Mr. PALLONE. Madam Speaker, today is the last day of this year of the session of Congress, and I just wanted to take the opportunity to thank my press secretary, Heather Lasher Todd, who is actually leaving today and going back to St. Louis, where she is from, with her husband. Both of them used to work for Congressman CARNAHAN, who was here before on the floor.

Many of my colleagues on the Democratic side of the aisle see Heather on a daily basis when she is down here with me trying to get Members to do 1-minutes and other message opportunities, and also worked very hard to have our weekly message meetings and come up with timely topics and people who would speak.

I am going to sorely miss her. I know that many of my colleagues will as well. I just want to wish her and her husband a great future back in St. Louis where they are from.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8, rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered or on which the vote is objected to under clause 6 of rule XX.

Recorded votes on postponed questions will be taken later.

MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

Mr. PALLONE. Madam Speaker, I move to suspend the rules and pass the Senate bill (S. 2499) to amend titles XVIII, XIX, and XXI of the Social Security Act to extend provisions under the Medicare, Medicaid, and SCHIP programs, and for other purposes.

The Clerk read the title of the Senate bill.

The text of the Senate bill is as follows:

S. 2499

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) IN GENERAL.—This Act may be cited as the ''Medicare, Medicaid, and SCHIP Extension Act of 2007''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—MEDICARE

SEC. 101. INCREASE IN PHYSICIAN PAYMENT UPDATE; EXTENSION OF THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) INCREASE IN PHYSICIAN PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(A) in paragraph (4)(B), by striking ''and paragraphs (5) and (6)'' and inserting ''and the succeeding paragraphs of this subsection''; and

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

''(8) UPDATE FOR A PORTION OF 2008.—

''(A) IN GENERAL.—Subject to paragraph (7)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2008, for the period beginning on January 1, 2008, and ending on June 30, 2008, the update to the single conversion factor shall be 0.5 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR THE REMAINING PORTION OF 2008 AND 2009.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for the period beginning on July 1, 2008, and ending on December 31, 2008, and for 2009 and subsequent years as if subparagraph (A) had never applied.''.

(2) REVISION OF THE PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

(A) REVISION.—Section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w–4(l)(2)) is amended—

(i) by striking subparagraph (A) and inserting the following:

''(A) AMOUNT AVAILABLE.—

''(i) IN GENERAL.—Subject to clause (ii), there shall be available to the Fund the following amounts:

''(I) For expenditures during 2008, an amount equal to $150,500,000.

''(II) For expenditures during 2009, an amount equal to $24,500,000.

''(III) For expenditures during 2013, an amount equal to $4,960,000,000.

''(ii) LIMITATIONS ON EXPENDITURES.—

''(I) 2008.—The amount available for expenditures during 2008 shall be reduced as provided by subparagraph (A) of section 225(c)(1) and section 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

''(II) 2009.—The amount available for expenditures during 2009 shall be reduced as provided by subparagraph (B) of such section 225(c)(1).

''(III) 2013.—The amount available for expenditures during 2013 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.''; and

(ii) in subparagraph (B), by striking ''entire amount specified in the first sentence of subparagraph (A)'' and all that follows and inserting the following: ''entire amount available for expenditures, after application of subparagraph (A)(ii), during—

''(i) 2008 for payment with respect to physicians' services furnished during 2008;

''(ii) 2009 for payment with respect to physicians' services furnished during 2009; and

''(iii) 2013 for payment with respect to physicians' services furnished during 2013.''.

(B) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(ii) SPECIAL RULE FOR COORDINATION WITH CONSOLIDATED APPROPRIATIONS ACT, 2008.—If the date of the enactment of the Consolidated Appropriations Act, 2008, occurs on or after the date described in clause (i), the amendments made by subparagraph (A) shall be deemed to be made on the day after the effective date of sections 225(c)(1) and 524 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008 (division G of the Consolidated Appropriations Act, 2008).

(C) TRANSFER OF FUNDS TO PART B TRUST FUND.—Amounts that would have been available to the Physician Assistance and Quality Initiative Fund under section 1848(l)(2) of the Social Security Act (42 U.S.C. 1395w–4(l)(2)) for payment with respect to physicians' services furnished prior to January 1, 2013, but for the amendments made by subparagraph (A), shall be deposited into, and made available for expenditures from, the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(b) EXTENSION OF THE PHYSICIAN QUALITY REPORTING SYSTEM.—

(1) SYSTEM.—Section 1848(k)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)(B)) is amended—

(A) in the heading, by inserting ''AND 2009'' after ''2008'';

(B) in clause (i), by inserting ''and 2009'' after ''2008''; and

(C) in each of clauses (ii) and (iii)—

(i) by striking '', 2007'' and inserting ''of each of 2007 and 2008''; and

(ii) by inserting ''or 2009, as applicable'' after ''2008''.

(2) REPORTING.—Section 101(c) of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note) is amended—

(A) in the heading, by inserting ''AND 2008'' after ''2007'';

(B) in paragraph (5), by adding at the end the following:

''(F) EXTENSION.—For 2008 and 2009, paragraph (3) shall not apply, and the Secretary shall establish alternative criteria for satisfactorily reporting under paragraph (2) and alternative reporting periods under paragraph (6)(C) for reporting groups of measures under paragraph (2)(B) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k)) and for reporting using the method specified in paragraph (4) of such section.''; and

(C) in paragraph (6), by striking subparagraph (C) and inserting the following new subparagraph:

''(C) REPORTING PERIOD.—The term 'reporting period' means—

''(i) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

''(ii) for 2008, all of 2008.''.

(c) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by subsections (a) and (b), in addition to any amounts otherwise provided in this title, there are appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $25,000,000 for the period of fiscal years 2008 and 2009.

SEC. 102. EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS.

Section 1833(u) of the Social Security Act (42 U.S.C. 1395l(u)) is amended—

(1) in paragraph (1), by striking ''before January 1, 2008'' and inserting ''before July 1, 2008''; and

(2) in paragraph (4)—

(A) by redesignating subparagraph (D) as subparagraph (E); and

(B) by inserting after subparagraph (C) the following new subparagraph:

''(D) SPECIAL RULE.—With respect to physicians' services furnished on or after January 1, 2008, and before July 1, 2008, for purposes of this subsection, the Secretary shall use the primary care scarcity counties and the specialty care scarcity counties (as identified under the preceding provisions of this paragraph) that the Secretary was using under this subsection with respect to physicians' services furnished on December 31, 2007.''.

SEC. 103. EXTENSION OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)), as amended by section 102 of division B of the Tax Relief and Health Care Act of 2006, is amended by striking ''before January 1, 2008'' and inserting ''before July 1, 2008''.

SEC. 104. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note) and section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), is amended by striking ''and 2007'' and inserting ''2007, and the first 6 months of 2008''.

SEC. 105. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking ''December 31, 2007'' and inserting ''June 30, 2008''.

SEC. 106. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY; EXTENSION TO THERAPEUTIC RADIOPHARMACEUTICALS.

(a) EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY.—Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by section 107(a) of division B of the Tax Relief and Health Care Act of 2006, is amended by striking ''January 1, 2008'' and inserting ''July 1, 2008''.

(b) PAYMENT FOR THERAPEUTIC RADIOPHARMACEUTICALS.—Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by subsection (a), is amended—

(1) in the heading, by inserting ''AND THERAPEUTIC RADIOPHARMACEUTICALS'' before ''AT CHARGES'';

(2) in the first sentence—

(A) by inserting ''and for therapeutic radiopharmaceuticals furnished on or after January 1, 2008, and before July 1, 2008,'' after ''July 1, 2008,'';

(B) by inserting ''or therapeutic radiopharmaceutical'' after ''the device''; and

(C) by inserting ''or therapeutic radiopharmaceutical'' after ''each device''; and

(3) in the second sentence, by inserting ''or therapeutic radiopharmaceuticals'' after ''such devices''.

SEC. 107. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note), is amended by striking ''the 3-year period beginning on July 1, 2004'' and inserting ''the period beginning on July 1, 2004, and ending on June 30, 2008''.

SEC. 108. EXTENSION OF AUTHORITY OF SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS TO RESTRICT ENROLLMENT.

(a) EXTENSION OF AUTHORITY TO RESTRICT ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended by striking ''2009'' and inserting ''2010''.

(b) MORATORIUM.—

(1) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals under part C of title XVIII of the Social Security Act. The preceding sentence shall not apply to plans designated as specialized MA plans for special needs individuals under such authority prior to January 1, 2008.

(2) ENROLLMENT IN NEW PLANS.—During the period beginning on January 1, 2008, and ending on December 31, 2009, the Secretary of Health and Human Services shall not permit enrollment of any individual residing in an area in a specialized Medicare Advantage plan for special needs individuals under part C of title XVIII of the Social Security Act to take effect unless that specialized Medicare Advantage plan for special needs individuals was available for enrollment for individuals residing in that area on January 1, 2008.

SEC. 109. EXTENSION OF DEADLINE FOR APPLICATION OF LIMITATION ON EXTENSION OR RENEWAL OF MEDICARE REASONABLE COST CONTRACT PLANS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), in the matter preceding subclause (I), is amended by striking ''January 1, 2008'' and inserting ''January 1, 2009''.

SEC. 110. ADJUSTMENT TO THE MEDICARE ADVANTAGE STABILIZATION FUND.

Section 1858(e)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395w–27a(e)(2)(A)(i)), as amended by section 3 of Public Law 110–48, is amended by striking ''the Fund'' and all that follows and inserting ''the Fund during 2013, $1,790,000,000.''

SEC. 111. MEDICARE SECONDARY PAYOR.

(a) IN GENERAL.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraphs:

''(7) REQUIRED SUBMISSION OF INFORMATION BY GROUP HEALTH PLANS.—

''(A) REQUIREMENT.—On and after the first day of the first calendar quarter beginning after the date that is 1 year after the date of the enactment of this paragraph, an entity serving as an insurer or third party administrator for a group health plan, as defined in paragraph (1)(A)(v), and, in the case of a group health plan that is self-insured and self-administered, a plan administrator or fiduciary, shall—

''(i) secure from the plan sponsor and plan participants such information as the Secretary shall specify for the purpose of identifying situations where the group health plan is or has been a primary plan to the program under this title; and

''(ii) submit such information to the Secretary in a form and manner (including frequency) specified by the Secretary.

''(B) ENFORCEMENT.—

''(i) IN GENERAL.—An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

''(ii) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund under section 1817.

''(C) SHARING OF INFORMATION.—Notwithstanding any other provision of law, under terms and conditions established by the Secretary, the Secretary—

''(i) shall share information on entitlement under Part A and enrollment under Part B under this title with entities, plan administrators, and fiduciaries described in subparagraph (A);

''(ii) may share the entitlement and enrollment information described in clause (i) with entities and persons not described in such clause; and

''(iii) may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

''(D) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.

''(8) REQUIRED SUBMISSION OF INFORMATION BY OR ON BEHALF OF LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO FAULT INSURANCE, AND WORKERS' COMPENSATION LAWS AND PLANS.—

''(A) REQUIREMENT.—On and after the first day of the first calendar quarter beginning after the date that is 18 months after the date of the enactment of this paragraph, an applicable plan shall—

''(i) determine whether a claimant (including an individual whose claim is unresolved) is entitled to benefits under the program under this title on any basis; and

''(ii) if the claimant is determined to be so entitled, submit the information described in subparagraph (B) with respect to the claimant to the Secretary in a form and manner (including frequency) specified by the Secretary.

''(B) REQUIRED INFORMATION.—The information described in this subparagraph is—

''(i) the identity of the claimant for which the determination under subparagraph (A) was made; and

''(ii) such other information as the Secretary shall specify in order to enable the Secretary to make an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

''(C) TIMING.—Information shall be submitted under subparagraph (A)(ii) within a time specified by the Secretary after the claim is resolved through a settlement, judgment, award, or other payment (regardless of whether or not there is a determination or admission of liability).

''(D) CLAIMANT.—For purposes of subparagraph (A), the term 'claimant' includes—

''(i) an individual filing a claim directly against the applicable plan; and

''(ii) an individual filing a claim against an individual or entity insured or covered by the applicable plan.

''(E) ENFORCEMENT.—

''(i) IN GENERAL.—An applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant. The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any Medicare secondary payer claim under this title with respect to an individual.

''(ii) DEPOSIT OF AMOUNTS COLLECTED.—Any amounts collected pursuant to clause (i) shall be deposited in the Federal Hospital Insurance Trust Fund.

''(F) APPLICABLE PLAN.—In this paragraph, the term 'applicable plan' means the following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement:

''(i) Liability insurance (including self-insurance).

''(ii) No fault insurance.

''(iii) Workers' compensation laws or plans.

''(G) SHARING OF INFORMATION.—The Secretary may share information collected under this paragraph as necessary for purposes of the proper coordination of benefits.

''(H) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this paragraph by program instruction or otherwise.''.

(b) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed to limit the authority of the Secretary of Health and Human Services to collect information to carry out Medicare secondary payer provisions under title XVIII of the Social Security Act, including under parts C and D of such title.

(c) IMPLEMENTATION.—For purposes of implementing paragraphs (7) and (8) of section 1862(b) of the Social Security Act, as added by subsection (a), to ensure appropriate payments under title XVIII of such Act, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportions as the Secretary determines appropriate, of $35,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008, 2009, and 2010.

SEC. 112. PAYMENT FOR PART B DRUGS.

(a) APPLICATION OF ALTERNATIVE VOLUME WEIGHTING IN COMPUTATION OF ASP.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w–3a(b)) is amended—

(1) in paragraph (1)(A), by inserting ''for a multiple source drug furnished before April 1, 2008, or 106 percent of the amount determined under paragraph (6) for a multiple source drug furnished on or after April 1, 2008'' after ''paragraph (3)'';

(2) in each of subparagraphs (A) and (B) of paragraph (4), by inserting ''for single source drugs and biologicals furnished before April 1, 2008, and using the methodology applied under paragraph (6) for single source drugs and biologicals furnished on or after April 1, 2008,'' after ''paragraph (3)''; and

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

''(6) USE OF VOLUME-WEIGHTED AVERAGE SALES PRICES IN CALCULATION OF AVERAGE SALES PRICE.—

''(A) IN GENERAL.—For all drug products included within the same multiple source drug billing and payment code, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1927(b)(3)(A)(iii) determined by—

''(i) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

''(I) the manufacturer's average sales price (as defined in subsection (c)), determined by the Secretary without dividing such price by the total number of billing units for the National Drug Code for the billing and payment code; and

''(II) the total number of units specified under paragraph (2) sold; and

''(ii) dividing the sum determined under clause (i) by the sum of the products (for each National Drug Code assigned to such drug products) of—

''(I) the total number of units specified under paragraph (2) sold; and

''(II) the total number of billing units for the National Drug Code for the billing and payment code.

''(B) BILLING UNIT DEFINED.—For purposes of this subsection, the term 'billing unit' means the identifiable quantity associated with a billing and payment code, as established by the Secretary.''.

(b) TREATMENT OF CERTAIN DRUGS.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w–3a(b)), as amended by subsection (a), is amended—

(1) in paragraph (1), by inserting ''paragraph (7) and'' after ''Subject to''; and

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

''(7) SPECIAL RULE.—Beginning with April 1, 2008, the payment amount for—

''(A) each single source drug or biological described in section 1842(o)(1)(G) that is treated as a multiple source drug because of the application of subsection (c)(6)(C)(ii) is the lower of—

''(i) the payment amount that would be determined for such drug or biological applying such subsection; or

''(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied; and

''(B) a multiple source drug described in section 1842(o)(1)(G) (excluding a drug or biological that is treated as a multiple source drug because of the application of such subsection) is the lower of—

''(i) the payment amount that would be determined for such drug or biological taking into account the application of such subsection; or

''(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied.''.

SEC. 113. PAYMENT RATE FOR CERTAIN DIAGNOSTIC LABORATORY TESTS.

Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

''(9) Notwithstanding any other provision in this part, in the case of any diagnostic laboratory test for HbA1c that is labeled by the Food and Drug Administration for home use and is furnished on or after April 1, 2008, the payment rate for such test shall be the payment rate established under this part for a glycated hemoglobin test (identified as of October 1, 2007, by HCPCS code 83036 (and any succeeding codes)).''.

SEC. 114. LONG-TERM CARE HOSPITALS.

(a) DEFINITION OF LONG-TERM CARE HOSPITAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Long-Term Care Hospital

''(ccc) The term 'long-term care hospital' means a hospital which—

''(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

''(2) has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or meets the requirements of clause (II) of section 1886(d)(1)(B)(iv);

''(3) satisfies the requirements of subsection (e); and

''(4) meets the following facility criteria:

''(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

''(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, as determined by the Secretary; and

''(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient.''.

(b) STUDY AND REPORT ON LONG-TERM CARE HOSPITAL FACILITY AND PATIENT CRITERIA.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the establishment of national long-term care hospital facility and patient criteria for purposes of determining medical necessity, appropriateness of admission, and continued stay at, and discharge from, long-term care hospitals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and administrative actions, including timelines for implementation of patient criteria or other actions, as the Secretary determines appropriate.

(3) CONSIDERATIONS.—In conducting the study and preparing the report under this subsection, the Secretary shall consider—

(A) recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services; and

(B) ongoing work by the Secretary to evaluate and determine the feasibility of such recommendations.

(c) PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES.—

(1) NO APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT TO FREESTANDING AND GRANDFATHERED LTCHS.—The Secretary shall not apply, for cost reporting periods beginning on or after the date of the enactment of this Act for a 3-year period—

(A) section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals; and

(B) such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by the amendment made by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33).

(2) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

(A) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraph (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in paragraph (c)(3) of such section) are admitted from a co-located hospital.

(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term ''applicable long-term care hospital or satellite facility'' means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations.

(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act for a 3-year period.

(3) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, for the 3-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904, 26992) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

(4) NO APPLICATION OF ONE-TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, for the 3-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(d) MORATORIUM ON THE ESTABLISHMENT OF LONG-TERM CARE HOSPITALS, LONG-TERM CARE SATELLITE FACILITIES AND ON THE INCREASE OF LONG-TERM CARE HOSPITAL BEDS IN EXISTING LONG-TERM CARE HOSPITALS OR SATELLITE FACILITIES.—

(1) IN GENERAL.—During the 3-year period beginning on the date of the enactment of this Act, the Secretary shall impose a moratorium for purposes of the Medicare program under title XVIII of the Social Security Act—

(A) subject to paragraph (2), on the establishment and classification of a long-term care hospital or satellite facility, other than an existing long-term care hospital or facility; and

(B) subject to paragraph (3), on an increase of long-term care hospital beds in existing long-term care hospitals or satellite facilities.

(2) EXCEPTION FOR CERTAIN LONG-TERM CARE HOSPITALS.—The moratorium under paragraph (1)(A) shall not apply to a long-term care hospital that as of the date of the enactment of this Act—

(A) began its qualifying period for payment as a long-term care hospital under section 412.23(e) of title 42, Code of Federal Regulations, on or before the date of the enactment of this Act;

(B) has a binding written agreement with an outside, unrelated party for the actual construction, renovation, lease, or demolition for a long-term care hospital, and has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000); or

(C) has obtained an approved certificate of need in a State where one is required on or before the date of the enactment of this Act.

(3) EXCEPTION FOR BED INCREASES DURING MORATORIUM.—

(A) IN GENERAL.—Subject to subparagraph (B), the moratorium under paragraph (1)(B) shall not apply to an increase in beds in an existing hospital or satellite facility if the hospital or facility—

(i) is located in a State where there is only one other long-term care hospital; and

(ii) requests an increase in beds following the closure or the decrease in the number of beds of another long-term care hospital in the State.

(B) NO EFFECT ON CERTAIN LIMITATION.—The exception under subparagraph (A) shall not effect the limitation on increasing beds under sections 412.22(h)(3) and 412.22(f) of title 42, Code of Federal Regulations.

(4) EXISTING HOSPITAL OR SATELLITE FACILITY DEFINED.—For purposes of this subsection, the term ''existing'' means, with respect to a hospital or satellite facility, a hospital or satellite facility that received payment under the provisions of subpart O of part 412 of title 42, Code of Federal Regulations, as of the date of the enactment of this Act.

(5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395oo), or otherwise, of the application of this subsection by the Secretary.

(e) LONG-TERM CARE HOSPITAL PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

''(2) UPDATE FOR RATE YEAR 2008.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the rate year ending in 2007.''.

(2) DELAYED EFFECTIVE DATE.—Subsection (m)(2) of section 1886 of the Social Security Act, as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before April 1, 2008.

(f) EXPANDED REVIEW OF MEDICAL NECESSITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk–1(a)(4)(G)), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act consistent with this subsection. Such reviews shall be made for discharges occurring on or after October 1, 2007.

(2) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (1) shall be conducted on an annual basis in accordance with rules specified by the Secretary. Such reviews shall—

(A) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

(B) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(3) CONTINUATION OF REVIEWS.—Under contracts under this subsection, the Secretary shall establish an error rate with respect to such reviews that could require further review of the medical necessity of admissions and continued stay in the hospital involved and other actions as determined by the Secretary.

(4) TERMINATION OF REQUIRED REVIEWS.—

(A) IN GENERAL.—Subject to subparagraph (B), the previous provisions of this subsection shall cease to apply for discharges occurring on or after October 1, 2010.

(B) CONTINUATION.—As of the date specified in subparagraph (A), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

(5) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under paragraph (1) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.

(g) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by, this title, in addition to any amounts otherwise provided in this title, there are appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $35,000,000 for the period of fiscal years 2008 and 2009.

SEC. 115. PAYMENT FOR INPATIENT REHABILITATION FACILITY (IRF) SERVICES.

(a) PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by adding at the end the following: ''The increase factor to be applied under this subparagraph for each of fiscal years 2008 and 2009 shall be 0 percent.''.

(2) DELAYED EFFECTIVE DATE.—The amendment made by paragraph (1) shall not apply to payment units occurring before April 1, 2008.

(b) INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA.—

(1) IN GENERAL.—Section 5005 of the Deficit Reduction Act of 2005 (Public Law 109–171; 42 U.S.C. 1395ww note) is amended—

(A) in subsection (a), by striking ''apply the applicable percent specified in subsection (b)'' and inserting ''require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006,''; and

(B) by amending subsection (b) to read as follows:

''(b) CONTINUED USE OF COMORBIDITIES.—For cost reporting periods beginning on or after July 1, 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts toward the percent specified in subsection (a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(A) shall apply for cost reporting periods beginning on or after July 1, 2007.

(c) RECOMMENDATIONS FOR CLASSIFYING INPATIENT REHABILITATION HOSPITALS AND UNITS.—

(1) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with physicians (including geriatricians and physiatrists), administrators of inpatient rehabilitation, acute care hospitals, skilled nursing facilities, and other settings providing rehabilitation services, Medicare beneficiaries, trade organizations representing inpatient rehabilitation hospitals and units and skilled nursing facilities, and the Medicare Payment Advisory Commission, shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes the following:

(A) An analysis of Medicare beneficiaries' access to medically necessary rehabilitation services, including the potential effect of the 75 percent rule (as defined in paragraph (2)) on access to care.

(B) An analysis of alternatives or refinements to the 75 percent rule policy for determining criteria for inpatient rehabilitation hospital and unit designation under the Medicare program, including alternative criteria which would consider a patient's functional status, diagnosis, co-morbidities, and other relevant factors.

(C) An analysis of the conditions for which individuals are commonly admitted to inpatient rehabilitation hospitals that are not included as a condition described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, to determine the appropriate setting of care, and any variation in patient outcomes and costs, across settings of care, for treatment of such conditions.

(2) 75 PERCENT RULE DEFINED.—For purposes of this subsection, the term ''75 percent rule'' means the requirement of section 412.23(b)(2) of title 42, Code of Federal Regulations, that 75 percent of the patients of a rehabilitation hospital or converted rehabilitation unit are in 1 or more of 13 listed treatment categories.

SEC. 116. EXTENSION OF ACCOMMODATION OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED SERVICES.

Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)), as amended by Public Law 110–54 (121 Stat. 551) is amended by striking ''January 1, 2008'' and inserting ''July 1, 2008''.

SEC. 117. TREATMENT OF CERTAIN HOSPITALS.

(a) EXTENDING CERTAIN MEDICARE HOSPITAL WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL YEAR 2008.—

(1) IN GENERAL.—Section 106(a) of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note) is amended by striking ''September 30, 2007'' and inserting ''September 30, 2008''.

(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through September 30, 2008, the special exception reclassifications made under the authority of section 1886(d)(5)(I)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

(3) USE OF PARTICULAR WAGE INDEX.—For purposes of implementation of this subsection, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on October 10, 2007 (72 Fed. Reg. 57634), and any subsequent corrections.

(b) DISREGARDING SECTION 508 HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173, 42 U.S.C. 1395ww note) is amended by adding at the end the following new subsection:

''(g) DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d) of the Social Security Act for purposes of discharges occurring during fiscal year 2008, a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) shall not be taken into account and shall not prevent the other hospitals in such area from continuing such a group for such purpose.''.

(c) CORRECTION OF APPLICATION OF WAGE INDEX DURING TAX RELIEF AND HEALTH CARE ACT EXTENSION.—In the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

(1) a reclassification of its wage index for purposes of such section was extended for the period beginning on April 1, 2007, and ending on September 30, 2007, pursuant to subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note); and

(2) the wage index applicable for such hospital during such period was lower than the wage index applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007,

the Secretary shall apply the higher wage index that was applicable for such hospital during the period beginning on October 1, 2006, and ending on March 31, 2007, for the entire fiscal year 2007. If the Secretary determines that the application of the preceding sentence to a hospital will result in a hospital being owed additional reimbursement, the Secretary shall make such payments within 90 days after the settlement of the applicable cost report.

SEC. 118. ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS, AREA AGENCIES ON AGING, AND AGING AND DISABILITY RESOURCE CENTERS.

(a) STATE HEALTH INSURANCE ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall use amounts made available under paragraph (2) to make grants to States for State health insurance assistance programs receiving assistance under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

(2) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2008.

(b) AREA AGENCIES ON AGING AND AGING AND DISABILITY RESOURCE CENTERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall use amounts made available under paragraph (2) to make grants—

(A) to States for area agencies on aging (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)); and

(B) to Aging and Disability Resource Centers under the Aging and Disability Resource Center grant program.

(2) FUNDING.—For purposes of making grants under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in the same proportion as the Secretary determines under section 1853(f) of such Act (42 U.S.C. 1395w–23(f)), of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2008 through 2009.

TITLE II—MEDICAID AND SCHIP

SEC. 201. EXTENDING SCHIP FUNDING THROUGH MARCH 31, 2009.

(a) THROUGH THE SECOND QUARTER OF FISCAL YEAR 2009.—

(1) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended—

(A) in subsection (a)—

(i) by striking ''and'' at the end of paragraph (9);

(ii) by striking the period at the end of paragraph (10) and inserting ''; and''; and

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

''(11) for each of fiscal years 2008 and 2009, $5,000,000,000.''; and

(B) in subsection (c)(4)(B), by striking ''for fiscal year 2007'' and inserting ''for each of fiscal years 2007 through 2009''.

(2) AVAILABILITY OF EXTENDED FUNDING.—Funds made available from any allotment made from funds appropriated under subsection (a)(11) or (c)(4)(B) of section 2104 of the Social Security Act (42 U.S.C. 1397dd) for fiscal year 2008 or 2009 shall not be available for child health assistance for items and services furnished after March 31, 2009, or, if earlier, the date of the enactment of an Act that provides funding for fiscal years 2008 and 2009, and for one or more subsequent fiscal years for the State Children's Health Insurance Program under title XXI of the Social Security Act.

(3) END OF FUNDING UNDER CONTINUING RESOLUTION.—Section 136(a)(2) of Public Law 110–92 is amended by striking ''after the termination date'' and all that follows and inserting ''after the date of the enactment of the Medicare, Medicaid, and SCHIP Extension Act of 2007.''.

(4) CLARIFICATION OF APPLICATION OF FUNDING UNDER CONTINUING RESOLUTION.—Section 107 of Public Law 110–92 shall apply with respect to expenditures made pursuant to section 136(a)(1) of such Public Law.

(b) EXTENSION OF TREATMENT OF QUALIFYING STATES; RULES ON REDISTRIBUTION OF UNSPENT FISCAL YEAR 2005 ALLOTMENTS MADE PERMANENT.—

(1) IN GENERAL.—Section 2105(g)(1)(A) of the Social Security Act (42 U.S.C. 1397ee(g)(1)(A)), as amended by subsection (d) of section 136 of Public Law 110–92, is amended by striking ''or 2008'' and inserting ''2008, or 2009''.

(2) APPLICABILITY.—The amendment made by paragraph (1) shall be in effect through March 31, 2009.

(3) CERTAIN RULES MADE PERMANENT.—Subsection (e) of section 136 of Public Law 110–92 is repealed.

(c) ADDITIONAL ALLOTMENTS TO ELIMINATE REMAINING FUNDING SHORTFALLS THROUGH MARCH 31, 2009.—

(1) IN GENERAL.—Section 2104 of the Social Security Act (42 U.S.C. 1397dd) is amended by adding at the end the following new subsections:

''(j) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS FOR FISCAL YEAR 2008.—

''(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $1,600,000,000 for fiscal year 2008.

''(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of November 30, 2007, that the Federal share amount of the projected expenditures under such plan for such State for fiscal year 2008 will exceed the sum of—

''(A) the amount of the State's allotments for each of fiscal years 2006 and 2007 that will not be expended by the end of fiscal year 2007;

''(B) the amount, if any, that is to be redistributed to the State during fiscal year 2008 in accordance with subsection (i); and

''(C) the amount of the State's allotment for fiscal year 2008.

''(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2008, the Secretary shall allot—

''(A) to each shortfall State described in paragraph (2) not described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

''(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

''(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

''(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2008, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

''(6) ONE-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2008, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2008. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

''(k) REDISTRIBUTION OF UNUSED FISCAL YEAR 2006 ALLOTMENTS TO STATES WITH ESTIMATED FUNDING SHORTFALLS DURING THE FIRST 2 QUARTERS OF FISCAL YEAR 2009.—

''(1) IN GENERAL.—Notwithstanding subsection (f) and subject to paragraphs (3) and (4), with respect to months beginning during the first 2 quarters of fiscal year 2009, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2006 under subsection (b) that are not expended by the end of fiscal year 2008, to a fiscal year 2009 shortfall State described in paragraph (2), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for such State for the month.

''(2) FISCAL YEAR 2009 SHORTFALL STATE DESCRIBED.—A fiscal year 2009 shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

''(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that was not expended by the end of fiscal year 2008; and

''(B) the amount of the State's allotment for fiscal year 2009.

''(3) FUNDS REDISTRIBUTED IN THE ORDER IN WHICH STATES REALIZE FUNDING SHORTFALLS.—The Secretary shall redistribute the amounts available for redistribution under paragraph (1) to fiscal year 2009 shortfall States described in paragraph (2) in the order in which such States realize monthly funding shortfalls under this title for fiscal year 2009. The Secretary shall only make redistributions under this subsection to the extent that there are unexpended fiscal year 2006 allotments under subsection (b) available for such redistributions.

''(4) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) are less than the total amounts of the estimated shortfalls determined for the month under that paragraph, the amount computed under such paragraph for each fiscal year 2009 shortfall State for the month shall be reduced proportionally.

''(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

''(6) AVAILABILITY; NO FURTHER REDISTRIBUTION.—Notwithstanding subsections (e) and (f), amounts redistributed to a State pursuant to this subsection for the first 2 quarters of fiscal year 2009 shall only remain available for expenditure by the State through March 31, 2009, and any amounts of such redistributions that remain unexpended as of such date, shall not be subject to redistribution under subsection (f).

''(l) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS FOR THE FIRST 2 QUARTERS OF FISCAL YEAR 2009.—

''(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed $275,000,000 for the first 2 quarters of fiscal year 2009.

''(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

''(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that will not be expended by the end of fiscal year 2008;

''(B) the amount, if any, that is to be redistributed to the State during fiscal year 2009 in accordance with subsection (k); and

''(C) the amount of the State's allotment for fiscal year 2009.

''(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for the first 2 quarters of fiscal year 2009, the Secretary shall allot—

''(A) to each shortfall State described in paragraph (2) not described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

''(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of

the amounts determined for each shortfall State under subparagraph (A).

''(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

''(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

''(6) AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2009, subject to paragraph (5), shall only remain available for expenditure by the State through March 31, 2009. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).''.

SEC. 202. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM.

Section 401 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432, 120 Stat. 2994), as amended by section 1 of Public Law 110–48 (121 Stat. 244) and section 2 of the TMA, Abstinence, Education, and QI Programs Extension Act of 2007 (Public Law 110–90, 121 Stat. 984), is amended—

(1) by striking ''December 31, 2007'' and inserting ''June 30, 2008''; and

(2) by striking ''first quarter'' and inserting ''third quarter'' each place it appears.

SEC. 203. EXTENSION OF QUALIFYING INDIVIDUAL (QI) PROGRAM.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended by striking ''December 2007'' and inserting ''June 2008''.

(b) EXTENDING TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(g)(2) of the Social Security Act (42 U.S.C. 1396u–3(g)(2)) is amended—

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

(2) in subparagraph (H), by striking the period at the end and inserting ''; and''; and

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

''(I) for the period that begins on January 1, 2008, and ends on June 30, 2008, the total allocation amount is $200,000,000.''.

SEC. 204. MEDICAID DSH EXTENSION.

Section 1923(f)(6) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)) is amended—

(1) in the heading, by inserting ''AND PORTIONS OF FISCAL YEAR 2008'' after ''FISCAL YEAR 2007''; and

(2) in subparagraph (A)—

(A) in clause (i), by adding at the end (after and below subclause (II)) the following:

''Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be ¾ of the amount specified in the previous sentence for fiscal year 2007.'';

(B) in clause (ii)—

(i) by inserting ''or for a period in fiscal year 2008 described in clause (i)'' after ''fiscal year 2007''; and

(ii) by inserting ''or period'' after ''such fiscal year''; and

(C) in clause (iv)—

(i) in the heading, by inserting ''AND FISCAL YEAR 2008'' after ''FISCAL YEAR 2007'';

(ii) in subclause (I)—

(I) by inserting ''or for a period in fiscal year 2008 described in clause (i)'' after ''fiscal year 2007''; and

(II) by inserting ''or period'' after ''for such fiscal year''; and

(iii) in subclause (II)—

(I) by inserting ''or for a period in fiscal year 2008 described in clause (i)'' after ''fiscal year 2007''; and

(II) by inserting ''or period'' after ''such fiscal year'' each place it appears; and

(3) in subparagraph (B)(i), by adding at the end the following: ''Only with respect to fiscal year 2008 for the period ending on June 30, 2008, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $7,500,000.''.

SEC. 205. IMPROVING DATA COLLECTION.

Section 2109(b)(2) of the Social Security Act (42 U.S.C. 1397ii(b)(2)) is amended by inserting before the period at the end the following ''(except that only with respect to fiscal year 2008, there are appropriated $20,000,000 for the purpose of carrying out this subsection, to remain available until expended)''.

SEC. 206. MORATORIUM ON CERTAIN PAYMENT RESTRICTIONS.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to June 30, 2008, take any action (through promulgation of regulation, issuance of regulatory guidance, use of Federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to impose any restrictions relating to coverage or payment under title XIX of the Social Security Act for rehabilitation services or school-based administration and school-based transportation if such restrictions are more restrictive in any aspect than those applied to such areas as of July 1, 2007.

TITLE III—MISCELLANEOUS

SEC. 301. MEDICARE PAYMENT ADVISORY COMMISSION STATUS.

Section 1805(a) of the Social Security Act (42 U.S.C. 1395b–6(a)) is amended by inserting ''as an agency of Congress'' after ''established''.

SEC. 302. SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2008'' and inserting ''2009''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking ''2008'' and inserting ''2009''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Texas (Mr. BARTON) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

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

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

There was no objection.

Mr. PALLONE. Madam Speaker, I yield 10 minutes to the gentleman from California (Mr. STARK) and ask unanimous consent that he be allowed to control that time.

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

There was no objection.

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

Madam Speaker, when this Congress was first gaveled into session by Speaker PELOSI, she declared it the Children's Congress. With that in mind, we set out to enact an ambitious agenda that included legislation to provide health care to 10 million low-income American children. But we were forced to go it alone. Instead of working with us, the President and his Republican foot soldiers in Congress chose to fight us tooth and nail.

We were not deterred by the President or the opposition that we faced from congressional Republicans. Earlier this summer, the House passed the CHAMP Act, which would have strengthened the Children's Health Insurance Program, CHIP, and helped secure health care coverage for 10 million American children, 4 million of which are presently uninsured and come from hardworking families.

The CHAMP Act also included dramatic improvements for beneficiaries and providers under Medicare, which, if enacted, would have put the program on a more stable financial footing and ensured that seniors have access to the medical care they need and deserve. The CHAMP Act would have also protected Medicaid from harmful regulations which are now about to go into effect and will cut billions of dollars in critical services for low-income and disabled citizens of all ages.

Now, some may see the defeat of the CHAMP Act this year as a great victory for the President and his Republican allies in Congress. But they may have succeeded in being nothing more than obstructionists. No one has gained anything from these actions by the President or my Republican colleagues, least of all the people who rely on these programs for their health care.

This year, we had a chance to strengthen our Nation's health care safety net and improve the lives of our most vulnerable citizens, the elderly, the young, the poor and the disabled. Instead, both the administration and congressional Republicans are content on leaving here this year with doing the bare minimum on CHIP and Medicare when we could have accomplished so much more to improve the health of millions of Americans.

So now, Madam Speaker, we are left with a package that addresses the most immediate concerns, but leaves any real health care improvements for another day, and I think that is very unfortunate. But with the current President and the current Senate, sadly, this is the best we can do. But I will say, Madam Speaker, the Democrats

are determined in the next year to revive the CHAMP Act and the provisions that we care so much about, because we know that that is the best for the American people.

Madam Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Madam Speaker, I yield myself 2½ minutes.

Madam Speaker, it is difficult to speak on this subject because we have debated it so many times in the last 1½ months. Suffice it to say that all is well that ends well, and today we have a bill before us that is going to temporarily fix the physician reimbursement issue. It is going to extend the SCHIP program through March of 2009. It is going to extend the special diabetes program for another year and a number of other things.

These are all good things and people on both sides of the aisle support them. It shouldn't have taken all year to do these things, but it has.

I want to speak very briefly about the SCHIP program. The language in the bill before us is essentially the Barton-Deal language, which Congressman DEAL of Georgia, the ranking member of the Health Subcommittee, and myself introduced 7 or 8 months ago to extend the existing SCHIP program for 18 months, to make sure that all children currently receiving coverage continue to receive coverage, to have a slight increase in funding so that some new enrollments could occur. It is a commonsense approach to an issue while we debate with our friends on the majority side the extent to which we want to expand or change the program.

We have had two Presidential vetoes. We have had enough speeches on the House floor and the other body to probably populate a national forest in terms of the amount of paper that has been used to cover those speeches. And yet we are here today doing what we could have done 11 months ago.

I am very pleased that the SCHIP program is going to be extended. I am very pleased that no State is going to lose funding. I am very pleased that we are going to continue to cover the children that have been covered. And I look forward in the next year to the same offer that Congressman DEAL and Mr. MCCRERY and Mr. CAMP and I have made to our friends on the majority, let's have some hearings.

We now have 15 months. We could hold regular hearings. We could introduce draft bills. We could circulate those bills. We could have a bipartisan dialogue. We could have an actual open, transparent committee markup in both the Ways and Means Committee and the Energy and Commerce Committee. It is still possible in this Congress to have the meetings of the mind on SCHIP in terms of changes to the program, and I hope, Madam Speaker, that that occurs in the next 12 months.

□ 1045

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

I wish I could say I was pleased to be here today to support this important legislation, but you can't say that about this bill the Republicans have brought us.

Last July we sent to the Senate the CHAMP Act, a strong bill that preserved and improved both the Medicare and SCHIP program. The CHAMP Act extended health coverage to 10 million children nationwide. This bill doesn't even come close.

This bill was designed by the Republicans to support their rich friends, the pharmaceutical industry, the for-profit insurance industry, and to destroy Medicare as millions of American seniors have known it, to harm children, and to cast blame at illegal immigrants and working single parents. It shows the Republicans in their truest form: Help the rich at the expense of the poor; to deny government services to anyone, and only help the profit industries who pay them so generously through their campaign contributions, which will be useless, because the public will realize that we don't need them anymore.

The CHAMP Act provided Medicare benefits for all, and it increased protections for low-income beneficiaries. It extended the physicians' reimbursement above par for 2 years and it protected rural providers for those same periods of time. The CHAMP Act overwrote provisions enacted by the former Republican majority designed to end Medicare as an entitlement program. The CHAMP Act was paid for by reducing overpayments to the substandard private plans in Medicare, plans designed to privatize the program by Republicans.

For this effort, House Members, five Republican Members and the Democrats, and our staffs are to be congratulated. They worked hard and took tough and reasoned positions. The Senate failed to act on our legislation and the irresponsible Republicans in the House of Representatives failed to help the children in this country as is their wont.

What we have before us gives the lowest common denominator a bad name. The Senate has sent us a bill that extends otherwise expiring Medicare provisions by a mere 6 months, meaning that we will be back here next summer, next spring trying to fix a system which the Republicans consistently try and privatize and destroy. That is Medicare and SCHIP. For the next 6 months, the bill delays the 10 percent physicians cut, prevents some therapy caps from going into effect, and protects rural providers by extending a host of particular provisions that would otherwise expire.

There are some provisions that run longer. SCHIP will go for 15 months, moving it forward in time when we have a new President, whom we hope will be willing to work with Congress to protect children's health and expand access to care. It also makes longer term reforms to Medicare payment policies for long-term care hospitals and rehab hospitals, two changes that are long overdue.

What is wrong with the bill is what it fails to do. It flat out fails to address real improvements needed for Medicare beneficiaries, many of which we had addressed in the CHAMP Act. It lacks increased protections for low-income beneficiaries; it lacks Medicare mental health parity; it lacks overdue improvements in preventive benefits and nonpayment related reforms to the HMO program. It lacks limits on physician hospital ownership and self-referral. And the list goes on.

Adding insult to injury, this legislation also lets HMOs in the insurance industry off virtually scot free, even though MedPAC, CBO, GAO, the Office of the Inspector General and even the administration's own actuaries confirm that we overpay these second-rate, for-profit plans relative to the rest of Medicare.

I would hope that those of you learned, as I learned, that if you don't like the food, don't eat it, but don't complain about it.

We still have a strong bill pending in the Senate, the CHAMP Act. The Senate must act early in 2008 so that we can reach a better outcome for Medicare. We just can't keep subsidizing the for-profit providers and failing to serve our own children and seniors. So we must proceed as best we can.

I reserve the balance of my time.

Mr. BARTON of Texas. Madam Speaker, may I inquire how much time I have remaining.

The SPEAKER pro tempore. The gentleman from Texas has 17½ minutes.

Mr. BARTON of Texas. Madam Speaker, I ask unanimous consent to yield 10 minutes of that time to the gentleman from Louisiana (Mr. MCCRERY), the ranking member of the Ways and Means Committee, for him to control.

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

There was no objection.

Mr. MCCRERY. Madam Speaker, I agree with some of the comments that have been made by the majority today, not all of them, of course, but some of them.

I think it is a shame that we were not able to reach a bipartisan agreement on a longer term extension of the SCHIP program. As Ranking Member BARTON has pointed out on more than one occasion, though, this process was pretty much doomed from the start because the majority failed to include the minority at all in the early stages of putting together legislation for this important program.

And I understand, it is difficult being in the majority for the first time in 12 years and not really knowing how to get things done. It's tough to govern. It's tough to have the responsibility to actually pass legislation and make law. We did it for 12 years, and we had some troubles ourselves in the first year or

so that we were in the majority. So I understand. But I hope the majority will learn from this experience.

We have two choices, the majority has two choices, really, insofar as dealing with the SCHIP program. And that is, number one, next year they could do as Ranking Member BARTON suggested and have hearings on the SCHIP program and work with the minority hand in hand to try to come up with a reasonable extension reauthorization of this important program.

Number two, they could try the same thing next year that they did this year and get the same result, and then just wait until after the elections and hope that they would have a Democratic President, a Democratic majority, and can do what they want, maybe.

I would submit that the better course is the former, and that is to work with the minority next year. We certainly made that offer this calendar year. I would extend it, at least from my committee's standpoint, that invitation again for next year. And I am hopeful that we can do that.

This bill before us today covers a lot of other things besides the SCHIP program. As Chairman STARK said, we do have in here kind of a stalling of the cliff that physicians find themselves looking over as far as Medicare reimbursement. We only do that for 6 months. We do several other things for 6 months, including therapy caps which I think are very important. So we are under the gun, this Congress is under the gun, and I would submit that means both the majority and the minority early next year to get some things done in the Medicare field.

Again, I certainly want to extend my hand to the majority and offer to work together to get these very important things that are only extended or only dealt with for 6 months in this bill, a more certain future with legislation next year.

Madam Speaker, I reserve the balance of my time.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Madam Speaker, December is a month of holidays, holidays about families; Hanukkah, the Festival of Lights; Kwanzaa about family traditions. At this time of year I always think about my children when they were little, their beautiful faces staring into the creche at the baby Jesus. But during this special time, the very best present we could give 4 million children in this country is the gift of health care.

Every parent knows that quality health care is the foundation for a happy and successful life. Sadly, at this special time, Congress is denying this gift to 4 million children who are eligible right now under the SCHIP program but are not enrolled. Although the House and Senate passed great legislation that would have expanded the coverage to these children, the President has vetoed it twice. And so, reluctantly, I stand here today in full support of current law.

The current SCHIP program is a great one that has worked for 10 years, one that we should all stand up for and be proud of. It will guarantee that the 6 million kids currently enrolled will not lose their health insurance until March 2009.

As the new year draws close though, Madam Speaker, we must recommit ourselves to ensuring that every child in this country who is eligible for SCHIP is enrolled. And that is why I ask the Speaker and my wonderful committee leadership to recommit ourselves to reauthorizing this program earlier than March 2009 so all these kids may be covered.

In addition, Madam Speaker, this bill contains protections for seniors. But, again, it is only a start. There is much more to be done, and I am committed to working with my colleagues to develop a comprehensive bill that will do more than extend protections to doctors and seniors for only 6 months.

Finally, Madam Speaker, I want to commend my colleagues for including extension of the special diabetes program in this bill. This will ensure cures for millions of Americans.

Mr. BARTON of Texas. Madam Speaker, I yield 2½ minutes to the distinguished ranking member of the Health Subcommittee, Mr. DEAL of Georgia, who has worked tirelessly on these issues this year.

Mr. DEAL of Georgia. I thank the gentleman from Texas for yielding.

Madam Speaker, I am pleased to rise today in support of S. 2499. This vital legislation will help preserve Medicare beneficiaries' access to their physicians' services, in addition to providing States certainty as to their ability to cover their SCHIP children for the next 13 months and to continue to enroll eligible children in their programs.

While this bill does not contain the needed reform of the sustainable growth rate formula in Medicare, it averts a payment cut for physicians which, I fear, would have dramatically impacted physician participation in Medicare. Moving forward, I hope that we would work in a bipartisan way to reform this SGR system rather than continuing these short fix programs that we have seen for the last several years. The physicians who serve this Nation's elderly population should not be subject to this annual uncertainty, constantly wondering whether or not they will be able to afford to see their Medicare patients.

On the second subject, for months I have supported a long-term extension of the SCHIP program to ensure that children currently enrolled would continue to have health care services, and to allow States the certainty of funding so that they can continue to enroll eligible children.

In the coming months there should be ample opportunity for SCHIP legislation to move through a regular legislative process without the pressures created by last-minute expiration of the program. I look forward to working with my colleagues on both sides of the aisle on this bill, which would help put and continue to put low-income children first, and continues the purpose of the original program: To serve the neediest children with health care. As a supporter of the program, it is unfortunate to me that we have not been able to reauthorize it for a longer period of time, but this extension should give us the opportunity to do so in a thoughtful and appropriate process. I would hope to work on these issues in a bipartisan fashion next year, and I urge my colleagues to support this bill.

Mr. STARK. Madam Speaker, I am delighted to yield 2 minutes to the distinguished gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. A lot of people have mentioned that in fact this extension will cover the children that presently are in the program. That is half true and half not true. Kids who are on the program will be covered. But if you live in 14 States in the United States, because of the President's executive order, if you live in California, Connecticut, Washington, D.C., Hawaii, Maryland, Massachusetts, Minnesota, Missouri, New Hampshire, New Jersey, Pennsylvania, Rhode Island, Vermont, or Washington, kids in those States will actually come off the rolls in August because of the President's executive order. And in those States, the Governors will have to begin to develop plans to notify those kids and their parents because of the President's executive order.

So not all kids who are on the program will actually stay on the program. And that is just a consequence, after passing two bills to give 10 million children health care, two bills with 45 Republicans and 220 plus Democrats here in the House, and 18 Republicans in the Senate and every Democrat in the Senate, we were unable, which is unique around here, but we were unable to get the President to sign this legislation. And so what we couldn't resolve, the American people will resolve in November.

President Kennedy once said, to govern is to choose. We have made our choice, the President and some on your side made your choice, and in November the American people will make their choice. And that is how differences get resolved here. I think we should understand that.

And so, as the President has said, a lot of children will have universal health care in this country because we have an emergency room in hospitals. A lot of kids will end up in emergency rooms that didn't need to go to emergency rooms.

We did right in a bipartisan fashion to get a bill. In my own view, this will be the first thing that the new Democratic President will get done. We don't need March 9. It will get done within

the first month. It will be a major accomplishment for a Democratic Congress, a Democratic Senate, and a Democratic President.

□ 1100

Starting this August in those 14 States, kids and their parents that did have health care will be notified they will no longer get health care. Now, there is a consequence to that, because August 2008 is 2 months before the election. And I don't think that is a problem. As a matter of fact, we can't protect the American people from the consequences of the President's decision, and a number of Republicans stand by him. We did right. There was a bipartisan bill to resolve a major problem to give 10 million children health care. We didn't accomplish it. We will be back and we will get it done because the American people deserve and the kids deserve the same health care that their Members of Congress and their kids get. This is what that would have done.

Mr. MCCRERY. Madam Speaker, before I recognize the gentleman from Pennsylvania (Mr. ENGLISH), I would just point out under the President's executive order, those States do have the option of covering the low-income children in their States first. If they do that, then they can certainly expand it to higher income children.

At this time I yield 1 minute to the gentleman from Pennsylvania (Mr. ENGLISH).

Mr. ENGLISH of Pennsylvania. Thank goodness they are not going to have to wait a generation for a Democratic President.

This bill, Madam Speaker, is a good resolution to a political impasse and a good solution to the hindering cuts that impede our Nation's physicians and would impact on the health care of our young people and our seniors.

It makes a substantial adjustment for physicians who participate in the Medicare program, albeit only temporary. Although I would have liked to have seen a more permanent and comprehensive solution to a range of Medicare issues, we just couldn't wait and allow 10 percent cuts in payments to physicians to occur. I hope to work with my colleagues on both sides of the aisle on a more permanent solution in the upcoming year to this particularly thorny issue.

The legislation before us also endorses important issues that I have fought hard to be involved with and to make progress on, including extending the exceptions process for therapy caps and a revision of the policy structure for long-term care hospitals. Those are legacy issues that we are going to have to take up sooner rather than later.

I am glad we have a final resolution temporarily on SCHIP. Thank you. I urge a vote for the bill.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from California (Ms. SOLIS).

Ms. SOLIS. Madam Speaker, I thank the gentleman for yielding me this time. Today I stand boldly in support of this Medicare, Medicaid and SCHIP Extension Act.

Madam Speaker, 800,000 children, as you know, in the State of California are covered by this program. It is essential that we continue to provide that coverage. But many, many low-income and minority children will not be covered because previously this President vetoed our bill twice where we would have taken this farther. Instead of the 6 million that are currently in the program, it would have gone to 10 million children. But we can't talk about that now.

But one thing is sure, our constituents, our seniors, are telling us we also need to provide a fix for our doctors because many of our seniors that are on low-income assistance now need to see their doctors, and we know how vitally important that is.

Each and every one of us has an obligation to provide support for the very vulnerable in our communities. And I think there is a saying somewhere, maybe in the Bible, that says we will be judged by how we deal with those that are most vulnerable. And those are our frail, elderly and our children.

I know we can do better. I also pray that we have better outcomes after 2008, because I do believe that our public, our constituents, are demanding that we step up to the plate on health care. That is the number one priority that we are reading about throughout this country, that we cannot stand behind and not speak up here on the House, on the floor and demand that we have better coverage for all of our populations. I speak not only as a Latina and as a woman representing a low-income community, but I think I speak for many millions of people who would like to hear their Congresspeople speaking out loud and shouting out loud about the need for better health care coverage. They are demanding it. Yes, as my former colleague said on the floor, we will probably see those results change once November 2008 arrives.

Merry Christmas to the Congress.

Mr. BARTON of Texas. Madam Speaker, I yield myself 15 seconds just to point out that the subregulatory deadline that Mr. EMANUEL referred to requires States to show a good-faith effort to cover 95 percent of those children below 200 percent of poverty before they cover children above 250 percent of poverty.

I yield 2 minutes to the gentlewoman from Tennessee (Mrs. BLACKBURN), a member of the committee.

Mrs. BLACKBURN. Madam Speaker, I want to compliment Mr. BARTON and Mr. DEAL for the extraordinary amount of work they have done on this issue this entire year. I know that they are pleased that the congressional leadership has joined them in working to be certain that we take the politics out of this issue and we keep the focus on how we address the health care needs of our Nation's most vulnerable, our children and our elderly.

A couple of things that we are going to see in this bill, as you have already heard, the Medicare physician payment schedule, the cut that was to take place is not going to. They are going to see a half percent increase through June 2008. My hope is that we will be able to have the majority work with us to resolve this issue.

I think it is just unconscionable that every single year this SGR gets revisited and we try to work it through. We know that this is something that we are going to be providing. It is a service. Health care is going to be provided for our Medicare enrollees. And, Madam Speaker, this needs to be dealt with and the problem needs to be solved.

I am also pleased that SCHIP is going to be extended through March 2009 and that we are keeping the focus there on standing in the gap between those children that are not eligible for Medicare and those that have the ability to afford private health insurance. This gets back to the original intent of that program to be certain that the children of the working poor are covered.

I am also pleased that this contains the 6-month extension of critical funding for the Tennessee Medicaid DSH payments to our hospitals.

Madam Speaker, there should be some lessons learned from the 1115 waiver process that my State of Tennessee has been through and through the experiment of HILLARY CLINTON health care and the failures of that. As we move forward, I hope we look at those lessons learned.

I appreciate this legislation does provide those DSH payments to these hospitals. I look forward to working with the majority.

Mr. PALLONE. Madam Speaker, I yield 2 minutes to the gentlewoman from New York (Mrs. LOWEY).

Mrs. LOWEY. Madam Speaker, I rise in strong support of the Medicare, Medicaid and SCHIP Extension Act of 2007.

This bill includes a provision based on legislation I introduced with Representatives TANNER, LOBIONDO and HULSHOF that would not only freeze compliance thresholds under the 75 percent rule at 60 percent, it would require CMS to consult rehabilitation facilities in developing recommendations on more appropriate criteria than the 75 percent rule for determining IRF admission policy.

The legislation will stop CMS in its tracks from continuing to implement an out-of-date 75 percent rule that is 100 percent wrong for Americans, and ensure that millions of individuals will continue to have access to the critical care and medical services provided by rehabilitation facilities.

There are a number of individuals I would like to thank for their tireless work on this legislation: Chairman RANGEL and the entire Ways and Means staff, particularly Jon Sheiner, Cybele Bjorklund, and Janice Mays; my partners on this legislation, Representatives TANNER, LOBIONDO, HULSHOF, and

their staffs, Vicki Walling, Dana Richter, and Erik Rasmussen; and my legislative director, Jean Doyle.

And last but certainly not least, the key advocates from hospitals in my district in New York: Dr. Walsh from Burke Rehabilitation Center, Maggie Ramirez from Helen Hayes Hospital, and Keith Safian from Phelps Memorial Hospital.

Your tireless work along with the support of Chairman RANGEL and others in Congress helped us get to where we are today. I urge my colleagues to support this very important legislation.

Mr. MCCRERY. Madam Speaker, how much time remains on each side?

The SPEAKER pro tempore. The gentleman from Louisiana (Mr. MCCRERY) has 6 minutes. The gentleman from New Jersey (Mr. PALLONE) has 2 minutes remaining. The gentleman from California has 2½ minutes remaining. The gentleman from Texas has 3¼ minutes remaining.

The Chair will recognize in reverse order the closing arguments, beginning with the gentleman from Louisiana (Mr. MCCRERY), the gentleman from California (Mr. STARK), the gentleman from Texas (Mr. BARTON), and the gentleman from New Jersey (Mr. PALLONE).

Mr. MCCRERY. Madam Speaker, at this time I recognize the distinguished ranking member of the Health Subcommittee of the Ways and Means Committee, the gentleman from Michigan (Mr. CAMP), for 2 minutes.

Mr. CAMP of Michigan. Madam Speaker, I appreciate the distinguished gentleman yielding me this time.

I am glad we have the opportunity to vote on this legislation today which is critical to protecting doctors from receiving the 10 percent Medicare cut and providing certainty to the SCHIP program, the State Children's Health Insurance.

But let's not kid ourselves. This is the bare minimum and we are capable of much more. It is disappointing that the majority would not work in a bipartisan fashion to craft at least a 1-year reprieve from the Medicare cuts for physicians, as Republicans were able to do in previous years. This 6-month extension is simply putting the problem off and not solving it. The majority knew this 10 percent cut was coming. So what did they do? They passed a CHAMP bill that was fraught with problems that cut home health, skilled nursing facilities, devastated Medicare Advantage and the individual care, and would have left 22 States without one senior receiving Medicare Advantage. That was nearly 6 months ago. And what has happened since then? Nothing.

It is unfortunate that we could not come to a bipartisan compromise on SCHIP, which was and is within reach. A simple extension, while better than what the majority offered, and their offer was transforming a program to assist low-income children to an entitlement for families earning $80,000 a year, is much worse than what was possible.

As I said before on this floor, I stand ready to work in a bipartisan fashion to address the looming cuts faced by physicians in Medicare. I hope we can see this legislation for the Band-Aid that it is and return next year with a commitment from leaders in both parties to enact real long-term Medicare payment reform.

Mr. BARTON of Texas. Madam Speaker, I yield 1¼ minutes to the gentleman from Alabama (Mr. ADERHOLT) who is one of the negotiators of an attempt at a compromise.

Mr. ADERHOLT. Madam Speaker, I would like to thank every Member who has worked on this piece of legislation, and there has been a lot, especially Mr. BARTON and Mr. DEAL who have gone beyond the call of duty in their work. I have been in meetings with them for many hours, so I appreciate their work.

I think we are all disappointed that it has taken so long to come up with a solution, but in the end we have arrived at a correct decision.

When SCHIP was first brought to the floor in 1997, I was a new Member of Congress. It was a bipartisan bill that was enacted by a Republican House and Senate. And it was signed into law by a Democrat President.

This year's process has been anything but bipartisan. I think it would be fair to say that the political rancor in the debate that has occurred over the last several months has surpassed anything that most of us have seen while we have been in Congress. But it is time to move forward and it is time that we remember what is important in this whole process, and that is the children that need health care in America, that are simply the poor in this country.

In my home State of Alabama, SCHIP has been a tremendous success and has helped a new generation of children live happier and healthier lives.

□ 1115

I'm pleased that this Congress has decided to extend this vital program into 2009 and provide a level of certainty to State health directors that did not exist under our previous resolutions. This is a good solution, and I encourage my colleagues to support it.

Mr. MCCRERY. Madam Speaker, I yield 1½ minutes to the gentleman from Texas, the ranking member of the Social Security Subcommittee of the Ways and Means Committee, Mr. JOHNSON.

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Madam Speaker, today we're considering a bill that does some important things. One, it stops the 2008 physician cuts. Two, it extends the Children's Health Insurance Program past the politics of the Presidential election; and three, it helps physicians who are called up for active duty to serve their country. But in reality, this isn't the best bill Congress could have put together, and y'all need to know that.

For the first time, physicians don't know what Medicare will pay them next year. In 6 short months, doctors will once again be facing more than a 10 percent cut in their reimbursements. That uncertainty is no help when you're trying to run a business.

When it comes to physicians who are called up to serve their country and their community, this bill does deliver temporary relief.

Earlier this year Congress moved in a bipartisan fashion to temporarily fix an oversight in Medicare. Previously, the law created a red tape nightmare for any Medicare physician who needed to leave his practice for more than 60 days at a time. The bill before us today continues this fix for just 6 months by allowing our Reservists to have one substitute doctor for their entire deployment.

I look forward to working with my colleagues next year on a permanent fix for this problem. We need to support our troops and the docs that are called up.

Mr. PALLONE. Madam Speaker, I just want to inquire if the other side is prepared to close or has any additional speakers.

Mr. BARTON of Texas. Madam Speaker, I am the only speaker remaining for my portion of the time, so I am prepared to close.

Mr. MCCRERY. Madam Speaker, I have two remaining speakers.

The SPEAKER pro tempore. The gentleman from Louisiana has 3 minutes remaining.

Mr. MCCRERY. Madam Speaker, I would yield 1½ minutes to the gentleman from Georgia (Mr. GINGREY).

Mr. GINGREY. Madam Speaker, I appreciate the gentleman yielding. And I stand today in full support of this 18-month extension of the Children's Health Insurance Program, and also the 6-month mitigation of the payment cut to our physicians under Medicare.

But, Madam Speaker, let me say in regard to that 6-month mitigation, we have done this the whole time that I've been in this Congress, the past 5 years, with a Band-Aid. We're literally doing it this time with a spot Band-Aid, and first thing you know we're going to do a 3-month mitigation and a month-to-month mitigation. It's time to end this flawed sustainable growth rate, just like it's time to end the alternative minimum tax that was not indexed for inflation. They're both flawed, and we need to strike both of them dead permanently.

In regard to the Children's Health Insurance Program, Madam Speaker, the distinguished chairman of the Democratic Conference spoke a little earlier, talking about certain children are going to lose their coverage during this 18-month extension. Well, certain children should lose their coverage if their

families make up to 300 percent of the Federal poverty level, which is about $65,000 a year, and it crowds out those children from needy families who are not being covered.

So this extension, I want to commend my colleague from Georgia, NATHAN DEAL, and Ranking Member BARTON. This is their bill, and this is exactly what we need to do. We need to make sure we have 90 percent coverage saturation and those children up to 250 percent of the poverty level before we consider anything else. I support this extension.

Mr. MCCRERY. Madam Speaker, I have two remaining speakers. I promise this will be the last time I will have two remaining speakers.

At this time I would yield 30 seconds to the gentleman from Missouri, the distinguished minority whip, Mr. BLUNT. And I believe my colleague, Mr. BARTON, is going to also give him 30 seconds.

Mr. BARTON of Texas. Madam Speaker, I would like to yield 30 of my seconds to the gentleman from Missouri (Mr. BLUNT).

The SPEAKER pro tempore. The gentleman from Missouri is recognized for 1 minute.

Mr. BLUNT. Madam Speaker, I thank the gentlemen for yielding.

I'm just here to say that I think this 18-month extension gives us the time we need to make SCHIP an even better program. It extends the current program. It increases funding for the current program. It helps the States that have a shortfall. It ensures that kids who don't have Medicaid, who are in that second 100 percentile, the families who are closest to the Medicaid number, get their coverage first, by not reversing the policies the administration has lately put in place on waivers. It does important things to ensure that the qualifying standards for SCHIP don't change. On those areas that extend Medicare payments to doctors, I would remind my friends here that we're paying for those, most of that, through the stabilization fund on the last big fight here we had. This was the fund we thought we might need to make part D addition to Medicare as a competitive and innovative addition to Medicare work. We didn't need that money because it's working on its own. The last fight we had this big on a health care issue, we kept hearing how terrible it would be for seniors. Eighty-seven percent of the seniors don't think it's terrible at all.

I think we're going to see that this debate also leads to better results for SCHIP, not worse results for SCHIP. I'm glad to see this extension.

The SPEAKER pro tempore. The gentleman from Louisiana has 1 minute remaining.

Mr. MCCRERY. Madam Speaker, I assume all managers of time have one remaining speaker?

Mr. STARK. I have one.

Madam Speaker, I would yield, at this point, 1½ minutes to the distinguished gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Madam Speaker, this pathetic excuse for a Medicare bill is made necessary by a Republican refusal to tackle waste, fraud and abuse. To fulfill an ideological dream, taxpayers are compelled to continue wasting billions of dollars to fund abusive private Medicare Advantage plans run by Bush administration buddies, rather than less expensive, more effective traditional Medicare.

And while doctors are rightly protected from a scheduled payment cut, how about the millions of poor seniors who are cut off from access to extra help for prescription drug coverage? As with so many battles in this Congress, where it is a contest between the poor and a well-financed special interest, guess who gets knocked out?

This shell of a bill actually means that millions of our youngest Americans will still be barred from access to the Children's Health Insurance Program, and, of course, it will enable my State, Texas, to maintain its dubious distinction of being number one, the number one State in the country with children who have no health insurance, due largely to the indifference of then Governor George Bush, now the ''veto-er in chief'' when it comes to children's health insurance.

This House had approved the CHAMP Act. Today, about all that remains of it, thanks to continued Republican obstructionism and one veto after another, is what could be called the CHUMP Act because it reeks of fiscal irresponsibility and social inequity. Something may be better than nothing, but this is barely something. In 18 months we'll correct it.

Mr. MCCRERY. Madam Speaker, I would yield 1 minute to the gentleman from Georgia (Mr. PRICE) and note that I still believe bipartisanship is the way to solving these problems, especially in the next year.

Mr. PRICE of Georgia. I thank my friend for yielding and for his leadership.

There's a recurrent theme that we've heard this month and that is from this majority party that continues to lament the work product of this 110th Congress. You'd think they weren't in the majority.

But it's time to set the record straight about a couple of items. One is SCHIP. The reason that SCHIP hasn't moved forward in the way that they envisioned is because the American people didn't believe that over half of the American children ought to be on a government-run system.

Were there alternatives? Absolutely. The alternative that we put on the table was to reauthorize the program, provide premium assistance for families up to $63,000 and give States greater flexibility. That's a positive solution.

In the area of SGR or the physician reimbursement in Medicare, it's important to appreciate that this 6-month extension is wrong. Medicare is woefully flawed. The 6-month extension is an insult to both patients and physicians.

What we call for is for bipartisanship, for working together to solve the Medicare physician payment program that works well for patients and works for physicians and makes certain that patients and their families control health care, not government.

Mr. STARK. Madam Speaker, I yield myself the balance of the time and agree with the gentleman from Georgia that the fix for the physicians is an abomination, but it was written by the Republicans in the Senate, and with concurrence with Republicans in the House. So I congratulate you for at least recognizing a lousy piece of legislation when it's drafted by Republicans.

The distinguished gentleman from Texas (Mr. BARTON) suggested that all's well that ends well, and that pretty much sums up the Republican philosophy. They've kept 4 million kids from getting health care. They've endangered the health care of many of the 6 million kids on SCHIP now, and they've protected the for-profit insurance industry and other special interests who fund their campaigns to the detriment of the children and the seniors in this country.

You might call that all well, but the Democrats don't.

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

Mr. BARTON of Texas. Madam Speaker, I yield myself the remainder of my time.

The SPEAKER pro tempore. The gentleman is recognized for 1½ minutes.

Mr. BARTON of Texas. I want to compliment Congresswoman LOWEY of New York for working to include the 60 percent fix for the rehabilitation hospitals. I wasn't aware that that was in the bill. I'm very pleased that that is.

I would like to, I guess, compliment my friend from California, Chairman STARK, for at least agreeing that this bill is worthy of coming to the floor.

I would like to point out that the whole purpose of SCHIP is to cover low- and moderate-income kids. That was the original intent. There are many of us on this side of the aisle that still think that should be the intent. If you want to go to some of the larger numbers of coverage of children that are currently not covered, you have to go above 250 and, in some cases, above 300 percent of poverty.

You also are covering right now six to 700,000 adults. There are those like myself that don't think adults need to be covered by SCHIP because those same adults can be covered by Medicaid, which is the coverage for low-income Americans, regardless of how old they are.

I would like to point out the obvious. When you're in the minority, the only way you can get anything passed is to work with the majority. That's self-evident. When you're in the majority

you can pass things in the House just by yourself, but if you want them to become law, you normally have to work with the minority. And I hope this debate on SCHIP has shown people on both sides of the aisle that we should be trying to legislate and work together instead of scoring political points for one particular side.

With that, Madam Speaker, I yield back the balance of my time.

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

The SPEAKER pro tempore. The gentleman from New Jersey is recognized for 2 minutes.

Mr. PALLONE. Madam Speaker, this bill is the result of Republican intransigence. This is a Band-Aid. And I would remind my Republican colleagues who seem to think that this is good legislation, that every day that goes by, more kids are going to get off SCHIP.

They put out that directive of August 17 that says that if a kid's parents lose their job, they would have to wait 1 year before they could get SCHIP coverage.

So the bottom line is more kids are going to go off SCHIP. We're just barely paying for the kids that are on it now.

They're not willing to do anything. They said that they were willing to negotiate. Well, we had negotiations, our majority leader said, for over 100 hours, and they still could not come up with an agreement.

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The President refuses to fund anything. He won't pay through a tobacco increase, the only tax increase. The only thing he says he will do is cut programs to pay for expanded SCHIP that would even make it harder, like cutting Medicare.

So the fact of the matter is we are stuck with this lousy bill that was negotiated between the White House and the Republicans in the Senate. We don't like it. It's simply a temporary measure, and we as Democrats are committed to the fact that in the beginning of next year we're going to take up SCHIP again. We're going to take up the issue of Medicare to try to prevent the privatization that takes place under the current program. We're determined to correct these programs.

But it won't happen if the Republicans continue their intransigence, both at the White House and here in the House of Representatives. There is no reason to believe, based on what they've done in the last 6 months, that this Republican minority wants to work with us to achieve a better result.

So we are stuck with this bill today. It is a Band-Aid approach. We have to pass it so we can continue with the existing programs. But every day that goes by, Medicare suffers because fewer and fewer doctors are likely to take Medicare and fewer and fewer kids are going to get coverage because they're going to have to go to the emergency room because they can't see a doctor on a regular basis. That's not the way to operate. And I have to say that it's totally due to the fault, in my opinion, of the President and the Republicans here in the House of Representatives. I hope this changes in the next year.

Mr. LEVIN. Madam Speaker, it has become clear, not only to my colleagues in Congress, but also to the American people, that the intransigence of President Bush and his supporters in the House and Senate have made it difficult to advance long-needed bills to improve Medicare and expand the Children's Health Insurance Program.

The bill we are considering today in no way reflects negotiations with the Senate on the CHAMP Act that the House approved with a bi-partisan majority on August 1st, and the Senate's Medicare and SCHIP priorities. Rather, it is a skinny health extenders package that generally extends some provisions in current law for only 6 months.

Shoring up Medicare from years of neglect under the Republican Congress and expanding the Children's Health Insurance Program to cover 10 million low-income children are top priorities for me and the New Democratic Majority in Congress. That is why the House approved the CHAMP Act of 2007 to eliminate the scheduled Medicare physician payment cuts for the next 2 years and expand the Children's Health Insurance Program to cover 10 million low-income children nationwide. The only reason that the legislation we approved in August to improve the Medicare and SCHIP programs has not been signed into law is because President Bush and his allies in Congress oppose it.

There are several provisions of importance back home that I wish to recognize. We were able to keep in the health extenders bill a moratorium on cuts to school-based Medicaid services that the Administration has proposed. We have included a 6-month extension of a wage-reclassification program in the Medicare program, and have provided funding to extend the Special Diabetes Program for research, treatment and prevention of diabetes through September 30, 2009.

Unfortunately, imperative improvements to the Medicare program have been dropped from the bill. Improvements approved in the House in August include mental health parity for seniors, making prevention more accessible by eliminating co-pays and deductibles for preventative services like mammograms and colonoscopy screenings, and expanding programs that help low-income seniors pay for their health care and prescription drugs.

The Children's Health Insurance expansion that has been dropped from the bill would have extended children's health insurance to enroll 6 million kids that are currently eligible for the program and not yet enrolled. That's in addition to the 6 million low-income children already receiving health care under the SCHIP program nationwide, including 55,000 kids in my home state of Michigan whose parents make between $20,535 and $41,300 a year.

I urge my colleagues to support the short-term extensions in the legislation before us today, and to join me in addressing long-needed reforms to Medicare and SCHIP in the new year.

Ms. WOOLSEY. Madam Speaker, I support S. 2499, the Medicare, Medicaid and SCHIP Extension Act of 2007. It's important that Congress pass this legislation today to ensure that our Nation's poorest children retain their health insurance and doctors who take care of our seniors on Medicare do not receive a 10 percent cut in reimbursements.

It's deeply disappointing that this bill doesn't address the issue of the Medicare physician geographic payment discrepancy that is faced by many areas in California and across the country. One of these areas is Sonoma County, in my District. This inconsistency has led to doctor's reimbursements being based upon their geographic location and not the true cost of providing services. Because of this discrepancy, doctors in Sonoma County receive a lower payment for the same services than doctors in next door Marin County and this discrepancy is causing doctors to leave Sonoma County. Congress needs to act to fix this discrepancy and ensure that physicians with Medicare patients can continue to afford to see their patients regardless of where their practice is located.

Because of the Republican led efforts, the bill only delays a real solution to the Medicare physician payment cuts that all doctors are facing. We can and must do better for our seniors. When the Medicare extension expires in June, we owe it to our seniors and physicians to replace it with a permanent fix to the physician payment cuts and payment discrepancies.

With this bill, the State Children's Health Insurance Program (SCHIP) will be extended and states will receive enough funding to keep all the children currently enrolled on SCHIP from being removed from the program. But, this bill doesn't help the millions more children whose families cannot afford health insurance and who should be covered under SCHIP. Earlier this year, Congress passed an SCHIP bill that would have given 4 million more children healthcare, for a total of 10 million children receiving healthcare on SCHIP. However, the Administration showed that its priorities are completely out of line with the rest of this country when it vetoed that legislation. We need to do better for our nation's children and provide all of them with the healthy start and security that SCHIP can provide.

I urge my colleagues to support this bill and look forward to working with them to provide a permanent solution to the Medicare physician payment issues and in ensuring that every child in America is insured.

Mr. LANGEVIN. Madam Speaker, I rise today to express my support for S. 2499, the Medicare, Medicaid and SCHIP Extension Act. This bill includes a number of provisions that are essential to the continued delivery of vital healthcare programs to our Nation's most vulnerable citizens.

This measure offers much-needed relief to physicians that serve our Medicare population by providing a 6-month suspension of the 10-percent cut in Medicare payments scheduled to occur on January 1, providing instead a modest increase of 0.5 percent. It also extends important incentive payment programs that provide a 5-percent bonus to physicians serving areas with a shortage of doctors, while ensuring that Medicare beneficiaries have continued access to therapy services through June 30, 2008.

Also included in this bill is a vital extension for the State Children's Health Insurance Program (SCHIP) through March 31, 2009. Currently, 24,900 Rhode Islanders are enrolled in

the SCHIP portion of Rhode Island's model RITE Care program. As a proud Representative of Rhode Island and a longtime supporter of SCHIP, I cannot stress enough how important this program is to the health and well-being of our children, expectant mothers and parents alike. Although this was not the outcome that I and many of my colleagues originally envisioned for SCHIP, this extension is crucial for States like Rhode Island that are facing tremendous budgetary shortfalls.

Madam Speaker, access to quality, affordable healthcare is integral to the prosperity of every American. While I am pleased that this Congress was able to reach a compromise to provide temporary relief for our country's most important safety net programs, I believe that we have the potential to do so much more. Health care providers that have pledged to continue serving the aging, disabled, and low-income citizens deserve more than stopgap measures and temporary relief. This Congress has an obligation to take meaningful action to reform and stabilize the Medicare provider payment system, as well as to ensure the continued strength and success of our Medicaid and SCHIP programs. To that end, I will continue to work in a bipartisan manner with my colleagues in an effort to guarantee that these issues are properly addressed in this and future Congresses.

Mr. ETHERIDGE. Madam Speaker, I rise in support of this legislation and the critical services provided by Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). This legislation ensures continued access to our nation's health care system for our most vulnerable citizens—children, seniors, the poor, and the disabled. It also extends incentives that allow health care providers to maintain practices in rural areas. These federal efforts are critical to maintaining healthy and productive communities across the country, and particularly in North Carolina's 2nd District.

North Carolina's citizens are at risk when reimbursements to physicians fall below the cost of providing care, and doctors must shut their doors or turn away patients because they cannot afford to attend to them. North Carolina's citizens are at risk when children go without care, and untreated illnesses or foregone preventative care reduces the health and productivity of those who will build our future. North Carolina's citizens are at risk when Congress fails to act to preserve benefits that they depend on.

The health of Americans and the future health of America depend upon the availability of and access to health care. I applaud our leaders in the House and Senate for working in a bicameral, bipartisan manner to craft this legislation so that our doctors, hospitals, and other health care providers can continue their service to keep our citizens healthy.

This legislation improves physician quality and access by averting the planned 10 percent cut in physician payments and extending the Medicare physician quality reporting system. It continues Medicare policy that provides a measure of fairness to the payment system for rural providers so that they can continue providing valuable services to individuals in rural parts of the 2nd District and across the country. I am hopeful that when Congress returns in 2008, we make extending these provisions on a long-term basis a priority so that providers can plan to remain in our communities for the long-term.

As the only former State schools chief serving in Congress, my life's work has been to provide for a better future for the next generation, and health care is critically important to that effort. This legislation averts the threat that States will run out of funds for the State Children's Health Insurance Program, or SCHIP. North Carolina's Health Choice, which serves over 250,000 needy children, will now be able to plan enrollment for the next year, whereas without this legislation it would have run out of money next March. While I am disappointed that this legislation does not enable the coverage of additional children, we owe it to the children currently served by SCHIP to ensure that they are continuously covered and can get the health care they need when they need it. I look forward to working with my colleagues in the future to fulfill the vision of health access for all children.

Madam Speaker, a lack of access to health care has impact beyond the individual who suffers a sickness without treatment. Untreated illnesses have long-term consequences, and ensuring access to health care contributes to a healthy and productive society and heads off expensive treatments down the road. This legislation is necessary to keep providers in our communities, and I urge my colleagues to join me in supporting it.

Mr. SPACE. Madam Speaker, I rise today in support of the legislation before us that will help both seniors and children alike receive the health care that they deserve, and continue our national investment in combating chronic disease.

I am particularly pleased to see that the legislation includes an extension of the Special Diabetes Program, which affords critical research funding to research into type one diabetes. Every year, thousands of parents receive the tragic news that their child will have to bear the burden of juvenile diabetes. With this news comes the realities of a life permanently changed by a disease for which we currently have no cure.

As I have shared with the House before, I am one of these parents. Nearly a decade ago, my wife and I learned that my son Nick would have to face the challenge of type one diabetes. We have been blessed and fortunate that Nick has lived an active and normal life. His successes are in large part thanks to the insulin pump he wears and other innovations that help type one diabetes patients manage their disease.

While Nick and so many other children have been able to manage their disease, they still worry about their future. It is the obligation of Congress to work towards finding a cure. The Special Diabetes Program provides the guarantee of continued, groundbreaking research into this disease. The yields of this research hold unquestioned promise for a better future.

I am disappointed that the extension of the program prescribed in this legislation is only one year. An overwhelming bipartisan group of my colleague in both the House and Senate expressed support for a longer extension of the program. Unfortunately, those who carry the weight of type one diabetes were casualties of partisan warfare over other, unrelated issues.

I look forward to working with my colleagues next year to ensure a longer renewal of this legislation. Congress has an obligation to lead the charge against this disease. I know that we can meet this challenge if we work together.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the Senate bill, S. 2499.

The question was taken.

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

Mr. BARTON of Texas. Madam Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECT, ATLANTA, GEORGIA

Mr. FILNER. Madam Speaker, I move to suspend the rules and pass the Senate bill (S. 1396) to authorize a major medical facility project to modernize inpatient wards at the Department of Veterans Affairs Medical Center in Atlanta, Georgia.

The Clerk read the title of the Senate bill.

The text of the Senate bill is as follows:

S. 1396

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

SECTION 1. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECT, ATLANTA, GEORGIA.

The Secretary of Veterans Affairs may carry out a major medical facility project for modernization of inpatient wards at the Department of Veterans Affairs Medical Center, Atlanta, Georgia, in an amount not to exceed $20,534,000.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. FILNER) and the gentleman from Indiana (Mr. BUYER) each will control 20 minutes.

The Chair recognizes the gentleman from California.

Mr. FILNER. Madam Speaker, I yield myself such time as I might consume.

I want to thank all the Congress colleagues from Georgia, especially my Atlanta colleagues Mr. JOHNSON and Mr. LEWIS, and especially the Senator from Georgia, Senator ISAKSON, for making sure this is on the floor today.

The poor state of a lot of the infrastructure of the Veterans Affairs is well-known.

Through what we call the CARES process, the Capital Asset Realignment for Enhanced Services, the department found that the existing inpatient wards at the Atlanta VA Medical Center are far below community standards.

This renovation project will go a long way to address the American with Disabilities Act accessibility requirements, the needs of women veterans, particularly as they relate to privacy issues, and the improvements in efficient functional design.

These deficiency corrections are long overdue, and we think they will be met