your collective concern regarding provisions in the American Infrastructure Investment and Improvement Act that relate to the manner in which tax revenues authorized in the Act are provided to the Federal Aviation Administration for its procurement needs. We all share the same interest in modernizing our air traffic control system as quickly and efficiently as possible.

We appreciate your concerns regarding the role of un-elected entities in developing Federal policy, and we believe strongly that Congress should retain its constitutional authority to raise revenue and appropriate funding.

In your letter, you voice your concern that our bill, as drafted, might result in the FAA receiving annual mandatory funding outside of your Committee's control. You also voice concern that provisions of our bill could result in an external un-elected board, rather than Congress, having the authority to make Federal funding allocations to specific FAA procurements.

In order to eliminate any ambiguity regarding these matters, it will be our intention to immediately modify the text of our bill when it either reaches the Senate Floor or is incorporated into any other vehicle so as to ensure that these concerns are addressed. Specifically, the bill will be modified to ensure that no new mandatory funding will be provided to the FAA and that the Committee on Appropriations will continue to retain its current role of determining the final funding level for all programs, projects, and activities within the Federal Aviation Administration through annual and supplemental appropriations acts.

Our national aviation enterprise faces a great many challenges in the years ahead as air traffic continues to grow faster than available capacity. Our Committee is committed to working as a partner with your Committee to ensure that we establish and maintain the safe and efficient state-of-the-art air traffic control system that the American taxpayers want and deserve.

MAX BAUCUS.
CHUCK GRASSLEY.

Mrs. MURRAY. Mr. President, the final paragraph of the letter our Appropriations Committee received from Chairman BAUCUS and Ranking Member GRASSLEY of the Finance Committee states that they look forward to working with our Appropriations Committee as partners in advancing the needs of our aviation system.

As one member of the subcommittee that oversees aviation funding, I express my strong interest in working as a partner with both committees to come up with a bill that fully addresses the future needs of our national aviation system. I hope that important effort will be one of the Senate's first priorities when we reconvene next year.

I yield the floor.

The PRESIDING OFFICER. The Senator from Illinois.

## MEDICARE, MEDICAID, AND SCHIP EXTENSION ACT OF 2007

Mr. DURBIN. Mr. President, I ask unanimous consent that the Senate proceed to immediate consideration S. 2499, introduced earlier today.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A 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.

There being no objection, the Senate proceeded to consider the bill.

Mr. GRASSLEY. Mr. President, as we approach the end of 2007, one cannot help but look ahead and see that there are many challenges that await us in the second session of the 110th Congress, specially in addressing issues relating to health care. In 2008, we will need to take a serious look at many issues in the Medicare Program. Among them will be continuing to work on developing a solution for Medicare's flawed physician reimbursement system. As usual, I look forward to working with my partner on the Senate Finance Committee, chairman, Senator MAX BAUCUS, in our usual bipartisan way to address this and many other issues.

However, before we could adjourn this first session and go home to enjoy the holidays with our families, there was still urgent work to finish. That was the purpose of this exercise. In the legislation we considered today, there were several provisions that rise to the level of ''must do's.'' These included ensuring that physicians do not receive a drastic cut in their Medicare reimbursement and extending a number of expiring provisions including the State Children's Health Insurance Program.

Ensuring health care access to my constituents is a top priority of mine and the possibility of a negative update for physicians was of great concern to me as well as to doctors and patients in Iowa and elsewhere. When discussions began to solve this problem I was in favor of a 2-year update. I know that several of my colleagues were as well. But in continuing negotiations with the House and Senate colleagues it became apparent that a 2-year fix was not possible.

I wanted to do more. I know Senator BAUCUS wanted to do more. We were unable to reach consensus even on the Republican side either and, therefore, the Finance Committee was unable to move ahead with the legislation that Senator BAUCUS and I had been developing. Unfortunately, for a variety of complex reasons, we are now here with a much more limited package. This is a disappointment for many of us. So the purpose of moving forward with a 6-month package now is to provide the opportunity for the Finance Committee to address these priorities next year.

One of my first priorities has been to ensure access to rural hospital services. Since hospitals are often not only the sole provider of health care in rural areas, but also significant employers and purchasers in the community, it is especially important that they are able to keep their doors open. One group of hospitals that I am especially concerned about are ''tweener'' hospitals, which are too large to be critical access hospitals, but too small to be financially viable under the Medicare hospital prospective payment systems. The struggles these facilities face in Iowa are real and serious. I am very disappointed we were not able to help these hospitals in this package. I look forward to working with Senator BAUCUS and other Members to include ''tweener'' hospital improvements in next year's package.

Second, we must address the problem of specialty hospitals. I have been an outspoken advocate against these facilities for several years now. My primary concern with these facilities is the inherent conflict of interest that exists when physicians have an ownership interest in the facilities to which they refer patients. The best interest of the patient should always be the deciding factor when a referral for treatment is made, not the financial self-interest of the doctor who is treating the patient. I strongly support a competitive marketplace and free market forces, but not at the expense of decreasing access to health care for the poor and uninsured or decreasing the quality of care for and safety of patients. I have been and remain concerned about the ability of community hospitals to provide care to all patients. I also look forward to working with Senator BAUCUS on addressing this issue in our package next year.

There are a number of other important issues that need to be addressed as well. We need to take on the reforms of the Medicare Quality Improvement Organization Program, we need to inject some sunshine into the payments that drug companies make to doctors, and we also need to make sure that Medicare is part of the solution when it comes to greater use of electronic prescribing and electronic health records.

In the meantime, we have this package with the following provisions that extend a number of Medicare, Medicaid and SCHIP provisions.

This legislation prevents the 10.1 percent cut to physician payment that would have occurred as of January 1, 2008, and instead gives a 6-month 0.5 percent update for physicians through June 30, 2008. In effect, this provides a 10.5 percent increase in physician fees from what they would otherwise have received beginning in January under current law. While this is not what many of us had in mind when we began this process, providing an update through next June will allow more time and the opportunity for a bill to fully go through the legislative process beginning with a committee markup next year.

This legislation also continues to provide additional payment incentives for physicians and other health care practitioners who report quality measures in the Physician Quality Reporting System. We must ensure that health care providers can afford to continue to practice medicine. We must also ensure that beneficiaries have access to physicians and other health care providers. And we must provide incentives for quality improvement.

We also accommodate physicians ordered to active duty in the Armed Services by extending for 6-months a provision that permits them to engage in substitute billing arrangements for longer than the 60 days allowed under current law when they are ordered to active duty.

Our legislation also revises the Physician Assistance and Quality Initiative Fund, which is intended to help stabilize physician payments and promote physician quality initiatives.

This new fund will be available in 2008 to help minimize fluctuations in physician payments and promote physician quality initiatives.

The physician payment changes will be offset, in part, by an adjustment to the Medicare Advantage stabilization fund. Our legislation does not repeal the stabilization fund but rather preserves the fund for future years. We use the $1.5 billion available in 2012, while preserving the fund in 2013. Given the continued strong participation by plans in the program right now, the legislation preserves the fund so that Congress can add more funds in future years if they are needed.

The legislation extends Medicare private plan cost contracts through 2009, which, without this legislation, are due to expire at the end of 2008. These are longstanding plans that provide health care to Medicare beneficiaries in many communities but have been unable to convert to Medicare Advantage plans. In addition, the legislation includes a 1-year extension to Medicare Advantage special needs plans through 2009. At the same time, the legislation puts a moratorium on new special needs plans. When Congress enacted the Medicare Modernization Act in 2003, it created a category of plans intended to provide specialized care models for certain populations, including Medicare beneficiaries who are also eligible for Medicaid, those who are chronically and severely ill or disabled, and those who are institutionalized (for example, in nursing homes). While these plans have proliferated, it is unclear how well they are meeting their mission of specialized care. The legislation freezes the program at the plans currently approved so that Congress and CMS can monitor the plans' performance and determine if any changes are needed.

In addition to reforming the manner in which Medicare pays for physician services, this legislation will extend several expiring provisions enacted in the Medicare Modernization Act to help ensure that beneficiaries will continue to have access to needed medical services. This includes provisions applicable to rural payments to physicians, extending the 1.0 floor on the work geographic adjustment, continuing direct payments to independent laboratories for physician pathology services, and continuing Medicare reasonable cost payments for lab tests in small rural hospitals.

Our legislation also provides a 6-month extension of the therapy cap exceptions process that was included in the Tax Relief and Health Care Act last year to ensure that beneficiaries receive the physical, occupational, and speech language therapy services they need. It also extends the existing payment methodology for brachytherapy services and extends it to therapeutic radiopharmaceuticals through June 30, 2008.

As in previous legislation that Congress has passed, this legislation will continue to improve accountability in the Medicare Program. There are situations when Medicare is not the primary payer for a beneficiary's health care, but it is currently difficult to identify these situations. This legislation will improve the Secretary's ability to identify beneficiaries for whom Medicare is the secondary payer by requiring group health plans and liability insurers to submit data to the Secretary.

The legislation will ensure beneficiary access to long-term care hospitals. These facilities will receive regulatory relief for 3-years. In order to ensure patients are receiving appropriate levels of care at long-term care hospitals, facility and medical review requirements will be established, and the Secretary will be required to conduct a study on long-term care hospital facility and patient criteria. Also, there will be a limited moratorium on the development of new long-term care facilities and a freeze to the annual long-term care hospital payment update for one quarter in rate year 2008.

The legislation will also ensure beneficiary access to inpatient rehabilitation facility services by addressing the 75-percent rule. This rule has been criticized as too blunt an instrument for ensuring that appropriate patients receive care at these facilities. Under current law, a percentage of Medicare patients must have at least 1 of 13 listed medical conditions in order to be classified as an inpatient rehabilitation facility. This percentage or compliance threshold is currently at 65 percent. This legislation would permanently freeze the compliance threshold at 60 percent and allow comorbid conditions to count permanently toward this threshold. The Secretary will be required to study beneficiary access to inpatient rehabilitation services and care at inpatient rehabilitation facilities and to make recommendations for alternatives to the 75-percent rule. In addition, there will be a freeze to the annual inpatient rehabilitation facility payment update from April 1, 2008 through fiscal year 2009.

This legislation will also continue to promote more accurate hospital payments. One aspect of Medicare hospital payments that has been subject to much criticism is the area wage index. Many say that the current method of calculating the wage index does not reflect a hospital's actual labor costs and is instead arbitrary in nature so that similarly situated hospitals can receive significantly different wage index values. Since the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, hospitals have been able to obtain relief from this unfair situation temporarily.

The legislation also provides more accurate payment for Part B drugs. It implements recommendations of HHS Office of Inspector General and requires CMS to adjust its average sales price, ASP, calculation to use volume-weighted ASPs based on actual sales volume. It also establishes appropriate reimbursement rates for generic albuterol and for glycated hemoglobin diabetes laboratory tests.

In the Medicaid arena, the legislation extends the provision of disproportionate share hospital payments to Tennessee and Hawaii for the first three-quarters of the current fiscal year. These payments were authorized for these States for the first time in last year's Tax Relief and Health Care Act and this is an extension of that policy.

The legislation also delays implementation of recently released regulations on school-based services and rehabilitation services in Medicaid so that the Finance Committee can appropriately review those regulations.

And finally, the legislation also includes an extension of the State Children's Health Insurance Program, SCHIP, through March 31, 2009. This provision makes additional funding available so that States do not have to scale back SCHIP. This SCHIP extension will ensure that no State has to cut back their program due to insufficient Federal funding.

I remain hopeful that when the 110th Congress reconvenes next year, there will be a renewed effort to reauthorize and improve SCHIP.

The bill we considered today addressed the things Congress needed to do before going home for the holidays. I am pleased we were able to act quickly and unanimously to pass the bill. I know many of my colleagues wanted to do more. I know some of my colleagues are disappointed because their individual priorities could not be included. It is unfortunate. I do hope we can do more when we come back next year.

Next year is an election year. The caucuses in my home state of Iowa are but days away. We have important business to conclude in Medicare and Medicaid and SCHIP. We have a Democratic Congress that has to work with a slim majority in the Senate and a Republican President. At times this year, I am not sure my colleagues on the other side of the aisle fully grasped the consequences of that reality. It certainly shows when you consider what we could have done this year and what was ultimately accomplished. I sincerely hope we do a better job of being bipartisan albeit in a political year.

Let me be clear that I stand ready to roll up my sleeves and get back to work come January. I am committed to moving ahead with the broader Medicare package when we return here next year. To make law, that package

will have to be one that the President will sign. It will require bipartisan cooperation and hard work. I am ready to get the job done. There are many problems that need to be addressed, and we can address the myriad issues that we left on the table. We can review and act on the proposed Medicaid regulations that have so many people vexed. We can pass a SCHIP reauthorization that can become law. We have learned the pathway to failure this year. I stand ready to join any of my colleagues who want to join me on the path not taken in 2007 to a more productive 2008.

As we move to the end of the first session of the 110th Congress, I want to extend my grateful appreciation to my health staff and others for the work they have done in 2007. My staff director on the Finance Committee, Kolan Davis, has been with me for many, many years and provides me invaluable counsel. My chief health policy counsel, Mark Hayes, accomplishes more every day than any other hundred people on the Hill combined and for his tireless work ethic, I am truly thankful. My Medicare Part A counsel, Mike Park, labored through the last several weeks though he was sick as a dog because it is that important. My Medicare Part B counsel, Sue Walden, ably deciphered the multiple variations we considered for providing an update to the physicians. The newest member of my team, Kristin Bass, who handles Medicare Parts C and D, helped us reach thoughtful compromises on numerous challenging issues. My Medicaid staffer, Rodney Whitlock, deftly handles the most controversial of issues day in and day out. I particularly want to pay tribute to my SCHIP staffer, Becky Shipp. We may have not accomplished what we hoped to do with SCHIP this year, but we wouldn't have been remotely close without Becky's expertise and effort. My team benefits from the able assistance of Sean McGuire and Shaun Freiman going above and beyond the call of duty to make sure the little things get done. I also want to thank Senator MCCONNELL's point person on health care, Meg Hauck, for working with us throughout the year. The Finance Committee benefits from that strong working relationship.

We work as hard as we possibly can to achieve bipartisan consensus in the Finance Committee and so I also want to pay tribute to Senator BAUCUS' staff: staff director Russ Sullivan, Michelle Easton, Neleen Eisinger, Billy Wynne, Shawn Bishop, David Schwartz, and Catherine Dratz.

We benefit greatly from the Congressional support staff as well. Tom Bradley, Tim Gronniger, Shinobu Suzuki, Jeanne De Sa, Eric Rollins and all of the hard-working scoring gurus at CBO. Jim Fransen, John Goetcheus, Kelly Malone, and Ruth Ernst at Senate Legislative Counsel. Jennifer O'Sullivan, Rich Rimkunas, Chris Peterson, April Grady, Elicia Herz, Sybil Tyson, Mark Hamelburg, Erin Taylor and all the folks at CRS. Mark Miller and all of his staff at MedPAC. They make us look a lot more intelligent and effective than we actually are some days.

Finally, I want to thank some folks at CMS. Liz Hall, Erin Clapton, Ira Burney, Richard Strauss are people who help make sure we get things right even when we aren't in complete agreement.

In closing, I want to thank all those folks for their hard work in 2007 in service to the people of Iowa, Montana, and all of America. Thank you.

Mr. HATCH. Mr. President, I rise in support of this package and want to commend my colleagues on a job well done.

To be fair, it would have been my preference to do a broader bill and resolve the myriad of Medicare-, Medicaid- and CHIP-related issues we have been discussing for many months now. Given that this has proven impossible, my overriding concern is that we move ahead with flawed correction to the physician reimbursement formula, as this bill does.

Indeed, while most of us would have preferred to have a longer term physician fix, this bill is a reasonable compromise. Physicians will be able to practice medicine without having their Medicare reimbursement rates significantly reduced. And that means that Medicare beneficiaries will continue to have access to quality health care.

I also am pleased about other provisions in this legislation, particularly those related to policy on long-term care hospitals and inpatient rehabilitation facilities, IRFs. With regard to long-term care hospitals, Senator CONRAD and I introduced legislation, S. 1958, Medicare Long-Term Care Hospital Patient Safety and Improvement Act of 2007. I am proud that the long-term care hospital provisions in today's Medicare legislation are based on the legislative language from the Conrad-Hatch bill. The legislation before us provides regulatory relief to allow continued access to current long-term care hospital services; requires new facility and medical reviews to ensure that patients are receiving appropriate care; and authorizes a study by the Secretary of Health and Human Services, HHS, on long-term care hospitals and patient criteria. This legislative language reflects compromises that were made between the various trade groups for long-term care hospitals and finding policy solutions which generate savings for Medicare.

As a proud cosponsor of S. 543, Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007, I am also pleased that the Medicare bill eliminates the 75 percent rule implemented by the Centers for Medicare and Medicaid Services, CMS, for rehabilitation hospitals. Instead, this legislation permanently freezes the inpatient rehabilitation services compliance threshold at 60 percent and allows comorbid conditions to count toward this threshold. Finally, it requires the Secretary of HHS to study beneficiary access to inpatient rehabilitation services and care at IRFs and make recommendations on how to classify inpatient rehabilitation facility hospitals and units.

Additionally, the legislation before the Senate extends the State Children's Health Insurance Program, CHIP, through March 31, 2009. Let me make one point perfectly clear on this provision I—am not going to give up on reauthorizing the CHIP program for an additional 5 years. I am still committed to that goal and intend to work with my colleagues early next year. I will not rest until this program is reauthorized and all eligible, low-income children are covered by the CHIP program.

On balance, while this bill is not what any of us would have liked, it does address many of the immediate concerns of Medicare patients, their physician and other health care providers. I strongly support this bipartisan legislation and urge my colleagues to support this bill.

Mr. AKAKA. Mr. President, I support the Medicare, Medicaid, SCHIP Extension Act of 2007. I appreciate the hard work and leadership of Senators BAUCUS and GRASSLEY in putting together this important legislation that will improve Medicare reimbursements, extend the State Children's Health Insurance Program, and extend other important Medicare and Medicaid policies.

In addition, this legislation includes a provision that extends Medicaid disproportionate share hospital, DSH, allotments for Hawaii and Tennessee for another 6 months. Medicaid DSH resources help support hospitals that care for significant numbers of Medicaid and uninsured patients.

Hawaii and Tennessee are the only two States that do not have permanent DSH allotments. The Balanced Budget Act of 1997 created specific DSH allotments for each State based on their actual DSH expenditures for fiscal year 1995. In 1994, Hawaii implemented the QUEST demonstration program that was designed to reduce the number of uninsured and improve access to health care. The prior Medicaid DSH program was incorporated into QUEST. As a result of the demonstration program, Hawaii did not have DSH expenditures in 1995 and was not provided a DSH allotment.

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 made further changes to the DSH program, which included the establishment of a floor for DSH allotments. However, States without allotments were again left out.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made additional changes in the DSH program. This included an increase in DSH allotments for low DSH States. Again, States without allotments were left out.

In the Tax Relief and Health Care Act of 2006, DSH allotments were finally provided for Hawaii and Tennessee for 2007. The act included a $10 million Medicaid DSH allotment for Hawaii for 2007. The Medicare, Medicaid, and SCHIP Extension Act of 2007 will extend the DSH allotments for Hawaii and Tennessee for an additional 6 months.

This extension authorizes the submission by the State of Hawaii of a State plan amendment covering a DSH payment methodology to hospitals which is consistent with the requirements of existing law relating to DSH payments. The purpose of providing a DSH allotment for Hawaii is to provide additional funding to the State of Hawaii to permit a greater contribution toward the uncompensated costs of hospitals that are providing indigent care. It is not meant to alter existing arrangements between the State of Hawaii and the Centers for Medicare and Medicaid Services, CMS, or to reduce in any way the level of Federal funding for Hawaii's QUEST program.

I look forward to continuing to work with Senators ALEXANDER, CORKER, and INOUYE to permanently restore allotments for Hawaii and Tennessee. I thank the chairman and ranking member of the Finance Committee for all of their efforts on this legislation and for their support on this issue of great importance.

Mr. DURBIN. Mr. President, I ask unanimous consent that the bill be read a third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 2499) was ordered to be engrossed for a third reading, was read the third time, and passed, 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''.

## CONSOLIDATED APPROPRIATIONS ACT, 2008—Continued

Mr. GREGG. Mr. President, I ask unanimous consent that the Senator from Idaho now be recognized for 5 minutes and that at 5:20, it be deemed that all time be yielded back by all sides relative to the motion.

The PRESIDING OFFICER (Mr. SALAZAR). Without objection, it is so ordered.

Mr. GREGG. Mr. President, I note for those people listening, under this agreement, there should be a vote beginning about 5:20 p.m.

Mr. LEAHY. Mr. President, I have no objection.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAIG. Mr. President, the Senator from Washington and all of us recognize that this may be the conclusion this evening of this session of Congress, and there may be a lot of issues out there that will be brought to a final vote. I think for all of us, as any session concludes, we have to look at the work product and say that is a job well done or a job not so well done. Frankly, for those of us on the Republican side who stayed together and fought the fight and exchanged our differences with those on the Democratic side, to bring a budget back into constraints that are at or near the President's proposal is without question a victory. Some of us will recognize that and honor that tonight as we conclude this first session of this Congress.

I yield the floor.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. Mr. President, I ask unanimous consent that I be permitted to proceed until the vote occurs, which is 2 minutes from now.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. COLLINS. Mr. President, I rise to discuss the funding for the Low Income Home Energy Assistance Program. This program is absolutely vital to the people of my State. This winter we have seen record-high prices for home heating oil.

I want to thank the appropriators for including additional funding for the LIHEAP program as part of the omnibus spending bill, but, Mr. President, I was hoping we would proceed to consideration of the amendment offered by the Senator from Vermont, of which I am proud to be a cosponsor, which would have provided 800 million additional dollars for the LIHEAP program.

Mr. President, this is a real crisis. I consider the amount of money in this bill to be a significant step forward, but it is not adequate to meet the overwhelming needs for the constituents that live in cold weather States and are struggling and literally choosing between paying their bills, buying food, purchasing prescription drugs, and staying warm. That is a choice that no family in this country should have to make.

I am pleased with this downpayment on the LIHEAP program. It is a major step forward that is going to make a significant difference, but, frankly, it is simply not adequate to meet the overwhelming need.

Nationwide, over the last 4 years, the number of households receiving LIHEAP assistance increased by 26 percent from 4.6 million to about 5.8 million, but during this same period, Federal funding increased by only 10 percent. The result is that the average grant declined from $349 to $305. In addition, since August, crude oil prices quickly rose from around $60 barrel to nearly $100 per barrel, so a grant buys less fuel today than it would have just 4 months ago. According to the Maine Office of Energy Independence and Security, the average price of heating oil