, sold to a hospital.

So our amendment changes how Medicare pays for drugs, helps to make sure seniors fighting cancer can continue to receive care in clinics that are near their

homes.

Excluding prompt pay discounts from the Medicare payment formula for drugs provided in clinics ensures that providers like community cancer clinics are fully reimbursed for the cost of drugs.

This would help protect the care provided at clinics so that patients do not have to travel long distances to get chemotherapy services.

I appreciate we will not proceed at this point with a vote at your request today, but this is a very, very important issue. It has strong bipartisan support, Mr. Chairman, and I hope we can continue to work to resolve this.

Senator Casey. Mr. Chairman?

The Chairman. Senator Casey?

Senator Casey. Thank you very much.

I want to thank Senator Stabenow for her work on this. It is not a number that I want to top Michigan on, but in Pennsylvania, we have some 50 clinics that have either sold or sold to a hospital because of this problem.

A lot of those tend to be in rural areas. We have a State that, as Senator Toomey knows, we are not thought of as a rural state, but we probably have more than -- something on the order of more than 3 million people that

live in so-called rural areas. So there are big populations in our rural areas.

It makes sense and, as you said, it has broad support and I am grateful for your leadership, and thank the Chair.

Senator Toomey. Mr. Chairman?

The Chairman. Senator Toomey?

Senator Toomey. Thank you, Mr. Chairman. I would just like to add my voice of support for this idea and I look forward to working with Senator Stabenow on this.

Senator Casey is exactly right. This is a very important issue in Pennsylvania. It does feel like we have been disproportionately impacted by this, and I do think it is something we need to address in a fiscally responsible manner.

So I look forward to working with you.

Senator Roberts. Mr. Chairman?

The Chairman. Senator Roberts?

Senator Roberts. I want to thank Chairperson Stabenow of the all powerful Senate Agriculture Committee, Senator Casey, Senator Toomey.

This is one of those policies I mentioned in my opening statement that I have long supported.

Bottom line, cancer clinics across the country are closing and denying patients access to care.

So we have to address the issue and I am committed to working with my colleagues, and I appreciate very much the Senator from Michigan offering this amendment at this time.

Thank you.

The Chairman. Any further discussion?

[No Response.]

The Chairman. If not, the amendment is withdrawn.

Senator Roberts, do you have an amendment you wish to bring up?

Senator Roberts. Mr. Chairman, I want to call up Robert-Enzi Amendment No. 2. I know this is a relatively new issue for some of the members of this Committee. It should not be, but it is. It is new for me, as well, to some extent.

CMS made a change in a recent rule that will significantly impact our critical access hospitals. I know that gets the attention of the Chairman.

Now, considering the number of regulations being issued right now, it is hard to keep track of all the ins and outs, but this policy change moves the goalpost for an industry vital to our rural communities and our rural health care delivery system.

Basically, they have been taken off guard. I am concerned that, to a large extent, they may not even

survive. This issue needs to be addressed and if CMS is unwilling to address it through rulemaking, it will have to be addressed legislatively.

I know, Mr. Chairman, that you have many critical access hospitals in your State and that we have worked on issues related to them in the past, and I appreciate that.

Now, because this is such a new issue, I am willing to withdraw my amendment, but hopefully, if you are willing to work with me and Senator Enzi and everybody else that has the critical access before them, Senator Thune, others, to talk to CMS, if that is possible, and get to the bottom of this policy change.

So with that confirmation on your part, I will withdraw the amendment.

The Chairman. Thank you, Senator. I have heard from a lot of Montana hospitals about this. I think it is a major concern, and definitely we will work with you. I appreciate it.

Senator Roberts. I withdraw the amendment. Thank you.

The Chairman. The amendment is withdrawn. Thank you.

Senator Bennet?

Senator Bennet. Thank you, Mr. Chairman. I would

like to call up Amendment No. 6.

The Chairman. You might turn on your microphone. I do not know if it is on.

Senator Bennet. Thank you, Mr. Chairman. Bennet Amendment No. 6, which is an amendment I am cosponsoring with Senator Cornyn.

Mr. Chairman, I am not going to ask for a vote today on this, although it pains me not to, because we have not been able to satisfy the staff about the language. But they tell me that we will work together on this.

Mr. Chairman, every year, American taxpayers have access to a Social Security statement that provides a concise, user-friendly record of their total contributions and a summary of their estimated lifetime benefits.

People in my home State of Colorado and Americans across the country deserve to receive the same information for Medicare, and that is what this amendment is about. It provides people the same information about Medicare that they already receive about their Social Security benefits.

It also provides and ensures coordination about this information on the same form so we do not duplicate information, but can continue to keep this information user-friendly.

This amendment is based on a bill called the Med Info Act that I previously introduced with Senator Corker.

Essentially, this amendment facilitates a greater understanding of the Medicare program. Most Americans today have no idea what their contribution into the Medicare program is nor do they know, on average what they receive in benefits when they are in Medicare. And this really matters.

In 2011, the Urban Institute conducted a study that showed that a couple retiring today will pay in about $119,000 in lifetime Medicare taxes and receive $357,000 in lifetime Medicare benefits. That is nearly a 3:1 ratio, and we are borrowing the difference from the Chinese and sticking our kids with the bill, and it is important for people to understand this.

So Io say this not because this amendment is designed to cut benefits, it is not, or take away promises that have been made for our Nation's seniors.

It is simply about our country understanding the fiscal challenges we face, even as we sit here today trying to make Medicare reforms.

We are all here to make Medicare solid for the next generation, or we should be. And people that are my age or younger than I am do not believe it is going to be

there.

The former CEO of AARP, Bill Novelli, has said about the provision that I had written, quote, "Every American needs to understand the costs and benefits of the Medicare program. This is a good start," he said, "and I hope it will be the beginning of a national conversation."

The bipartisan Policy Center has said, quote, "The cost to provide this information is incredibly low, little more than the small printing cost. The education it will return to American citizens is quite high."

As we members of Congress consider ways to make Medicare more solvent, it is important that all Americans have a shared understanding of the facts so they can know what changes they are willing to accept to continue making Medicare solvent, to preserve it for the next generation, and to allow us to come into fiscal balance over a period of time.

Senator Cornyn is not here now, but I would like to thank him for his help on this amendment.

Mr. Chairman, I would like to ask you and the Ranking Member if you would be willing to work with me with the relevant agencies to see if between now and when this very worthy bill is on the floor that we could incorporate language that allowed us to be able to

illustrate to the American people what we are paying into Medicare and what we are taking out from Medicare.

The Chairman. Absolutely. I think it is a very worthy goal. I think more should understand the contributions that one receives compared with -- the benefits one receives compared with the contributions one makes. It is a major question of financial literacy.

The more people know what their personal financial situation is and that certainly includes the payroll taxes they pay and the benefits they are going to receive in the future, the more likely it is people are going to make intelligent decisions, and, frankly, I believe it might even help the Congress because they will be more informed and more educated when they talk to us about what they do and do not want us to do here.

I think it is a great idea. Let us see if we can work it out.

Senator Bennet. Well, I appreciate that, Mr. Chairman. Thank you very much.

The Chairman. You bet.

Senator Portman, do you have another amendment?

Senator Portman. I do. First of all, Amendment 2 I am not going to offer, because you kindly included it within the text of the bill.

The Chairman. Here we go again.

Senator Portman. This was on purpose. No, sorry. Trying to get something done in the dark of the night, slip it by.

[Laughter.]

Senator Portman. But Amendment No. 3 I do have, which is the behavioral IT health amendment, and I think Senator Stabenow may want to speak on this, also. She has spent a lot of time on this issue.

As you know, Mr. Chairman, under the American Recovery and Reinvestment Act of 2009 and under the high Tech Act, we created this incentive program for the adoption of electronic health records, which I think is a good idea.

I believe that there was an oversight in the establishment of those electronic health records, because it did not include behavioral health, mental health, or substance abuse treatment professionals or facilities in the program.

In addition to mental illness, many patients often have other health disorders, we were told. There is a recent study by SAMHSA, the Substance Abuse and Mental Health Services Administration, points to a particularly high incidence of cancer, heart disease, diabetes, asthma, among the more than 6 million Americans served by the public mental health system.

So this amendment would allow these critical behavioral mental health providers to participate in Medicare and Medicaid incentive programs for electronic health records.

Senator Stabenow apparently mentioned earlier in my absence this tragic case of the woman who crashed her car actually right near this building into a guard house and I think that is an example of where the mental health system was not communicating with the other health providers and there was a gap.

We are learning more about that now, but that is an example that is very close to home for many of us and certainly to the Capitol Hill Police.

This amendment would allow these critical behavioral health providers, mental health providers to participate in Medicare and Medicaid incentive programs, again, for electronic health records.

It would also create a parallel timeline for those incentive payments and Medicare penalties for the newly eligible behavioral health providers. I believe that this increased coordination between behavioral health providers and other health providers is essential to ensuring that the country's mental health system functions properly and that we avoid these miscommunications.

The policy proposed in this amendment, Mr. Chairman, I am told does have an estimated price tag of $1.1 billion over 10 years. We are still looking into that.

But, of course, I will withdraw the amendment today and we are not dealing with offsets today. But I would like to continue to work with the Chairman and Senator Stabenow and other members of the Committee on both sides to find ways to improve coordination of behavioral health and mental health services.

The Chairman. Senator Stabenow?

Senator Stabenow. Thank you, Mr. Chairman.

I just want to briefly commend Senator Portman. I think that he is right on. This is a real gap in the system and if we are going to actually focus on comprehensive health care, regardless of which organ of the body it is or which part of the body it is for individuals, we have got to make sure that something as integral as electronic medical records are connected and that we are not seeing gaps in information that cause the wrong things or lack of service to be done.

So I just want to commend Senator Portman. I think this has got to happen if we are going to have a comprehensive response for our health care system.

Senator Portman. Thank you, Mr. Chairman.

The Chairman. Thank you, Senator.

The next item, Stabenow No. 3. Is that correct?

Senator Stabenow. Yes, Mr. Chairman. I wanted to speak about something I will be offering and withdrawing. I understand there is a desire not to do a vote on this today.

But it relates to home health care, which I know we all care about and all support. Home health is critically important in terms of services for seniors, for people with disabilities, people who remain in their homes, short-term or long-term, being able to have a quality of life by getting home health care.

Almost 70 percent of home health care patients are seniors, about 60 percent are women, more likely o live alone, more likely to have multiple medical conditions than other seniors.

We all know that folks would rather be at home being treated than in some kind of a hospital or other institutional care.

Unfortunately, we have recently seen what I believe is a dramatic cut proposed in home health care through a payment rebasing rule by CMS, and I believe this jeopardizes access to home health care services.

So I am proposing this amendment that actually is, Mr. Chairman, a proposal that is being looked at in the House, as well as here in the Senate to postpone this cut

for 1 year so we can have a thorough analysis of the impact and instead actually put in place some other policies that would make this a revenue neutral proposal and actually possibly save money by changing the home health outlier policy.

So I know that we have a lot of interest on both sides of the aisle in home health care, Mr. Chairman. I hope we can work together on this to stop what I think will be a cut that will close home health facilities across the country. Certainly, we have seen numbers in Michigan that are very alarming to me, and we need to have a different approach to this.

I want to work with the leadership to get that done. Thank you.

The Chairman. Thank you, Senator. The amendment is withdrawn.

Next, Mr. Isakson, do you have an amendment? We do not have many amendments left, frankly. I have four or five to be offered and withdrawn.

Senator Isakson. Mr. Chairman, I do have an amendment.

The Chairman. Why do you not proceed?

Senator Isakson. Isakson Amendment No. 4.

Mr. Chairman, I am the Ranking Member of the Labor Subcommittee. We are dealing with the reauthorization of

the Workforce Investment Act and have been for the last 6 years.

The House has passed a reauthorization bill. We are in the process in the Senate Committee of doing the same.

There is a provision in the underlying bill that would add a health workforce demonstration project for another job training project which would be under this legislation, which would be the 48th Federal program for workforce development and investment.

We have been trying to figure a way to consolidate these programs under the Department of Labor and the Training Department of the Department of Education to get the maximum bang for the buck.

The amendment that I have submitted would strike the provision that is underlying bill because of the duplication that already exists within the programs in the Workforce Investment Act and the Department of Labor and the Department of Education.

The Chairman. Further discussion?

[No Response.]

The Chairman. And you are offering and withdrawing. Is that correct?

Senator Isakson. Let me make sure the Ranking Member is aware of the amendment that we are on.

The Chairman. Let us make him aware. I think he

is aware.

[Laughter.]

Senator Isakson. That being the case, I will take my advice from the Ranking Member as to whether I withdraw or whether I do not.

The Chairman. Well, at this point, I think it is more appropriate to offer and withdraw.

Senator Isakson. I will offer and withdraw, but I underline by saying that we are going to be coming forward with a bill out of the HELP Committee. It is going to attempt to consolidate these and not reduce the amount of investment in workforce investment, but instead enhance the dollars and the bang for the buck, and I hope the Chair and the Ranking Member will help me work toward that end.

The Chairman. Well, I applaud your goal, that is, in duplication and I very much appreciate that. We can certainly work with you.

Are there other amendments?

[No Response.]

The Chairman. Apparently, there are other amendments, but the sponsors are not present. I will just read them if I --

Senator Toomey. Mr. Chairman?

The Chairman. Senator Toomey?

Senator Toomey. If you are looking for a present member who has an amendment, I would volunteer.

The Chairman. I am. You got it.

Senator Toomey. Thank you very much. I intend to offer and withdraw this amendment, Toomey-Casey No.3.

Senator Casey and I have legislation, Mr. Chairman, that clarifies and corrects an oversight in the Affordable Care Act that has to do with orphan drugs.

The fee that is imposed on the sale of pharmaceuticals under the Affordable Care Act was intended to exclude drugs that treat rare diseases. These drugs are commonly referred to as "orphan drugs." Unfortunately, the way in which it was drafted and subsequently interpreted, created a scenario in which some orphan drugs, nevertheless, are facing that fee.

It was not intended that way, but that is the way it works because of the mechanism by which the exemption occurs.

Our amendment would simply clarify that those drugs solely designated to treat a rare disease by the Food and Drug Administration would be exempt from this pharmaceutical fee, as was the intention.

I understand because this is a tax matter, it is not germane to this bill. Therefore, I am prepared to withdraw the amendment, but I am hopeful that we can work

to clarify the matter. Otherwise, this provision will continue to have the unintended consequence of potentially decreasing access and increasing costs to these very important medicines.

It is my hope we can address this matter in the future.

The Chairman. I appreciate it, Senator. That is not Casey 2, is it?

Senator Toomey. Is it Casey 2? I am told it is. Sorry about that.

The Chairman. No, no, no. I am just trying to keep it clear here. Thank you.

Senator Toomey. No. No. Now, I am corrected. This is Toomey No. 3.

The Chairman. Because I am looking for Toomey 3 and it --

Senator Toomey. We are on the same side on this one, though.

The Chairman. That was not in any of the lists. That is fine. You have offered the amendment and it is withdrawn.

Let me just read some of the Senators who I understand have still amendments that are not here. Maybe their staffs here so they could take notes.

I have Roberts No. 2. I have got Cardin No. 1. I

have another Grassley No. 1. This is round 3. I have an Isakson No. 4. Carper 7. Thune 4. And another Grassley.

These are, according to my information, to be offered and withdrawn.

Does anyone here wish to offer an amendment?

Senator Crapo. Mr. Chairman?

The Chairman. Senator Crapo?

Senator Crapo. On behalf of Senator Thune, I am not quite ready yet. Could I have just 30 seconds?

The Chairman. Yes. But we are getting to the point where we are going to have to vote on the amendment.

Senator Crapo. I am ready, Mr. Chairman.

The Chairman. You are ready?

Senator Crapo. Yes.

The Chairman. Senator Crapo?

Senator Crapo. On behalf of Senator Thune --

The Chairman. Has this been distributed? Do we know what it is?

Senator Crapo. It is Thune No. 4.

The Chairman. You are offering Thune No. 4.

Senator Crapo. Yes.

The Chairman. Thank you.

Senator Crapo. And on behalf of Senator Thune,

this amendment would specify that $10 million of the $25 million available each year from 2014 to 2018 to provide technical assistance through quality improvement organizations be available solely for assistance to small practices of 10 or fewer eligible professionals located in the health professional shortage areas.

This funding is to be used to help practices succeed in the VBP program or to move to an advanced payment model.

The original proposal from the Finance Committee released on October 30 included $10 million for this purpose, and this amendment would seek to reinstitute that provision.

The Chairman. You are offering and withdrawing?

Senator Crapo. Mr. Chairman, I am asking for a voice vote on behalf of Senator Thune.

The Chairman. On behalf of Senator Thune.

Senator Crapo. Yes.

The Chairman. All right. All those in favor of the amendment, signify by saying aye?

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[No Response.]

The Chairman. The ayes have it. It is agreed to.

We are about ready for final passage. So I am just

asking if Senators have amendments that they wish to offer, because if not, we are going to proceed to final passage.

The Chair recognizes Senator Carper.

Senator Carper. Thank you, Mr. Chairman.

I am offering this amendment on behalf of Senator Grassley of Iowa and myself. And so he can tune in on this one, too, if he wants, but I want to call up, if I could, our Amendment No. 7, Carper Amendment No. 7, with Senator Grassley, amendment to improve medication adherence.

I want to thank Senator Grassley and his staff for working with us on what I think is a real important issue. This probably sounds like common sense, but medication adherence are just making sure that patients take the right medication at the right time at the correct dosage.

It sounds like a simple problem to solve, but this is a problem that costs our country tens of thousands of deaths each year and close to $300 billion each year in wasted health care dollars.

This amendment requires CMS to begin testing innovative solutions to improve medication adherence and to establish quality metrics so that we can measure our progress in solving this problem.

And with broad support that ranges from AARP to the pharmaceutical industry for this amendment, I believe we need to start working on solutions to improve medication adherence sooner rather than later.

And I would say to our friends from CBO that join us here today, thank you for being here and for your work on a lot of issues, including postal issues. But I want to thank you and your colleagues for your work on this issue, as well, thus far. We hope we can continue to work with you closely as we head for the holidays. So thank you very much.

With that, Senator Grassley wants to say some kind words about our amendment.

Senator Grassley. You have spoken about the value of it. I just want to say thank you for working with me on that.

Senator Carper. The pleasure is mine. With that, Mr. Chairman, I would withdraw our amendment.

The Chairman. The amendment is withdrawn.

Any other Senators wish to offer amendments?

Senator Grassley. Yes. Grassley Amendment No. 1.

The Chairman. Go ahead.

Senator Grassley. This is an amendment that I will discuss and withdraw. In the future, this Committee needs to exercise responsibility to build a life span

benefit for the disabled.

Much of the jurisdiction over disability is shared between the Finance and the Health Committees, but the smile fact is that the massive funding in the Medicaid and Medicare programs for people with disabilities should be used to drive policy.

This amendment is an example of that type of thinking. Our amendment creates Medicaid bonuses for States that think creatively in coordinating the support for the disabled across programs to achieve outcomes that lead to more independent living and employment in the community.

Medicaid can and should help drive better outcomes. We need the attention of the Committee moving forward and the SGR off the table. And with that off the table, I hope that we can do more to improve the quality of care provided through Medicaid.

Further, we need more help from the Congressional Budget Office. Better outcomes amongst people with disabilities should lower cost outcomes. Outcomes that require less intensive services are necessarily lower cost. We need CBOs expertise in reviewing policies and determining the value of those policies and lower the cost of care.

I believe it is possible, but CBO is the ultimate

arbiter. So once again, I ask Dr. Elmendorf for a commitment to work with us going forward. I will defer to my colleagues from Oregon or anybody else that would like to speak before withdrawing the amendment.

But I would like to ask Dr. Elmendorf if he would consider that.

Mr. Elmendorf. Yes, Senator. We would be happy to work with you and other members of the Committee on this issue or other issues. Whatever the Committee views as its most important priorities will be priorities for us.

Senator Grassley. If nobody else wants to speak, then I will go to Grassley --

Senator Wyden. Mr. Wyden, I would just like to associate myself with Senator Grassley's remarks. We have worked on this together for a long time. I think it is an excellent amendment and I thank you.

The Chairman. The amendment is withdrawn.

Senator Grassley. And now I go to another amendment, Grassley No. 10, and this is cosponsored with Senators Rockefeller and Carper. Thank you, again, Mr. Carper.

I also want to recognize the work from several Senators not on the Committee on this issue -- Franken, Collins, Murkowski.

I will withdraw this amendment. I look forward to

comments from other Senators that would like to consider this.

The amount of money our country spends to combat obesity and diabetes is incredible. This amendment coins the term "diabesity" to capture the interactive effects of the two conditions.

There are ways to address diabetes, like the diabetes prevention program. There are ways to address obesity, like counseling and a new spate of FDA-approved weight control drugs.

But, look, we need to be clear. These efforts do require spending. But these are investments in healthier outcomes and reduce incidence of diabetes and obesity. Reducing the incidence should lead to healthier individuals. Healthier individuals should cost Medicare and Medicaid less money.

We need the attention of the Committee moving forward and with the SGR off the table, I hope that we can do more to address the issue of diabetes and obesity.

Further, we need the help that I always say we need to get from CBO, and I am not going to repeat that and you do not need to repeat what you said, Dr. Elmendorf. There is no sense of having a broken record. But thank you for your cooperation.

Senator Carper. Mr. Chairman?

The Chairman. Senator Carper?

Senator Carper. Very, very briefly. Senator Grassley is onto something big and, unfortunately, we as a people are getting bigger and bigger. And a lot of times we focus on symptoms or problems we have, symptoms of diseases or maladies.

One of the underlying causes of the problem is obesity, and he is right on the money. And Senator Murkowski and a bunch of other -- Jay Rockefeller and I, we all are focused on this and we need to be focused on it not just as a Committee, not just as a Congress, but as a country.

You are on the right track. I am pleased to be part of your amendment. I think we have got a couple of good proposals here with Senator Murkowski and others and I would just hope that we can work together as a team and get this done.

Thank you.

The Chairman. The amendment is withdrawn.

Senator Casey. Mr. Chairman?

The Chairman. Senator Casey?

Senator Casey. Mr. Chairman, I wanted to call up Casey No. 3 and just speak to it for a couple of moments. The issue is here is wound healing; in particular, wound healing products; and, even more particularly, FDA-

approved advanced therapeutic wound healing products.

CMS created a bundling payment policy that would include FDA-approved products like the one I just spoke to, a wound healing product, in the same group or packaging really with products that do not go through the same approval process.

That creates a problem for these kinds of wound healing products. And I am not calling for a vote on this amendment, but I was seeking a commitment from both the Chair and the Ranking Member to get both the CBO score, as well as to continue work toward getting a solution into the manager's package on the floor.

So I am offering and withdrawing it, but I wanted to secure a commitment from both.

Senator Crapo. Mr. Chairman?

The Chairman. Senator Crapo?

Senator Crapo. I would just like to ask to be listed as a cosponsor of this amendment before it is withdrawn.

The Chairman. Absolutely.

Senator Isakson. Mr. Chairman?

The Chairman. Senator Isakson?

Senator Isakson. As one who has been involved in this issue for the past 2 years with CMS and with the people involved and has a lot of knowledge, and I have

worked with Senator Casey the last 2 days in his preparation on this amendment, any work the Committee does toward this amendment or in the final markup that goes to the floor, I would appreciate being considered, as well, because there are differences of opinion in terms of the end result and I would like to be a part of that.

Senator Menendez. Mr. Chairman?

The Chairman. Senator Menendez?

Senator Menendez. Mr. Chairman, I just want to speak to Senator Casey's amendment and to, in a parallel context, a very similar set of circumstances, which is important to 72,000 people a year who are diagnosed with bladder cancer.

CMS inappropriately classified a new bladder cancer drug called seitzvu (phonetic), a drug that leads to a reduction in recurrence of bladder cancer up to 70 percent. And the rule that CMS used to misclassify is the same exact rule in which they erred in addressing the issue with artificial skin that Senator Casey just discussed.

So I look forward to being a part of those discussions and hopefully getting a global resolution to it.

Senator Casey. And I should add, Mr. Chairman,

that we had some good discussions today and the last couple of days with Senator Isakson which -- we are on different sides on this, but it has been very helpful to have that engagement. I want that to continue, as well.

Thank you.

The Chairman. Thank you, Senator.

Also, Dr. Elmendorf, you heard the request.

Mr. Elmendorf. Yes, I did, Mr. Chairman.

The Chairman. Good. And we will work with both, and other Senators, on this.

Senator Casey. Thank you.

The Chairman. We are getting close to where we can vote on the mark.

Any Senators wishing to offer any amendments at this point? I have a couple, three on the list here, but I do not see Senators here.

[No Response.]

The Chairman. Since all amendments have been dispensed with, I will entertain a motion that the Committee report an original bill to repeal the sustainable growth rate and consider health care extenders.

The Chair will entertain a motion to move the adoption of the chairman's mark, as modified.

Senator Hatch. I so move.

The Chairman. It has been moved.

All those in favor of adopting the mark, say aye?

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[A Chorus of Nays.]

The Chairman. The ayes have it. The mark is adopted and reported.

Senator Burr. Mr. Chairman, would the record reflect that I voted no?

The Chairman. Senator, if that is the case, we have to have a recorded vote.

Senator Hatch. I would ask the Senator to withdraw that request and --

Senator Burr. I am not sure why that would require a recorded vote, Mr. Chairman. It is never required in any other committee.

The Chairman. Sometimes things are just done the way they are.

[Laughter.]

Senator Burr. I would like the recorded vote.

The Chairman. Suspend and why do you not talk to your Ranking Member for a second?

[Pause.]

The Chairman. This is a little unusual, but I am going to, again, ask for the vote.

All those in favor, signify by saying aye?

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[A Chorus of Nays.]

The Chairman. The ayes have it and the mark is ordered reported.

We have one more item to deal with, and that is the mark on Supporting At-Risk Children Act and the modification of the mark. The mark is so modified.

This should not take long. I encourage Senators to stay since we have a quorum here.

I would ask Diedra Spires to briefly explain the modifications to the mark. I am unaware of any amendments. There may be some, but I am not aware of any. But if Ms. Diedra Spires could speak to the -- I thank the staff for helping us with the last bill. Thank you all very much.

While we are waiting for the next round of staff, Senator Portman, did you seek recognition?

Senator Portman. I would just like to offer an amendment and I will withdraw it.

The Chairman. Diedra is not there. I do not see Diedra. We are just going to go ahead.

I think this is sufficiently understood. We will dispense with the walkthrough.

At some point, Senators may have questions they may want to ask of Senators or of staff.

At this point, the Chair will entertain any amendments to the bill.

Senator Portman. Mr. Chairman?

The Chairman. Senator Portman?

Senator Portman. Mr. Chairman, I have an amendment. It is Portman No. 1. It is an amendment to ensure that post-adoption services would be available to children who are U.S. citizens brought into this country through international adoption.

This fall, as you know, a *Reutter's* series exposed a very disturbing trend involving underground child trading within the international adoption community. Due, in part, to a lack of post-adoption resources, these kids have been privately rehomed to new families.

This trend does not involve state oversight by child welfare or the courts. These children are made vulnerable to predators and, in many cases, are abused and exploited.

Since state child welfare agencies are not involved in international adoption proceedings, there is really no way for them to track internationally adopted kids at the state level.

This amendment opens up resources for kids and

families who are struggling and need help after the adoption is complete, before problems rise to the level of placing the child in foster care or, worse, giving =the child to another family without the necessary screening and vetting that should always be part of that process of adoption.

I am pleased, Mr. Chairman, that you have agreed to examine this issue further, as I understand it, and you have committed to hold a committee hearing on the role of child welfare and protecting these vulnerable children sometime in the future.

And in light of that commitment, Mr. Chairman, I would withdraw my amendment.

The Chairman. You have the commitment to work with you, Senator, and I appreciate that.

Senator Menendez?

Senator Menendez. Mr. Chairman, I would like to call up Menendez-Grassley Amendment 1, although I will seek to withdraw it.

I just want to take the opportunity to thank Senator Grassley for joining with me on this amendment, and, even more importantly, in the introduction of the Safe Child Support Act.

In 2011, the Department of Health and Human Services reported that there are more than 11 million cases of

unpaid child support, totaling in the tens of billions of billions of dollars.

That is money that is owed to children so that they would be able to live the best life they can, and I cannot think of a more worthwhile cause than ensuring children are provided the child support they are owed. And I was lucky to have Senator Grassley as a partner on that important bill.

I want to thank you, Mr. Chairman, for incorporating a significant amount of the policies from our bill in today's mark, including the authorization of a multilateral child support provision that allows for child support to be collected from parents overseas; the addition of parenting time provisions to foster better connections between their children and noncustodial parents.

And, additionally, the mark establishes a task force of experts in the field to report back to Congress a consensus agreement on ways that we can address some of these other pressing issues, issues like the establishment of a national lien registry, which are too important to not get right. And I believe this task force's report will form the foundation of legislation I look forward to working with you on.

So the mark represents a lot of hard work aimed at

helping children and I am glad that our bill was a significant part of that work, and I look forward to supporting you, Mr. Chairman, in its passage.

The Chairman. Thank you, Senator. The amendment is withdrawn.

Senator Wyden, do you have an amendment?

Senator Wyden. Mr. Chairman, let me just make sure that we understand which one of the amendments we are talking about.

The Chairman. I have Wyden 1. Do we have another?

Senator Wyden. That means that you and Senator Hatch have already included the amendment that I and Senator Portman have worked on with respect to child sex trafficking. Very good.

Then that takes us to Wyden 1, which is an amendment to ensure that you can have effective evaluation of Federal programs. It seems to me that there are a couple of points that I would like to start with so that we are clear on this.

First, this is an amendment that strictly parallels what passed the other body by a vote of 394-27. I would just repeat that -- overwhelming passage in the other body, 394-27.

Since then, there have been concerns that have been raised, particularly by my colleague from North Carolina,

and I have worked very closely with Senator Hatch and his staff. I believe we have addressed those concerns.

I am particularly struck because I gather that my friend form North Carolina is concerned about privacy. I think about as much as anybody who has been involved in public service, I am a privacy hawk. It would be pretty hard to be as hawkish as I am on privacy issues. And because my friend and I serve on the Intelligence Committee, I think he knows that.

So what we have in terms of privacy protections in this amendment is violators not only can be fined under Title 18 for violating the privacy provisions here, Title 18 of the United States Code, or they can be imprisoned for up to 5 years, or both. So that is number one.

Number two, which I think is even more important, the people who run this have never had a data breach. Let me repeat that. There has never been a data breach in the history of these programs.

So I am happy to yield my time, but for colleagues who have had questions, A, this parallels what happened in the House, overwhelming vote there; B, we have tried and I thought we had actually addressed the concerns that had come up on the other side, and particularly with Senator Burr.

And it just seems to me without this data, you

cannot evaluate a program very responsibly.

What I will close with is the reason I am always anxious to work with my friend from North Carolina, he makes so many good points with respect to the need to get at duplication of programs and inefficient programs and the like, and we have worked together on a whole of those kinds of things.

That is what we are talking about here and I do not know how you get at inefficiency in programs if you cannot get the basic information to do something about it, and that is why it got practically 400 votes in the House of Representatives.

So if there are other things that the Senator from North Carolina would like in this, I am happy to try and take that up and yield him any time for a response or whatever comments. But I know you are trying to vote, Mr. Chairman, sometime soon. So leave it at that.

Senator Burr. Mr. Chairman?

The Chairman. Senator Burr?

Senator Burr. Is it possible to get recognized in opposition to the amendment? Is that all right with the Committee rules?

The Chairman. You say whatever you want to say.

Senator Burr. Mr. Chairman, let me just say that the gold standard of data protection up until recently

was the Internal Revenue Service, and this Committee is now looking at the breach of personal information out of an agency that we never thought we would have to worry about and any penalties that might have been in place were apparently resolved with resignations.

I hope the Committee will not cut short its investigation of what went on there.

But let me share for my colleagues what Senator Wyden is trying to do. Let me say, from the onset, right now, I think he has got the votes. So the onus is on me to try to convince you why this is a very, very bad thing to do.

The Wyden amendment is patterned off of legislation that would allow the use of the national directory for new hires to be used for Federal, State and private research organizations' use for the evaluation of whether Federal programs work by tracking the individuals personal wage data.

Currently, NDNH is used for very discreet purposes for which the Federal Government is uniquely suited to provide this data; enforcement of child support payments; enforcement of debt collection for student loans; and, the administration of unemployment compensation.

These are appropriate uses of this highly personal data and very limited in scope.

Now, the problem with Senator Wyden's amendment is that it would expand in a very dramatic way several agencies' access to personal individual information such as Social Security numbers, employee addresses, dates of hire at their jobs, the name of their employers, the amount of money they make, and the address of their employers.

These are some of the most personal information that the Federal Government can collect and should be used in the most limited of fashions.

Now, under the Wyden amendment, here are the agencies that would have access to this data with individually identifiable records -- the Department of Labor, the Department of Education, the Department of Housing and Urban Development, the Department of Justice, the Department of Veterans; Affairs, the Bureau of Census, the Department of Agriculture, and the National Science Foundation.

It is probably easier to list the ones that have been left out.

Now, why is this a problem? These agencies would now have access to personal identifiers. Provided the agencies use the information for evaluation or statistical analysis or for reasons likely -- likely to contribute to promoting good work outcomes.

After concerns with data breaches over the healthcare.gov Website, do you really want to give even further access to information for such broad purposes?

But let me suggest that this amendment does not stop there. It allows, through grants or contracts, the access to Americans' personal information by private research organizations.

Now, I have significant concerns over providing such broad access and for such broad purposes this information, because the Federal Government has an atrocious record in protecting the security of Americans' private protection.

In fact, on July 15, 2013, a memo by the Congressional Research Service on this very piece of legislation, the Wyden amendment, said this, and I quote, "The expansion of access to and use of personal information contained in FPLS," -- the amendment -- "especially in the national directory of new hires could potentially lead to privacy and confidentiality breaches, financial fraud, identity theft, and other crimes.

There is also concern that a broader array of legitimate users of the NDNH may conceal the unauthorized use of personal and financial data in the NDNH. Moreover, the concerns about data security and the privacy rights of employees have been a point of

contention in many of the debates regarding expansion of the NDNH," unquote.

Further, Mr. Chairman, the GAO, last year, testified before the Homeland Security and Government Affairs Committee that Federal data breaches increased 19 percent in just the past year and the Federal Government needed to promptly reassess the amount of information on Americans we currently store here in Washington, but also how we safeguard that information.

Let me state the GAO went further. GAO went further and the current law and guidance imposes -- and said only -- and guidance imposes only modest requirements for collecting personal data and how it is to be used.

They state that this could allow the unnecessary broad range of the use of information.

The Wyden amendment would add further broad application to the Federal Government's use of personal data.

In short, Washington does not have some unending claim on personal information of Americans and we certainly do not have some right to use their data without their knowledge and in ways for which they never granted us permission, and certainly not to evaluate Federal programs.

I would urge my colleagues -- do not do this. If

you do it, it will never be reversed. And no matter -- listen, Ron has been trying to address things through what the severity of the penalty is.

You can make the penalty whatever you want to today. Do you really want to risk the individual data of the American people to practically every Federal agency for a mission as broadly placed as what the definition states?

Well, GAO does not think you should do it, CRS does not think you should do it, the American people will be outraged if we do it. But we will have a recorded vote and I will allow every individual member to make that determination themselves.

Mr. Chairman, I suggest we have a recorded vote.

The Chairman. Is there further discussion?

Senator Wyden. I am happy to have a recorded vote.

The Chairman. Do you want to discuss it more?

Senator Wyden. Well, I will just briefly respond. Colleagues, again, this parallels what passed the House 394-27, A. B, there has never been a data breach at these agencies, never. That is number two. And, number three, ever since we saw the need particularly to have this to eliminate the duplication in programs, which I thought was a bipartisan cause, certainly, a conservative cause, we sought to reach out to Senator Hatch and we add penalties here. You add penalties in case you have a

data breach at an agency that has never had a data breach.

So I would hope that we could track what passed the other body overwhelmingly and, if anything, has strengthened the privacy protections.

I appreciate the sincerity of my colleague's views, but as much as anybody around here, I have tried to make privacy protection a centerpiece -- a centerpiece of what we do to guide our policy approaches when you are talking about individuals and at an agency that has not had a data breach in history.

I think we have done that. I would urge a "yes" vote.

The Chairman. A recorded vote has been requested.

All those in favor, signify their position by -- recorded vote, the Clerk will call the roll.

The Clerk. Mr. Rockefeller?

The Chairman. Aye by proxy.

The Clerk. Mr. Wyden?

Senator Wyden. Aye.

The Clerk. Mr. Schumer?

The Chairman. Aye by proxy.

The Clerk. Ms. Stabenow?

Senator Stabenow. Aye.

The Clerk. Ms. Cantwell?

Senator Cantwell. Aye.
The Clerk. Mr. Nelson?
The Chairman. Aye by proxy.
The Clerk. Mr. Menendez?
Senator Menendez. Aye.
The Clerk. Mr. Carper?
Senator Carper. Aye.
The Clerk. Mr. Cardin?
Senator Cardin. Aye.
The Clerk. Mr. Brown?
The Chairman. Aye by proxy.
The Clerk. Mr. Bennet?
Senator Bennet. Aye.
The Clerk. Mr. Casey?
Senator Casey. Aye.
The Clerk. Mr. Hatch?
Senator Hatch. No.
The Clerk. Mr. Grassley?
Senator Grassley. Aye.
The Clerk. Mr. Crapo?
Senator Hatch. No by proxy.
The Clerk. Mr. Roberts?
Senator Hatch. No by proxy.
The Clerk. Mr. Enzi?
Senator Hatch. No by proxy.

The Clerk. Mr. Cornyn?

Senator Hatch. No by proxy.

The Clerk. Mr. Thune?

Senator Hatch. No by proxy.

The Clerk. Mr. Burr?

Senator Burr. No.

The Clerk: Mr. Isakson?

Senator Isakson. No.

The Clerk. Mr. Portman?

Senator Hatch. No by proxy.

The Clerk. Mr. Toomey?

Senator Toomey. No.

The Clerk. Mr. Chairman?

The Chairman. Votes aye.

The Clerk will tally the vote.

The Clerk. Mr. Chairman, the final tally is 14 ayes, 10 nays.

The Chairman. 14 ayes, 10 nays. The ayes have it, and the amendment is agreed to.

[A statement of support for the amendment from Senator Grassley appears at the end of the transcript.]

The Chairman. Are there further amendments?

[No response.]

The Chairman. Seeing none, the chair will entertain a motion to report the mark, as amended.

Senator Hatch. So move.

The Chairman. Moved and seconded.

All those in favor of reporting the mark, as amended, signify by saying aye?

[A Chorus of Ayes.]

The Chairman. Those opposed, no?

[No Response.]

The Chairman. The ayes have it. The mark is reported.

Seeing no further business before the Committee, I thank all members.

I ask consent the staff be granted authority to make technical, confirming and budgetary changes.

Without objection, it is so ordered.

I thank all the Senators. The Committee is adjourned.

[Whereupon, at 3:14 p.m., the hearing was concluded.]

I N D E X

Senator Nelson's Statement for the Record

Executive Session
The SGR Repeal and Medicare Beneficiary Access Improvement Act of 2013 & The Supporting At-Risk Children Act of 2013
December 12, 2013

Mr. Chairman, thank you for holding this important mark up. Let me begin by expressing my gratitude to you, Senator Hatch, and your staffs for working with me to include three important provisions in the mark.

The first is my amendment, cosponsored by Senator Grassley, to expand eligibility for the use of federal funds to go after abusive behaviors in Medicaid. Currently, these Medicaid Fraud Control Units can only use federal dollars to pursue abusers in certain settings like nursing homes and hospitals. That made sense when the law was written in 1978, but today, folks receive services from Medicaid outside of traditional settings – such as their own home, day care facilities, or even transportation to and from the doctor. This amendment will allow federal funds to be used to investigate and prosecute abuse and neglect – no matter where it occurs.

The second amendment incorporates the Special Needs Trust Fairness Act, which is cosponsored by Senators Grassley, Rockefeller, and Enzi. Twenty years ago, Congress authorized special needs trusts to help low-income persons with disabilities save money toward their long-term needs, such as rent payments or other non-health needs. However, currently the person with the disability cannot create the trust themselves. This puts an unnecessary and sometimes costly burden on the individual. To fix this issue, our amendment allows an individual to set up a special needs trust for him or herself.

Third, I am very pleased at the inclusion of an Annual Report on Medicaid Disproportionate Share Hospitals, a measure I introduced with my colleagues Senators Rockefeller and Casey. This study will help us better understand how we spend Medicaid dollars and the services that vital hospital systems provide.

I would also like to speak briefly on Grassley amendment 5 Coordinated Care for Medically Complex Children. I am a cosponsor of this amendment, which advances a model of care that will benefit some of our sickest children while lowering health costs and improving Medicaid. This coordinated model of care is already been proven to work in my state at hospitals such as St. Joseph's Children's in Tampa and Wolfson

Children's in Jacksonville. We will not ask for a vote on this amendment but I look forward to working with my colleagues on the committee to make this proposal a reality in the coming year.

Finally, the focus of today is how we pay our Medicare doctors. I applaud the Chairman and Ranking Member on the extraordinary work they have done to reach a bipartisan agreement on repealing the Sustainable Growth Rate.

For far too long we have gone through this kabuki dance each year- or sometimes more frequently- of averting dramatic cuts to Medicare providers which subjects our seniors and their health care providers to unnecessary uncertainty. We must ensure that our doctors, nurses and other health care providers are properly compensated. At the same time, we must pay for quality – not just quantity – of care.

This bill permanently repeals the flawed SGR and provides stability in Medicare payments. And it makes serious strides in moving our health care system towards one that rewards based on quality and performance.

Mr. Chairman, thank you again for holding this markup and I look forward to working with my colleagues on moving this important legislation forward.

Statement by Senator Chuck Grassley on Wyden Amendment #1
December 12, 2013

Mr. Chairman,

I want to explain why I voted for the Wyden amendment. This amendment would provide certain federal agencies with access to the Federal Parent Locator Service data, including the National Directory of New Hires. The National Directory of New Hires, known as NDNH, includes earnings data, which could be used to better understand labor markets and the economy. Access to this data will help federal agencies evaluate federal policies and programs to ensure they are working effectively. Knowing if programs are working effectively will help us better target our limited government resources. According to GAO, we spend $18 billion on 47 different job training programs, and only five of them have had any sort of evaluation to determine if they are successful.

As many know, States provide the data that feed into the National Directory of New Hires from their own directories of new hires. The feds receive this information and control access, but there's nothing prohibiting a State from sharing their data with researchers. Currently, for national or multi-state program evaluations, researchers have to go state to state requesting this information, which is expensive and time consuming. The alternative is to use survey data, which is also expensive, but also unreliable.

The data is currently shared with State agencies who administer child welfare, foster care and adoption, cash welfare under the Temporary Assistance for Needy Families programs, and food stamps, as well as other Federal agencies, such as the Social Security Administration and the Department of Housing and Urban Development to improve program administration. In all those exchanges and expansions over the last 17 years, there has, thankfully, not been a single privacy breach of the data.

Researchers have no interest in the personal identifying information. In fact, the personally identifiable information is stripped. Nonetheless, I understand the concern about privacy and agree that it is paramount in moving forward with this effort.

It is an issue that was discussed at length by the other body, which is why the House bill strengthens privacy protections that protect the NDNH. They control the manner in which researchers gain access. They do that by putting the burden on the agency that funds the research to be held accountable and requires them to put controls in place. Under the House version, NDNH data will not be released until that agency can prove that the controls are sufficient. Even then, there's a secure method to provide the data to researchers. According to one expert in the nonprofit research field that testified before the House Ways and Means Committee, entities that want the data, whose reputations are also on the line, usually follow

the more strict National Institute for Standards and Technology's set of standards for data exchange.

Further, the House bill increases penalties for individuals who willfully disclose personal identifying information. Violators who make unauthorized disclosure of personally-identifiable information will now be charged with a class E felony, which is punishable by up to five years in jail.

The Wyden amendment is modeled after a provision in the bipartisan House bill that was voted out of the Ways and Means Committee. The House child support bill passed the entire body by nearly 400 votes in June.

I support the amendment because we need to do all we can to improve federal programs that are currently in place. We have excessive duplication in workforce job training programs and no idea if any of them are actually successful. Chances are some the programs just don't work, and yet taxpayers are being asked to fund these programs. We can do better with each dollar to help Americans get back to work and increasing research using the NDNH will help us improve these programs.

I am open to discussing ways to improve the language, but I believe the House language is a good start at addressing this data sharing and research initiative.

STATEMENT FOR THE RECORD OF SENATOR BENJAMIN L. CARDIN

SENATE FINANCE COMMITTEE MARKUP OF THE SGR REPEAL AND MEDICARE BENEFICIARY ACCESS IMPROVEMENT ACT OF 2013

Cardin Amendment #1

Mr. Chairman, I am offering Cardin Amendment #1, a provision that I believe would greatly improve the foundation you have established for modernizing Medicare's physician reimbursement system. My amendment would increase access to chronic care by eliminating beneficiary coinsurance for the new Chronic Care Management codes created in the Chairman's Mark. I want to applaud you, Chairman Baucus and Ranking Member Hatch, for recognizing need to focus on the treatment of chronic diseases in the Medicare population. MedPAC data and other research indicate that the highest concentration of Medicare expenditures is found in the cohort of patients with chronic conditions; however, the program's reimbursement structure has failed to incentivize management of these conditions. In fact, CMS has determined that 14 percent of Medicare beneficiaries with six or more chronic conditions account for 46 percent—nearly half of all Medicare spending. These patients already pay higher-of-pocket costs due to more frequent hospitalizations and physicians' office visits.

I am encouraged by Section 104 of the Chairman's mark, which moves Medicare in the right direction, directing the Secretary of Health and Human Services to create one or more Healthcare Common Procedure Coding System (HCPCS) codes for chronic care management services for individuals with chronic care needs. Medicare would begin paying for services furnished on or after January 1, 2015.

I am concerned, however, that beneficiaries who do not have Medigap plans, or whose incomes do not qualify them for Medicaid, would be less likely to receive these services because of the financial burden of a 20% coinsurance. Numerous research studies have shown that Medicare beneficiaries are more likely to receive services when cost-sharing is eliminated. I am attaching for the Record letters of support for this amendment from the Medicare Rights

Center and from CareFirst BlueCross BlueShield, an innovative company that has a proven record of lowering costs and improving the quality of care for patients with chronic conditions.

I recognize that the Congressional Budget Office has been unable to score this amendment in time for its inclusion in today's package, and so I will not ask for a vote. I ask the Chair to work with me in the coming weeks to get a score from the CBO, and I ask CBO Director Elmendorf and his health team to provide their assistance in estimating what the direct costs of this provision might be. Congress has recognized the value of prevention and wellness in improving both health outcomes and the cost-effectiveness of Medicare, and it has wisely eliminated beneficiary coinsurance for the annual wellness visit and many preventive services offered as part of Medicare. I believe we should similarly encourage participation in chronic care management programs by eliminating coinsurance for these new codes, and that any costs attributable to this amendment will be outweighed by reduced overall expenditures for the Medicare program. I urge the Committee to work with me to adopt this amendment as part of the SGR reform bill before it reaches the Senate floor.

Cardin Amendment #3

Mr. Chairman, this amendment, Cardin #3, would block further implementation of a misguided rule issued by the Centers for Medicare and Medicaid Services that imposes a severe and unjustified cut to the professional component of radiologists' reimbursement. The professional component (PC) represents radiologists' interpretation of an image for either the presence of disease, such as cancer, or patient trauma. CMS initially implemented this arbitrary reduction through the 2012 Medicare Physician Fee Schedule Final Rule without any in-depth, publicly available data analyses in justification of the cut. The Agency has argued incorrectly that when radiologists interpret multiple images from the same patient, during the same session, on the same day, there are ample "efficiencies," or overlapping work, to justify a corresponding reduction in reimbursement.

But radiologists spend an equal amount of time, energy, and expertise interpreting images regardless of the date of service, equipment being used, or section of the body that is under examination. In June 2011 an expert panel of

radiologists published a peer-reviewed study in the *Journal of American College of Radiology* (JACR) which found that professional component efficiencies vary by modality and are ultimately no greater than 3 to 5%. Rectifying the unintended consequences of CMS's PC MPPR policy will ensure that radiologists can continue to provide patients with important, life-saving advanced diagnostic imaging services.

Although CMS reports that they completed their own analysis in the 2012 MPFS Final Rule and even provide ranges of data related to the total amount of efficiencies in the PC. Yet the agency has been unwilling to fully disclose the "line-by-line" data in a format that can be reviewed by Congress. Without the release of a line-by-line data analysis, Congress is unable to determine whether the reduction is warranted.

My amendment is budget neutral. It would stop CMS from further implementing the 25% multiple procedure payment reduction assessed to the professional component of radiologists' services. It would also require CMS to disclose within 60 days of enactment, any relevant empirical analyses used by CMS to justify the imposition of the professional component MPPR in 2012. The amendment closely mirrors language of S. 623, the Diagnostic Imaging Services Access Protection Act, which has 20 bipartisan cosponsors including four other members of this Committee—Senators Burr, Isakson, Roberts, and Stabenow—and which has been endorsed by the American Medical Association and the American College of Radiology. The bipartisan House companion bill, introduced by Rep. Pete Olson, has secured the support of 183 members. I would also add that the Energy and Commerce-passed SGR repeal bill includes one element of this amendment—requiring CMS to release the data used in developing the rule. Although I will not ask for a vote, I ask the Chairman to work with me on language that might be accepted when the SGR repeal bill is brought to the Senate floor.

SUBMITTED BY SENATOR STABENOW

Supporters of the Excellence in Mental Health Act Proposal

National Sheriff's Association
National Association of Police Organizations
Iraq and Afghanistan Veterans of America
Military Mental Health Project
American Medical Association
American Psychiatric Association
American Psychological Association
National Alliance on Mental Illness
National Council for Behavioral Healthcare
Give an Hour
American Foundation for Suicide Prevention
Mental Health America
American Academy of Child and Adolescent Psychiatry
American Art Therapy Association
American Association for Geriatric Psychiatry
American Association on Health and Disability
American Association for Marriage and Family Therapy
American Association of Pastoral Counselors
American Association for Psychosocial Rehabilitation
American Counseling Association
American Dance Therapy Association
American Group Psychotherapy Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Orthopsychiatric Association
American Psychiatric Nurses Association
Anxiety and Depression Association of America
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Association for Behavioral Health and Wellness
Bazelon Center for Mental Health Law
Child Welfare League of America
Clinical Social Work Association
Clinical Social Work Guild
Depression and Bipolar Support Alliance
The Jewish Federations of North America
NAADAC, The Association for Addiction Professionals
National Association of Anorexia Nervosa and Associated Disorders
National Association of County Behavioral Health and Developmental Disability Directors

National Association of Mental Health Planning & Advisory Councils
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Disability Rights Network
National Federation of Families for Children's Mental Health
School Social Work Association of America
The Trevor Project
United States Psychiatric Rehabilitation Association
Witness Justice

Senator Toomey's Statement for the Record

Senator Toomey. Thank you, Chairman Baucus and Ranking Member Hatch, for your leadership and for holding this mark-up to repeal Medicare's flawed sustainable growth rate system.

I find that one of the things that most frustrates Americans about Washington is the Congress's irresponsible tendency to put off tough decisions and kick the can down the road. Medicare's sustainable growth rate is the epitome of this tendency. There have been fifteen short-term fixes over the last ten years to this flawed policy; fifteen missed opportunities to address the problem. These actions do not happen in a vacuum. Congress has forced health care providers to operate in an environment of perpetual uncertainty where they face the potential of harsh reductions in reimbursement at the end of each year. Therefore, I am pleased that we are finally taking this significant step to repeal the sustainable growth rate once and for all.

Perhaps just as noteworthy as breaking the trend of Congress's regular abdication of its responsibilities, is that this mark will continue to move Medicare reimbursement for physicians away from an inefficient fee-for-service system that reimburses based on quantity of services. When it was originally passed, the sustainable growth rate was an attempt to constrain rapid increases in the volume of services

provided per beneficiary under Medicare. While the sustainable growth rate was flawed, the potential for this problem still exists in the fee-for-service system. That is why I am hopeful that this mark's movement in the direction of value-based reimbursement will produce more efficient and cost-effective provision of health care services in the Medicare program.

There are a couple of amendments I look forward to discussing with you over the course of this hearing. The first is titled the Standard of Care Protection Act, of which Senator Carper is my cosponsor. This amendment is modeled on my legislation S. 1769 that clarifies lawsuits could not be based solely on whether medical providers have followed, implemented, or otherwise achieved national guidelines, practice standards, or other quality measures created in federal health laws. While quality measures have an important role in moving towards value-based reimbursement, we must be careful federal constructs do not add to the burden physicians already face with the high costs of medical liability insurance. My second amendment, with Senators Carper and Brown, mirrors an effort that Senator Carper and Coburn have worked hard on for years: illegal diversion of prescription drugs in government health care programs. Unfortunately, prescription drug abuse is a continuing problem in the Commonwealth of Pennsylvania, and our amendment requires the Secretary of Health and Human Services to take new steps to

curb prescription drug abuse involving Medicare beneficiaries.

I would like to thank you for including in the mark two other provisions that are important to me. They include a Government Accountability Office study that Senator Carper and I have requested to focus on opportunities of quality measure alignment and the reduction of compliance burdens on providers. Additionally, Senator Carper and I supported a provision which allows the Program of All-Inclusive Care for the Elderly, known as PACE, to participate in demonstration programs to improve health care services and increase program efficiency. PACE is aimed at keeping frail, elderly Medicare and Medicaid beneficiaries in the community rather than in more costly, long-term care institutions. In Pennsylvania, this program has been extremely successful. We have nineteen PACE programs, the most in the nation.

It is also crucial to mention the importance that the legislation be offset. I look forward to working with colleagues to address how to offset the total cost of the legislation we pass today. It is imperative that Congress act in a fiscally responsible way. While it is fine to have our dessert, we must eat our spinach too.

Repealing the sustainable growth rate and engaging in honest budgeting provides Pennsylvania's 2.3 million Medicare beneficiaries and over 160,000 employees of medical practices with some certainty. This proposal will help Pennsylvania

doctors, improve health outcomes, and is a great – and unfortunately rare – example of members working in a bipartisan manner to address our nation's problems.