driving us deeper into debt, and a fairer, cleaner Tax Code. We are committed to saving our economy for future generations, and I hope the President and his fellow Democrats will join us.

RESIGNATION AS MEMBER OF COMMITTEE ON THE BUDGET

The SPEAKER pro tempore (Mr. STUTZMAN) laid before the House the following resignation as a member of the Committee on the Budget:

WASHINGTON, DC,
January 25, 2013.

Hon. JOHN BOEHNER,
Speaker of the House,
The Capitol, Washington, DC.

DEAR SPEAKER BOEHNER: I am writing to inform you of my resignation, effective immediately, from the House Committee on the Budget. It is my intention that this is a leave of absence as I hope to serve on this Committee again in a future Congress. If you have any questions, please feel free to contact me directly, or your staff can contact my Deputy Chief of Staff, Ian Rayder.

Sincerely,

DEBBIE WASSERMAN SCHULTZ,
Member of Congress.

The SPEAKER pro tempore. Without objection, the resignation is accepted.

There was no objection.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess until approximately 5 p.m. today.

Accordingly (at 2 o'clock and 17 minutes p.m.), the House stood in recess.

□ 1705

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. SHIMKUS) at 5 o'clock and 5 minutes p.m.

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the House by Ms. Evans, one of his secretaries.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

Record votes on postponed questions will be taken later.

CHILDREN'S HOSPITAL GME SUPPORT REAUTHORIZATION ACT OF 2013

Mr. PITTS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 297) to amend the Public Health Service Act to reauthorize support for graduate medical education programs in children's hospitals.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 297

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Children's Hospital GME Support Reauthorization Act of 2013''.

SEC. 2. PROGRAM OF PAYMENTS TO CHILDREN'S HOSPITALS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

(a) IN GENERAL.—Section 340E of the Public Health Service Act (42 U.S.C. 256e) is amended—

(1) in subsection (a), by striking ''through 2005 and each of fiscal years 2007 through 2011'' and inserting ''through 2005, each of fiscal years 2007 through 2011, and each of fiscal years 2013 through 2017'';

(2) in subsection (f)(1)(A)(iv), by inserting ''and each of fiscal years 2013 through 2017'' after ''2011''; and

(3) in subsection (f)(2)(D), by inserting ''and each of fiscal years 2013 through 2017'' after ''2011''.

(b) REPORT TO CONGRESS.—Section 340E(b)(3)(D) of the Public Health Service Act (42 U.S.C. 256e(b)(3)(D)) is amended by striking ''Not later than the end of fiscal year 2011'' and inserting ''Not later than the end of fiscal year 2016''.

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

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. PITTS. Mr. Speaker, I ask that all Members may have 5 legislative days to revise and extend their remarks and insert extraneous material into the RECORD.

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

There was no objection.

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

Mr. Speaker, Pennsylvanians are fortunate to have several excellent children's hospitals in the State. One of these hospitals is the Children's Hospital of Philadelphia, the country's first hospital to exclusively care for children, and they have remained one of the best for over 150 years.

In a recent survey, the hospital was rated number one in six separate pediatric specialties and ranked no lower than fourth in another four specialty categories.

Other children around the country aren't so fortunate to have access to excellent doctors. A study in the journal Pediatrics found that more than 8 million children have no pediatrician in their area. Many other sick children have to drive hundreds of miles to see a doctor who specializes in treating their condition.

Children aren't just miniature adults, and treating them isn't just a matter of working on a smaller scale and shrinking the equipment. A doctor who is experienced in treating adults may not be able to apply that same expertise to a child. Treating children is both a medical and an emotional challenge. Often, doctors have to correctly diagnose an illness in little patients who haven't even learned to speak. It takes a special person to go into pediatrics.

For a time in the 1990s, our Nation was facing an acute shortage of pediatricians. With much of government assistance to train doctors being funneled through the Medicare program, it was becoming significantly more expensive for a doctor to choose to be trained in pediatrics.

To help correct this imbalance, Congress created the Children's Hospital Graduate Medical Education program. This is a program that was created, and has been sustained, with bipartisan support.

Unfortunately, the program is facing elimination. President Obama's budget for the 2012 fiscal year called for elimination of the program, despite the positive results.

I support getting rid of programs that are duplicative, unproven, or unnecessary, especially with the budget pressures we are facing now; however, CHGME has a proven track record. Over 40 percent of pediatricians in the United States are trained through CHGME.

□ 1710

Forty-three percent of those in subspecialities are trained through the program.

The Children's Hospital of Philadelphia runs the largest pediatric residency program in the country. Their residents will treat children in my community and then move across the country to practice in other communities. We need their expertise now more than ever.

Last Congress, I worked with my Democratic counterpart on the Energy and Commerce Health Subcommittee, Representative FRANK PALLONE, to introduce legislation to renew the program. Our legislation passed the House of Representatives twice in the 112th Congress, both times by voice vote.

Unfortunately, the bill was tied up in the Senate and was not considered. Congressman PALLONE and I wasted no time in reintroducing the bill this year, and I'm proud to say that in the very first meeting of the Energy and Commerce Committee, on January 22, the bill was reported out unanimously. The bill is a very simple, 5-year reauthorization of the CHGME program at current funding levels.

H.R. 297 is supported by the Children's Hospital Association, the American Hospital Association, the Academic Pediatric Association, the American Academy of Pediatrics, the American Pediatric Society, the Association of Medical School Department Chairs, the Society for Pediatric Research, the

Association of American Medical Colleges, the American Osteopathic Association, and the American College of Surgeons, among others.

Far too many children in our Nation already lack access to a pediatrician or doctor trained in a pediatric subspecialty. Without CHGME, we will once again be discouraging medical residents from choosing pediatrics.

On a personal note, nearly 2 years ago, I met Anna Lipsman, who was receiving treatment for leukemia at the Children's Hospital of Philadelphia. Today, thanks to the excellent care she received, she is happy, energetic and in school full time. She continues to remind me about what is really at stake.

I urge all of my colleagues to vote ''yes'' on H.R. 297 and reserve the balance of my time.

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

Mr. Speaker, I'm pleased to rise in support of H.R. 297, the Children's Hospital Graduate Medical Education Support Reauthorization Act of 2013.

As every parent knows, it's very important to have a trusted doctor to turn to when their child gets sick. Since its inception in 1999, the Children's Hospital Graduate Medical Education program, known as CHGME, has helped to make sure that the doctor is there and prepared to diagnose any symptoms that our children face.

In fact, the program has been a true success. In the 1990s, declines in pediatric training programs threatened the stability of the pediatric workforce, and CHGME helped to reverse these dangerous declines. Even then, Congress, in a bipartisan way, recognized that if we didn't create and fund programs that would train doctors to treat these children, there won't be anyone left to take care of them.

That's why the House overwhelmingly supported reauthorization of the program in the 112th Congress, passing stand-alone legislation in September 2011 and also including the reauthorization in broader legislation in December 2012.

With this Federal CHGME support, children's hospitals can play a key role in ensuring the continued growth of our Nation's pediatric workforce. In 2009, the program supported the training of 5,361 resident physicians nationally. The program will also help to enhance hospitals' research capabilities and improve hospitals' ability to provide care to vulnerable and underserved children.

Reauthorizing CHGME continues to be one of my top health priorities, and I want to thank Congressman PITTS, the chairman of our Health Subcommittee, for working with me on this bill. Together with his help and leadership, we were able to move this bill again swiftly through our committee and to the floor upon convening this Congress.

Mr. Speaker, this program has proven results, and it's past time that we finally reauthorize CHGME so that we can provide certainty to hospitals, doctors, and their patients. Children in our communities are counting on this program to train a future generation of pediatricians, and I urge my colleagues to vote ''yes'' on the bill. I reserve the balance of my time.

Mr. Speaker, I would like to now yield 3 minutes to my colleague from Rhode Island (Mr. CICILLINE).

Mr. CICILLINE. I thank the gentleman for yielding.

The reauthorization of the Children's Hospital Graduate Medical Education program is critically important and something we must do. But I rise today to express some frustration with the bill as presented.

Specifically, while our Nation faces an acute need for additional health professionals trained in psychiatry, this reauthorization continues a glaring mental health parity failure within the Children's Hospital Graduate Medical Education program: the failure to include children's psychiatric teaching hospitals in the program. Because Medicare classifies these hospitals as psychiatric hospitals rather than as children's hospitals, child psychiatric hospitals are ineligible to participate in CHGME.

This presents a particular burden to a spectacular pediatric hospital in my district, Bradley Hospital. And that is why, last Congress, I introduced the Children's Hospitals Education Equity Act, which was designed to fix this oversight by simply expanding the definition of a children's hospital to cover child psychiatric hospitals.

I'm disappointed, therefore, that the CHGME reauthorization is being considered under suspension of the rules today, as it prevents consideration of amendments to improve the program and to correct this omission in the bill.

Our Nation must fulfill its commitment to mental health parity, and Congress must do its part to enhance access to child and adolescent mental health care. Despite this shortcoming, I intend to support the bill, and I look forward to working with my colleagues in both parties and in both Chambers to correct this serious inequity. I thank the gentleman.

Mr. PALLONE. I have no additional speakers. I yield back the balance of my time.

Mr. PITTS. Mr. Speaker, I urge Members to support this legislation. It has tremendous bipartisan support, and, with that, I yield back the balance of my time.

Mr. WAXMAN. Mr. Speaker, I rise today to support H.R. 297, the Children's Hospital GME Support Reauthorization Act of 2013.

H.R. 297 reauthorizes the children's hospital graduate medical education—or CHGME—program at the program's current authorization level. This program provides ongoing and consistent financial support to hospitals such as Children's Hospital of Los Angeles for the training of doctors who want to specialize in pediatrics. Over the years, the CHGME program has been enormously successful in reversing the significant decline in the number of pediatrician trainees across the country. Indeed, today, children's hospitals nationwide that are supported by the program train 40% of all pediatricians and 43% of all pediatric specialists.

Not surprisingly, the CHGME program has a decade-long history of bipartisan support. The program was first established in 1999 and has subsequently been reauthorized on two occasions. During the 112th Congress, the House passed legislation that would have reauthorized the CHGME program for another five years.

I'm sure that Members of both sides of the aisle agree we want to make certain this important program remains in place, and we want to send a strong message about the importance of fully funding it.

I want to commend the work of members of the Energy and Commerce Committee for advancing H.R. 297 to the floor today. I especially want to recognize and applaud the leadership of Ranking Member PALLONE and Chairman PITTS on this bill. I know we are all hopeful the Senate will act quickly to enact H.R. 297, so we can send legislation to the President for his signature.

I urge my colleagues to join me in supporting H.R. 297.

Mr. GENE GREEN of Texas. Mr. Speaker, I strongly support the Children's Hospital Graduate Medical Education program and I am a cosponsor of H.R. 297. This successful program is the most important federal investment in the pediatric workforce and must be reauthorized. Failure to do so would be catastrophic to pediatric care in our country. Since this program began, it has allowed Children's Hospitals across the country, including Texas Children's Hospital in Houston, to increase training by 35%.

I believe we must spend more on Graduate Medical Education entirely, but today we have the opportunity to extend the successful Children's Hospital program which, like other GME funds, is money well spent. Despite the successes of the program, there are still many pediatric specialties that are experiencing shortages. This bill will help address this and will continue to strengthen our pediatric workforce. I look forward to voting in favor of this bill and encourage my colleagues to do the same.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise today in support of H.R. 297, the Children's Hospital GME Support Reauthorization Act of 2013. The Children's Hospital Graduate Medical Education Program not only provides a critical investment in the pediatric health workforce, but also helps improve children's access to health care.

The Children's Hospital Graduate Medical Education Program was first authorized in 1999 and has achieved incredible success. The program has enabled children's hospitals to host teaching programs while maintaining high-quality clinical care. It currently supports 56 children's hospitals and is responsible for a significant increase in the number of physicians trained in children's hospitals.

As the first registered nurse in Congress, I know firsthand that a well-trained primary care workforce is crucial to our health system. Only by ensuring the security of pediatric residency programs can we successfully work to promote the health of all Americans.

Ms. JACKSON LEE of Texas. Mr. Speaker, I rise today in support of H.R. 297 the ''Children's Hospital Graduate Medical Education

(GME) Support Reauthorization Act of 2013'' This legislation would authorize the appropriation of $110 million a year for 2013 through 2017, for payment toward the direct costs of graduate medical education in children's hospitals.

As the Founder and Co-Chair of the Congressional Children's Caucus, I understand the important of this vital program. The Children's Hospital Graduate Medical Education Program (CHGME) trains 40 percent of our Nation's pediatricians and more than half of our Nation's pediatric subspecialists. Each year, over 5,000 residents take part in this program.

We are all aware that we must continue to support the development and training of all medical professionals. Me must do more to ensure that we have enough qualified medical professional choosing to specialize in key fields in order to address the growth in both our baby boomers and child populations. I believe this legislation is a step in the right direction.

In the early 90's, we witnessed a thirteen percent decrease in the amount of qualified graduate medical students entering into pediatrics. Upon the enactment of the Children's Hospital Graduate Medical Education program we saw a significant increase in the amount of qualified medical school graduates choosing to enter into pediatrics, their numbers increased by 35 percent.

In 1999, Children's Hospital Graduate Medical Education, CHGME, was enacted as part of the Healthcare Research and Quality Act to provide freestanding children's hospitals with discretionary federal support for direct and indirect expenses associated with operating medical residency training programs. Since few children's hospitals receive Medicare funds, the program is designed to correct the exclusion of pediatric training in the Medicare Graduate Medical Education, GME, program.

Under the Children's Hospital Graduate Medical Education Program, direct medical education funding is designed to cover costs associated with stipends for residents, salaries, salaries for faculty, overhead and other costs of running a training program. The CHGME also provides indirect medical education funds that are designed to assist in expenditures such as reduced productivity of staff training residents and the processing of additional diagnostic tests those residents may order.

Graduate Medical Education, GME, begins upon graduation from medical school and passed the examination needed to obtain general board certification. GME in a specialty field (residency) and further specializations in a specific clinical field (fellowship) are generally provided in hospital settings with additional clinical experiences in non-hospital site. This can take between three and seven years to complete, depending on the medical, dental or podiatric specialty track chosen.

Freestanding children's hospitals receiving Federal GME funds have increased the number of residents and fellows that they are training since 2000:

The number of residents and fellows claimed for Federal support for the 2000 Federal fiscal year (FY) was about 4,263.

In the latest Government Performance Results Acts, GPRA, report for Federal FY 2009, the hospitals described training 5,631 pediatricians, pediatric subspecialists, and other physicians in the clinical care of children within the U.S.

Of the 5,631 resident FTEs being trained, about 48 percent were in general pediatrics, 24 percent were in pediatric subspecialties, and 28 percent were non-pediatric residents.

In FY 2009, 56 children's hospitals located in 30 states and Puerto Rico had nearly half a million inpatient discharges. Children's hospitals vary in size and service mix. The number of available beds at these hospitals varies from 30 to 456.

These freestanding children's hospitals provide services ranging from outpatient ambulatory care to inpatient critical care.

TEXAS

In Texas, excluding military and Veterans Affairs programs, there are currently 5,902 resident physicians in Texas training in 468 accredited graduate medical education (GME) programs.

It is likely that many of these resident physicians will join the ranks of the 39,872 licensed physicians currently practicing in Texas.

These practicing and resident physicians, together with 656 resident physicians training in Texas military and Veterans Affairs hospitals, provide health care to Texas 22,016,911 people.

Texas ranks 40th nationally in the number of physicians per 100,000 civilian population and faces serious challenges in attracting physicians to locate and practice in rural, remote, and urban underserved areas.

With Texas' population increasing at both age ends of the population spectrum, the ratio of 158 direct patient care physicians per 100,000 population ratio will likely not improve unless policy changes are implemented to encourage expansion of the Texas physician workforce and foster greater distribution of physicians across the state. As Texas continues to grow in general, pediatric and our aging population we will more physicians—and more specialized physicians—to care for our citizens.

With 25 percent of Texas total population uninsured and 22 percent of its children uninsured, Texas has the highest number of uninsured individuals in the country. Which is one of the many reasons I supported the Affordable Health Care Act.

The majority of under-insured Texans receive health care through the our network of locally tax-funded and privately funded teaching hospitals and clinics.

Uninsured Texans play an important role in graduate medical education; they are one of the groups of patients that residents care for and treat, while honing their medical skills and expertise.

Graduate medical education is just one piece, albeit an important piece, of the complex health-care delivery system. While ensuring the viability of the safety-net hospitals and clinics in Texas is important to the future of Texas, solving all of the problems associated with ensuring that viability is beyond the scope of this. The medical school/hospital partnerships responsible for training many of the next generation of Texas physicians are stressed financially. Especially Children's Hospitals.

The GME and The CHGME programs both train resident physicians while providing essential health-care services to those who might not otherwise receive access to care.

Currently, Five children's hospitals in Texas benefit from the CHGME program: Texas Children's Hospital (Houston), Children's Medical Center of Dallas, Driscoll Children's Hospital (Corpus Christi), Dell Children's Hospital (Austin) and Cook Children's Hospital (Fort Worth). Last year alone, more than $23 million in CHGME funds was allocated to Texas.

I can say that Texas Children's is the largest pediatric hospital in the nation, providing medical care in more than 40 pediatric subspecialties. It also has the largest pediatric cancer and hematology research and treatment center in the country

As an internationally recognized children's hospital it is the primary pediatric training site for Baylor College of Medicine, which has one of the largest pediatric residency programs in the country.

Baylor College of Medicine, operates the nation's first Children's Nutrition Research Center, a U.S. Department of Agriculture facility that conducts research on the nutritional needs of pregnant and nursing women and their children.

Since opening its doors in 1954, Texas Children's Integrated Delivery System has cared for more than one million children from every corner of the world and has more than 2 million patient encounters a year.

Together with Baylor, Texas Children's participates in approximately 400 research projects annually and received $59 million in research funding in 2003. Current projects include testing of medications to improve the quality of life for patients with HIV infection and AIDS; diagnostic methods based on DNA analysis for cystic fibrosis, muscular dystrophy, and other genetic disorders; development of treatments through human gene therapy; and other basic and applied research studies.

I must also mention the Lyndon Baine Johnson General Hospital operated by the Harris County Hospital District, it is the second primary teaching facility or the University of Texas at Houston. They have been dedicated to serving the people of Houston for over two decades. Those who are fortunate enough to receive their training under the CHGME program may very well one day be treating children who arrive at this hospital.

We must remember who these soon to be specialists will serve . . . our nation's children. Children like Audrina, who was born in October of last year. Little Audrina was born with her heart outside of her body. After six hours of surgery, baby Audrina is going home. Supporting funding for programs like the CHGME supports the training of specialists who will one day save the lives of countless children.

FAST FACTS—CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION (CHGME)

The Children's Hospital Graduate Medical Education, CHGME, Payment Program currently supports 56 children's hospitals in 30 States.

Train about a third of the Nation's pediatricians.

Trains about 50 percent of pediatric subspecialists.

The CHGME Payment Program has provided more than 2 billion dollars to eligible freestanding children's hospitals since its inception.

Fifty-Six U.S. hospitals participate in the program, which enables them to:

Provide GME to graduates of medical schools.

Enhance research capabilities.

Care for vulnerable and underserved children.

A hospital is eligible to apply for CHGME Payment Program funding if it:

Participates in an approved Graduate Medical Education (GME) program.

Has a Medicare Provider Agreement.

Is excluded from the Medicare Inpatient Prospective Payment System, IPPS, under section 1886(d)(1)(B)(iii) of the Social Security Act, and its accompanying regulations.

Operates as a ''freestanding'' children's teaching hospital.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Pennsylvania (Mr. PITTS) that the House suspend the rules and pass the bill, H.R. 297.

The question was taken.

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

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

The yeas and nays were ordered.

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

NATIONAL PEDIATRIC RESEARCH NETWORK ACT OF 2013

Mr. PITTS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 225) to amend title IV of the Public Health Service Act to provide for a National Pediatric Research Network, including with respect to pediatric rare diseases or conditions.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 225

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Pediatric Research Network Act of 2013''.

SEC. 2. NATIONAL PEDIATRIC RESEARCH NETWORK.

Section 409D of the Public Health Service Act (42 U.S.C. 284h; relating to the Pediatric Research Initiative) is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (c) the following:

''(d) NATIONAL PEDIATRIC RESEARCH NETWORK.—

''(1) NETWORK.—In carrying out the Initiative, the Director of NIH, acting through the Director of the Eunice Kennedy Shriver National Institute of Child Health and Human Development and in collaboration with other appropriate national research institutes and national centers that carry out activities involving pediatric research, may provide for the establishment of a National Pediatric Research Network consisting of the pediatric research consortia receiving awards under paragraph (2).

''(2) PEDIATRIC RESEARCH CONSORTIA.—

''(A) IN GENERAL.—The Director of the Institute may award funding, including through grants, contracts, or other mechanisms, to public or private nonprofit entities—

''(i) for planning, establishing, or strengthening pediatric research consortia; and

''(ii) for providing basic operating support for such consortia, including with respect to—

''(I) basic, clinical, behavioral, or translational research to meet unmet needs for pediatric research; and

''(II) training researchers in pediatric research techniques in order to address unmet pediatric research needs.

''(B) RESEARCH.—The Director of NIH shall ensure that—

''(i) each consortium receiving an award under subparagraph (A) conducts or supports at least one category of research described in subparagraph (A)(ii)(I) and collectively such consortia conduct or support all such categories of research; and

''(ii) one or more such consortia provide training described in subparagraph (A)(ii)(II).

''(C) NUMBER OF CONSORTIA.—The Director of NIH may make awards under this paragraph for not more than 20 pediatric research consortia.

''(D) ORGANIZATION OF CONSORTIUM.—Each consortium receiving an award under subparagraph (A) shall—

''(i) be formed from a collaboration of cooperating institutions;

''(ii) be coordinated by a lead institution;

''(iii) agree to disseminate scientific findings, including from clinical trials, rapidly and efficiently; and

''(iv) meet such requirements as may be prescribed by the Director of NIH.

''(E) SUPPLEMENT, NOT SUPPLANT.—Any support received by a consortium under subparagraph (A) shall be used to supplement, and not supplant, other public or private support for activities authorized to be supported under this paragraph.

''(F) DURATION OF SUPPORT.—Support of a consortium under subparagraph (A) may be for a period of not to exceed 5 years. Such period may be extended at the discretion of the Director of NIH.

''(3) COORDINATION OF CONSORTIA ACTIVITIES.—The Director of NIH shall—

''(A) as appropriate, provide for the coordination of activities (including the exchange of information and regular communication) among the consortia established pursuant to paragraph (2); and

''(B) require the periodic preparation and submission to the Director of reports on the activities of each such consortium.

''(4) ASSISTANCE WITH REGISTRIES.—Each consortium receiving an award under paragraph (2)(A) shall provide assistance to the Centers for Disease Control and Prevention in the establishment or expansion of patient registries and other surveillance systems as appropriate and upon request by the Director of the Centers.

''(e) RESEARCH ON PEDIATRIC RARE DISEASES OR CONDITIONS.—

''(1) IN GENERAL.—In making awards under subsection (d)(2) for pediatric research consortia, the Director of NIH shall ensure that an appropriate number of such awards are awarded to such consortia that agree to—

''(A) focus primarily on pediatric rare diseases or conditions (including any such diseases or conditions that are genetic disorders (such as spinal muscular atrophy and Duchenne muscular dystrophy) or are related to birth defects (such as Down syndrome and fragile X)); and

''(B) conduct or coordinate one or more multisite clinical trials of therapies for, or approaches to, the prevention, diagnosis, or treatment of one or more pediatric rare diseases or conditions.

''(2) DATA COORDINATING CENTER.—

''(A) ESTABLISHMENT.—In connection with support of consortia described in paragraph (1), the Director of NIH shall establish a data coordinating center for the following purposes:

''(i) To distribute the scientific findings referred to in paragraph (1)(C).

''(ii) To provide assistance in the design and conduct of collaborative research projects and the management, analysis, and storage of data associated with such projects.

''(iii) To organize and conduct multisite monitoring activities.

''(B) REPORTING.—The Director of NIH shall—

''(i) require the data coordinating center established under subparagraph (A) to provide regular reports to the Director of NIH and the Commissioner of Food and Drugs on research conducted by consortia described in paragraph (1), including information on enrollment in clinical trials and the allocation of resources with respect to such research; and

''(ii) as appropriate, incorporate information reported under clause (i) into the Director's biennial reports under section 403.''.

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

The Chair recognizes the gentleman from Pennsylvania.

GENERAL LEAVE

Mr. PITTS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials into the RECORD on the bill.

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

There was no objection.

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

Mr. Speaker, I rise in support and urge my colleagues to vote for H.R. 225, the National Pediatric Research Network Act of 2013.

Simply put, this legislation will foster important research on diseases that affect children. The bill will allow the National Institutes of Health to establish a national research network compromised of pediatric research consortia. According to NIH, there are between 6,000 and 7,000 diseases considered rare that affect 25 to 30 million people. Most of the approximately 7,000 rare diseases are pediatric diseases and often genetic.

Sadly, there are insufficient therapies for doctors to treat such diseases. The use of pediatric research consortia is a proven way to support pediatric applied research and to promote coordinated research activities that focus on translating research to practice. This will help improve care for children.

As an example, it is important to note that this bill will address some devastating diseases such as spinal muscular atrophy. This is a rare pediatric disease that kills more babies than any other genetic disease. Right now, it is incurable, untreatable, and fatal.

H.R. 225, introduced by Representatives LOIS CAPPS and CATHY MCMORRIS RODGERS, amends the Public Health Service Act so that the director of the NIH, acting through the director of the National Institute of Child Health and Human Development, could provide for the establishment of a national pediatric research network compromised of pediatric research consortia.