By Mr. THOMPSON:

S. 3030. A bill to amend title 31, United States Code, to provide for executive agencies to conduct annual recovery audits and recovery activities, and for other purposes; to the Committee on Governmental Affairs.

By Mr. CAMPBELL:

S. 3031. A bill to make certain technical corrections in laws relating to Native Americans, and for other purposes; to the Committee on Indian Affairs.

By Mr. SMITH of New Hampshire (for himself, Mr. WARNER, and Mr. L. CHAFEE):

S. 3032. A bill to reauthorize the Junior Duck Stamp Conservation and Design Program Act of 1994, and for other purposes; to the Committee on Environment and Public Works.

By Mr. BOND:

S. 3033. A bill to delegate the Primary Responsibility for the Preservation and Expansion of Affordable Low-Income Housing to States and Localities; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. KERRY:

S. 3034. A bill to amend title XVIII of the Social Security Act with respect to payments made under the prospective payment system for home health services furnished under the Medicare program; to the Committee on Finance.

By Mr. BAUCUS (for himself, Mr. GRASSLEY, Mr. JEFFORDS, Mr. ROCKEFELLER, and Mr. HATCH):

S. 3035. A bill to amend title XI of the Social Security Act to create an independent and nonpartisan commission to assess the health care needs of the uninsured and to monitor the financial stability of the Nation's health care safety net; to the Committee on Finance.

By Mr. TORRICELLI:

S. 3036. A bill to assure that recreation and other economic benefits are accorded the same weight as hurricane and storm damage reduction benefits as well as environmental restoration benefits; to the Committee on Environment and Public Works.

By Mr. SANTORUM:

S. 3037. A bill to amend title XVIII of the Social Security Act to increase payments under the Medicare program to Puerto Rico hospitals; to the Committee on Finance.

By Mr. CONRAD (for himself, Mr. FRIST, Mr. DEWINE, Mr. BRYAN, and Mr. THOMPSON):

S. 3038. A bill to amend title XVIII of the Social Security Act to update the renal dialysis composite rate; to the Committee on Finance.

By Mr. CRAIG:

S. 3039. To authorize the Secretary of Agriculture to sell a Forest Service administrative site occupied by the Rocky Mountain Research Station located in Boise, Idaho, and use the proceeds derived from the sale to purchase interests in a multiagency research and education facility to be constructed by the University of Idaho, and for other purposes; to the Committee on Energy and Natural Resources.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. BIDEN (for himself, Mr. ABRAHAM, Mr. AKAKA, Mr. ASHCROFT, Mr. BAYH, Mr. BINGAMAN, Mrs. BOXER, Mr. BREAUX, Mr. BRYAN, Mr. BYRD, Mr. CLELAND, Mr. CONRAD, Mr. DEWINE, Mr. DOMENICI, Mr. DORGAN, Mr. DURBIN, Mrs. FEINSTEIN, Mr. FITZGERALD, Mr. FRIST, Mr. GORTON, Mr. GRAHAM, Mr. GRAMM, Mr. HAGEL, Mr. HELMS, Mrs. HUTCHISON, Mr. INOUYE, Mr. JEFFORDS, Mr. JOHNSON, Mr. KENNEDY, Mr. KERREY, Mr. KERRY, Mr. HOLLINGS, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mrs. LINCOLN, Mr. LUGAR, Mr. MACK, Ms. MIKULSKI, Mr. MILLER, Mr. MURKOWSKI, Mrs. MURRAY, Mr. REID, Mr. ROBB, Mr. ROTH, Mr. SARBANES, Mr. SCHUMER, Mr. SMITH of Oregon, Ms. SNOWE, Mr. SPECTER, Mr. VOINOVICH, Mr. WARNER, and Mr. WELLSTONE):

S. Res. 353. A resolution designating October 20, 2000, as "National Mammography Day"; to the Committee on the Judiciary.

By Mr. LOTT (for himself and Mr. DASCHLE):

S. Res. 354. A resolution amending paragraphs 2 and 3(a) of Rule XXV and providing for certain appointments to the Agriculture, Nutrition, and Forestry Committee, the Banking, Housing, and Urban Affairs Committee, the Finance Committee, the Small Business Committee, and the Veterans' Affairs Committee; considered and agreed to.

By Mr. LEAHY (for himself and Mr. JEFFORDS):

S. Res. 355. A resolution commending and congratulating Middlebury College; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WYDEN:

S. 3026. A bill to establish a hospice demonstration and grant program for beneficiaries under the Medicare Program under title XVIII of the Social Security Act, and for other purposes; to the Committee on Finance.

HOSPICE DEMONSTRATION AND GRANT PROGRAM

Mr. WYDEN. Mr. President, today, I am introducing groundbreaking legislation to make a difference in the way in which dying patients and their families can access hospice care. Ninety percent of Americans do not realize that there is a hospice benefit provided under the Medicare program. Over time, the length of stay in a hospice is decreasing so that patients do not get the full benefit of services that could make them more comfortable at a crucial time in their lives.

The issues related to how we die are too important to permit the Medicare Hospice benefit to remain fixed in time. Now is the time to begin to test new ways to design the benefit so that the benefit can remain truly patient-centered at one of the most crucial times in patients' and their families' lives.

Just as we push our health care system for medical breakthroughs that will allow more of us to live healthier and longer, we need to drive our health care system to create accessible, positive care for those facing the end of life.

My legislation, the Hospice Improvement Act of 2000, would require the Secretary to establish a demonstration program to increase access and use of hospice care for patients at the end-of-life, and to increase the knowledge of hospice among the medical, mental health and patient communities. My legislation stresses the following:

Supportive and Comfort Care: To assist families and patients in getting the benefit of hospice care, the Demonstration program will allow for a new supportive and comfort care benefit. This benefit, elected at the option of the patient, will not require the terminally ill to elect hospice care instead of other medical treatment, but will permit a patient to have supportive and comfort care in place while the patient still seeks "curative treatment." This will permit patients and families to learn about hospice without forcing them to make a choice between hospice and other care. Case management would be provided through a hospice provider reimbursed on a fee-for-service basis.

Severity Index Instead of a Six-Month Prognosis: To determine whether or not a patient is eligible for the supportive and comfort care option, a severity index will be used instead of the current hospice requirement of a 6 month prognosis. This will permit patients to have access to support services, as needed, instead of relying on an often inaccurate time-related prognosis.

Increase Rural Hospice Access: Permit nurse practitioners and physician assistants to admit patients to hospice if this is within their authority under state practice law. In communities without a qualified social worker, other professionals with skills, knowledge and ability may provide medical social services such as counseling on the effects of illness on the family.

Respite Care: Nursing facilities used for respite care would not be required to have skilled nurses on the premises 24 hours a day (because hospice will be caring for the patient) or respite could be provided in the patient's home.

Payment Issues: Permit reimbursement for consultations, preadmission informational visits, even if the patient does not elect hospice/supportive care and provide minimum payment for Medicare hospice services provided under the demonstration program based on the provision of services for a period of 14 days, regardless of length of stay.

In addition, the demonstration project could address other payment issues such as offsetting changes in services and oversight and the increased cost of providing services in rural areas and creating a per diem rate of payment for respite care that reflects the range of care needs.

In addition to the Demonstration program, the Secretary would be required to establish an education grant program for the purpose of providing information about the Medicare hospice benefit, and the benefits available under the demonstration program. Education grants could be used to provide individual or group education to patients and their families and to the medical and mental health community, and to test messages to improve public

knowledge about the Medicare hospice benefit.

Let me conclude by saying that in the time left for this Congress, we have a unique opportunity to truly begin to improve care for the dying. There are fewer who are more vulnerable than someone who is dying and having to cope with the physical breakdown of their body and the emotional turmoil that imminent death brings to a family. This legislation provides us an opportunity to begin to remove the barriers to care for those who facing death.

Mr. President, I ask unanimous consent that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 3026

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 ''Hospice Improvement Program Act of 2000''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Each year more than ⅓ of the people who die suffer from a chronic illness.

(2) Approximately ⅓ of Americans are unsure about whom to contact to get the best care during life's last stages.

(3) Americans want a team of professionals to care for the patient at the end of life.

(4) Americans want emotional and spiritual support for the patient and family.

(5) Ninety percent of Americans do not realize that hospice care is a benefit provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) Health Care Financing Administration data show that beneficiaries were enrolled in hospice for an average of less than 7 weeks in 1998, far less than the full 6-month benefit under the medicare program.

(7) According to the most recent data available, although the average hospice enrollment is longer, half of the enrollees live only 30 days after admission and almost 20 percent die within 1 week of enrollment.

(8) Use of hospice among medicare beneficiaries has been decreasing, from a high of 59 days in 1995 to less than 48 days in 1998.

SEC. 3. HOSPICE DEMONSTRATION PROGRAM AND HOSPICE EDUCATION GRANTS.

(a) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROGRAM.—The term ''demonstration program'' means the Hospice Demonstration Program established by the Secretary under subsection (b)(1).

(2) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means any individual who is entitled to benefits under part A or enrolled under part B of the medicare program, including any individual enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization under part C of such program.

(3) MEDICARE HOSPICE SERVICES.—The term ''medicare hospice services'' means the items and services for which payment may be made under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)).

(4) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration.

(b) HOSPICE DEMONSTRATION PROGRAM.—

(1) ESTABLISHMENT.—The Secretary shall establish a Hospice Demonstration Program in accordance with the provisions of this subsection to increase the utility of the medicare hospice services for medicare beneficiaries.

(2) SERVICES UNDER DEMONSTRATION PROGRAM.—The provisions of section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) shall apply to the payment for items and services provided under the demonstration program, except that—

(A) notwithstanding section 1862(a)(1)(C) of such Act (42 U.S.C. 1395y(a)(1)(C)), the Secretary shall provide for reimbursement for items and services provided under the supportive and comfort care benefit established under paragraph (3);

(B) any licensed nurse practitioner or physician assistant may certify a medicare beneficiary as the primary care provider when necessary and within the scope of practice of such practitioner or assistant under State law;

(C) if a community does not have a qualified social worker, any professional who has the necessary knowledge, skills, and ability (other than social workers) to provide medical social services shall provide such services;

(D) the Secretary shall waive any requirement that nursing facilities used for respite care have skilled nurses on the premises 24 hours per day;

(E) the Secretary shall permit respite care to be provided to the medicare beneficiary at home; and

(F) the Secretary shall waive reimbursement regulations to provide—

(i) reimbursement for consultations and preadmission informational visits, even if the medicare beneficiary does not choose hospice care (including the supportive and comfort care benefit under paragraph (3)) at that time;

(ii) a minimum payment for medicare hospice services provided under the demonstration program based on the provision of medicare hospice services to a medicare beneficiary for a period of 14 days, that the Secretary shall pay to any hospice provider participating in the demonstration program and providing such services (regardless of the length of stay of the medicare beneficiary);

(iii) an increase in the reimbursement rates for hospice services to offset—

(I) changes in medicare hospice services and oversight under the demonstration program;

(II) the higher costs of providing medicare hospice services in rural areas due to lack of economies of scale or large geographic areas; and

(III) the higher costs of providing medicare hospice services in urban underserved areas due to unique costs specifically associated with people living in those areas, including providing security;

(iv) direct payment of any nurse practitioner or physician assistant practicing within the scope of State law in relation to medicare hospice services provided by such practitioner or assistant; and

(v) a per diem rate of payment for in-home care under subparagraph (E) that reflects the range of care needs of the medicare beneficiary and that—

(I) in the case of a medicare beneficiary that needs routine care, is not less than 150 percent, and not more than 200 percent, of the routine home care rate for medicare hospice services; and

(II) in the case of a medicare beneficiary that needs acute care, is equal to the continuous home care day rate for medicare hospice services.

(3) SUPPORTIVE AND COMFORT CARE BENEFIT.—

(A) IN GENERAL.—For purposes of the demonstration program, the Secretary shall establish a supportive and comfort care benefit for any eligible medicare beneficiary (as defined in subparagraph (C)).

(B) BENEFIT.—Under the supportive and comfort care benefit established under subparagraph (A), any eligible medicare beneficiary may—

(i) continue to receive benefits for disease and symptom modifying treatment under the medicare program (and the Secretary may not require or prohibit any specific treatment or decision);

(ii) receive case management and medicare hospice services through a hospice provider, which the Secretary shall reimburse on a fee-for-service basis; and

(iii) receive information and experience in order to better understand the utility of medicare hospice services.

(C) ELIGIBLE MEDICARE BENEFICIARY DEFINED.—

(i) IN GENERAL.—In this paragraph, the term ''eligible medicare beneficiary'' means any medicare beneficiary with a serious illness that has been documented by a physician to be at a level of severity determined by the Secretary to meet the criteria developed under clause (ii).

(ii) DEVELOPMENT OF CRITERIA.—

(I) IN GENERAL.—The Secretary, in consultation with hospice providers and experts in end-of-life care, shall develop criteria for determining the level of severity of an established serious illness taking into account the factors described in subclause (II).

(II) FACTORS.—The factors described in this clause include the level of function of the medicare beneficiary, any coexisting illnesses of the beneficiary, and the severity of any chronic condition that will lead to the death of the beneficiary.

(III) PROGNOSIS NOT A BASIS FOR CRITERIA.—The Secretary may not base the criteria developed under this subparagraph on the prognosis of a medicare beneficiary.

(4) CONDUCT OF PROGRAM.—Under the demonstration program, the Secretary shall—

(A) accept proposals submitted by any State hospice association;

(B)(i) except as provided in clause (ii), conduct the program in at least 3, but not more than 6, geographic areas (which may be statewide) that include both urban and rural hospice providers; and

(ii) if a geographic area does not have any rural hospice provider available to participate in the demonstration program, such area may substitute an underserved urban area, but the Secretary shall give priority to those proposals that include a rural hospice provider;

(C)(i) except for the geographic area designated under clause (ii), select such geographic areas so that such areas are geographically diverse and readily accessible to a significant number of medicare beneficiaries; and

(ii) designate as such an area 1 State in which the largest metropolitan area of such State had the lowest percentage of medicare beneficiary deaths in a hospital compared to the largest metropolitan area of each other State according to the Hospital Referral Region of Residence, 1994–1995, as listed in the Dartmouth Atlas of Health Care 1998;

(D) provide for the participation of medicare beneficiaries in such program on a voluntary basis;

(E) permit research designs that use time series, sequential implementation of the intervention, randomization by wait list, and

other designs that allow the strongest possible implementation of the demonstration program, while still allowing strong evaluation about the merits of the demonstration program; and

(F) design the program to facilitate the evaluation conducted under paragraph (6).

(5) DURATION.—The Secretary shall complete the demonstration program within a period of 6½ years that includes a period of 18 months during which the Secretary shall complete the evaluation under paragraph (6).

(6) EVALUATION.—During the 18-month period following the first 5 years of the demonstration program, the Secretary shall complete an evaluation of the demonstration program in order to determine—

(A) the short-term and long-term costs and benefits of changing medicare hospice services to include the items, services, and reimbursement options provided under the demonstration program;

(B) whether increases in payments for the medicare hospice benefit are offset by savings in other parts of the medicare program;

(C) the projected cost of implementing the demonstration program on a national basis; and

(D) in consultation with hospice organizations and hospice providers (including organizations and providers that represent rural areas), whether a payment system based on diagnosis-related groups is useful for administering the medicare hospice benefit.

(7) REPORTS TO CONGRESS.—

(A) PRELIMINARY REPORT.—Not later than 3 years after the date of enactment of this Act, the Secretary shall submit a preliminary report to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate on the progress made in the demonstration program.

(B) INTERIM REPORT.—Not later than 30 months after the implementation of the demonstration program, the Secretary, in consultation with participants in the program, shall submit an interim report on the demonstration program to the committees described in subparagraph (A).

(C) FINAL REPORT.—Not later than the date on which the demonstration program ends, the Secretary shall submit a final report to the committees described in subparagraph (A) on the demonstration program that includes the results of the evaluation conducted under paragraph (6) and recommendations for appropriate legislative changes.

(8) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

(9) SPECIAL RULES FOR PAYMENT OF MEDICARE+CHOICE ORGANIZATIONS.—The Secretary shall establish procedures under which the Secretary provides for an appropriate adjustment in the monthly payments made under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) to any Medicare+Choice organization offering a Medicare+Choice plan in which a medicare beneficiary that participates in the demonstration program is enrolled to reflect such participation.

(c) HOSPICE EDUCATION GRANTS.—

(1) IN GENERAL.—The Secretary shall establish a Hospice Education Grant program under which the Secretary awards education grants to entities participating in the demonstration program for the purpose of providing information about—

(A) the medicare hospice benefit; and

(B) the benefits available to medicare beneficiaries under the demonstration program.

(2) USE OF FUNDS.—Grants awarded pursuant to paragraph (1) shall be used—

(A) to provide—

(i) individual or group education to medicare beneficiaries and their families; and

(ii) individual or group education of the medical and mental health community caring for medicare beneficiaries; and

(B) to test strategies to improve the general public knowledge about the medicare hospice benefit and the benefits available to medicare beneficiaries under the demonstration program.

(d) FUNDING.—

(1) HOSPICE DEMONSTRATION PROGRAM.—

(A) IN GENERAL.—Except as provided in subparagraph (B), expenditures made for the demonstration program shall be in lieu of the funds that would have been provided to participating hospices under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)).

(B) SUPPORTIVE AND COMFORT CARE BENEFIT.—The Secretary shall pay any expenses for the supportive and comfort care benefit established under subsection (a)(3) 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 proportion as the Secretary determines is appropriate.

(2) HOSPICE EDUCATION GRANTS.—The Secretary is authorized to expend such sums as may be necessary for the purposes of carrying out the Hospice Education Grant program established under subsection (c)(1) from the Research and Demonstration Budget of the Health Care Financing Administration.

By Mr. THURMOND (for himself and Mr. HOLLINGS):

S. 3027. A bill to authorize the Secretary of Agriculture to purchase and transfer certain land; to the Committee on Agriculture, Nutrition, and Forestry.

A BILL TO AUTHORIZE THE SECRETARY OF AGRICULTURE TO PURCHASE LAND ADJACENT TO THE COASTAL PLAINS SOIL, AND PLANT RESEARCH CENTER IN FLORENCE, SOUTH CAROLINA

Mr. THURMOND. Mr. President, I rise today, along with Senator HOLLINGS, to introduce legislation that will enable the Secretary of Agriculture to purchase up to ten acres of land for the U.S. Department of Agriculture's Coastal Plains Soil, Water, and Plant Research Center in Florence, South Carolina. This land is located within 150 feet of the Center's administrative offices. Part of it has been leased and used for agricultural research for almost 25 years. If these ten acres were to be developed commercially the Center's operations would be impaired substantially. This land will be used for agricultural research.

The Coastal Plains Soil, Water, and Plant Research Center focuses its research on the agricultural needs of farmers in both North and South Carolina. However, much of the work done by its staff benefits all U.S. agriculture. The Center undertakes basic and applied research with an emphasis toward total resource management. I would like to highlight just a few of its research programs in soil, water, and plant management. The Center's staff investigates the effects of soil erosion, non-point-source pollution, and animal waste disposal. Further, they work to develop better cropping systems for major field crops including cotton, corn, soybeans, and small grains; to identify high-value horticultural crops suitable for production on the soils of the coastal plains; and to improve cotton germ plasm.

Mr. President, the Coastal Plains Soil, Water, and Plant Research Center does outstanding work that is not only very important to the farmers of the Carolinas but to all our Nation's farmers. This land purchase is important to the efficient continued operation of the Florence Center, and I urge my colleagues to support the legislation.

I ask unanimous consent that the bill be printed in the RECORD following my statement.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 3027

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

ASECTION 1. AUTHORIZATION FOR SECRETARY OF AGRICULTURE TO PURCHASE AND TRANSFER LAND.

Subject to the availability of funds appropriated to the Agricultural Research Service, the Secretary of Agriculture may—

(1) purchase a tract of land in the State of South Carolina that is contiguous to land owned on the date of enactment of this Act by the Department of Agriculture, acting through the Coastal Plains Soil, Water, and Plant Research Center of the Agriculture Research Service; and

(2) transfer land owned by the Department of Agriculture to the Florence Darlington Technical College, South Carolina, in exchange for land owned by the College.

By Mr. THOMPSON:

S. 3030. A bill to amend title 31, United States Code, to provide for executive agencies to conduct annual recovery audits and recovery activities, and for other purposes; to the Committee on Governmental Affairs.

A BILL TO PROVIDE FOR ANNUAL RECOVERY AUDITS

Mr. THOMPSON. Mr. President, I rise today to introduce a bill which begins to address the issue of improper payments in Federal programs.

Each year, the Federal government spends hundreds of billions of dollars for a variety of grants, transfer payments, and the procurement of goods and services. The Federal government must be accountable for how it spends these funds and for safeguarding against improper payments. Unfortunately, the problem of improper payments by Federal agencies and departments is immense. Today, I released a GAO report which I requested which identifies $20.7 billion in improper payments in just 20 major programs administered by 12 Federal agencies in Fiscal Year 1999 alone. And this represents an increase of more than $1.5 billion from the previous year's estimate. In its report, GAO writes that its "audits and those of agency inspectors general continue to demonstrate that

improper payments are much more widespread than agency financial statement reports have disclosed thus far.''

Legislative efforts have focused on improving the Federal government's control processes. Recently-enacted laws, such as the Chief Financial Officers Act, the Government Management Reform Act, and the Government Performance and Results Act, have provided an impetus for agencies to systematically measure and reduce the extent of improper payments.

However, the risk of improper payments and the government's ability to prevent them continue to be a significant problem. While we continue to work to improve the government's widespread financial management weaknesses, we also can attempt to recover the tens of billions of dollars in improper payments. And that's what the legislation I am introducing today will do.

The legislation is modeled on H.R. 1827, a bill sponsored by House Committee on Government Reform Chairman DAN BURTON, to require the use of a management technique called ''recovery auditing'' which would be applied to a Federal agency's records to identify improper payments or payment errors made by the agency.

Recovery auditing is used extensively by private sector businesses, including a majority of Fortune 500 companies. These businesses typically contract with specialized recovery auditing firms that are paid a contingent fee based on the amounts recovered from overpayments they identify. Recovery auditing is not ''auditing'' in the usual sense. Recovery auditing firms do not examine the records of vendors doing business with their client companies or assess the vendors' performance. Instead, these firms develop and use computer software programs that are capable of analyzing their clients' own contract and payment records in order to identify discrepancies in those records between what was owed and what was paid. They focus on obvious but inadvertent errors, such as duplicate payments or failure to get credit for applicable discounts and allowances.

The bill I am introducing today would require Federal agencies to perform recovery audits in order to identify discrepancies between what was actually paid by the agency and what should have been paid. This bill seeks to address concerns with H.R. 1827 which were raised after its passage by the House. For example, this bill would make clear that the relationship established by this bill is one between the agency and the recovery audit contractor, and all communications and interaction on the part of the recovery audit contractor is with the agency. Further, this bill includes exemptions for contracts which, under current law, already are subject to extensive audit scrutiny and oversight. Also, this bill includes Federal agency authority for recovery audit pilot programs for contracts, grants or other arrangements other than those covered by this bill.

I appreciate all the work done by Chairman BURTON on H.R. 1827. I believe my legislation appropriately addresses concerns raised with that bill and goes a long way in addressing the wasted taxpayer dollars and government inefficiencies resulting from Federal agency payment errors which are made each year.

Mr. CAMPBELL:

S. 3031. A bill to make certain technical corrections in laws relating to Native Americans, and for other purposes; to the Committee on Indian Affairs.

TECHNICAL AMENDMENTS TO LAWS RELATING TO NATIVE AMERICANS

Mr. CAMPBELL. Mr. President, today I introduce a bill making certain technical amendments to laws relating to Native Americans. As my colleagues know, Congress typically considers legislation like this every year or so. This bill provides an opportunity to address a series of corrections to the law or other non-controversial, minor amendments to Indian laws in one broad stroke, rather than having to introduce several separate bills.

This bill includes amendments regarding issues of importance to a number of my colleagues that have been brought to my attention over recent months. The amendments include, for instance, one-year reauthorizations of the Indian Health Care Improvement Act and the Indian Alcohol and Substance Abuse Prevention and Treatment Act, as well as a clarification of a bill signed into law earlier this year relating to the status of certain lands held in trust by the Mississippi Band of Choctaw Indians.

All amendments included in this bill will serve to promote the original intent of the affected laws, and do not alter the meaning or substance of the laws they amend. I urge my colleagues to join me in supporting this bill, the sole purpose of which is to ensure that the laws this body has already passed are carried forward in the way we originally intended.

Mr. President, I ask unanimous consent that a copy of the bill be printed in the RECORD. I thank the Chair and yield the floor.

There being no objection, the bill was order to be printed in the RECORD, as follows:

S. 3031

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

SECTION 1. TECHNICAL CORRECTION TO AN ACT AFFECTING THE STATUS OF MISSISSIPPI CHOCTAW LANDS AND ADDING SUCH LANDS TO THE CHOCTAW RESERVATION.

Section 1(a)(2) of Public Law 106–228 (an Act to make technical corrections to the status of certain land held in trust for the Mississippi Band of Choctaw Indians, to take certain land into trust for that Band, and for other purposes) is amended by striking ''September 28, 1999'' and inserting ''February 7, 2000''.

SEC. 2. TECHNICAL CORRECTIONS CONCERNING THE FIVE CIVILIZED TRIBES OF OKLAHOMA.

(a) INDIAN SELF-DETERMINATION ACT.—Section 1(b)(15)(A) of the model agreement set forth in section 108(c) of the Indian Self-Determination Act (25 U.S.C. 450l(c)) is amended—

(1) by striking ''and section 16'' and inserting '', section 16''; and

(2) by striking ''shall not'' and inserting ''and the Act of July 3, 1952 (25 U.S.C. 82a), shall not''.

(b) INDIAN SELF-DETERMINATION AND EDUCATION ASSISTANCE ACT.—Section 403(h)(2) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 458cc(h)(2)) is amended—

(1) by striking ''and section'' and inserting ''section''; and

(2) by striking ''shall not'' and inserting ''and the Act of July 3, 1952 (25 U.S.C. 82a), shall not''.

(c) REPEALS.—The following provisions of law are repealed:

(1) Section 2106 of the Revised Statutes (25 U.S.C. 84).

(2) Sections 438 and 439 of title 18, United States Code.

SEC. 3. WAIVER OF REPAYMENT OF EXPERT ASSISTANCE LOANS TO THE RED LAKE BAND OF CHIPPEWA INDIANS AND THE MINNESOTA CHIPPEWA TRIBES.

(a) RED LAKE BAND OF CHIPPEWA INDIANS.—Notwithstanding any other provision of law, the balances of all expert assistance loans made to the Red Lake Band of Chippewa Indians under the authority of Public Law 88–168 (77 Stat. 301), and relating to Red Lake Band v. United States (United States Court of Federal Claims Docket Nos. 189 A, B, C), are canceled and the Secretary of the Interior shall take such action as may be necessary to document such cancellation and to release the Red Lake Band of Chippewa Indians from any liability associated with such loans.

(b) MINNESOTA CHIPPEWA TRIBE.—Notwithstanding any other provision of law, the balances of all expert assistance loans made to the Minnesota Chippewa Tribe under the authority of Public Law 88-168 (77 Stat. 301), and relating to Minnesota Chippewa Tribe v. United States (United States Court of Federal Claims Docket Nos. 19 and 188), are canceled and the Secretary of the Interior shall take such action as may be necessary to document such cancellation and to release the Minnesota Chippewa Tribe from any liability associated with such loans.

SEC. 4. TECHNICAL AMENDMENT TO THE INDIAN CHILD PROTECTION AND FAMILY VIOLENCE PROTECTION ACT.

Section 408(b) of the Indian Child Protection and Family Violence Prevention Act (25 U.S.C. 3207(b)) is amended—

(1) by striking ''any offense'' and inserting ''any felonious offense, or any of 2 of more misdemeanor offenses,''; and

(2) by striking ''or crimes against persons'' and inserting ''crimes against persons; or offenses committed against children''.

SEC. 5. TECHNICAL AMENDMENT REGARDING THE TREATMENT OF CERTAIN INCOME FOR PURPOSES OF FEDERAL ASSISTANCE.

Notwithstanding any other provision of law, none of the funds paid by the State of Minnesota to the Bois Forte Band of Chippewa Indians and the Grand Portage Band of Chippewa Indians pursuant to the agreement of such Bands' to voluntarily restrict tribal rights to hunt and fish in territory ceded under the Treaty of September 30, 1854 (10 Stat. 1109), including all interest accrued on such funds during any period in which such funds are held in a minor's trust, shall be

considered as income or resources, or otherwise be used as the basis for denying or reducing the financial assistance or other benefits to which a household or member of such Bands would be entitled to under the Social Security Act (42 U.S.C. 301 et seq.), the Personal Responsibility and Work Opportunity Reconciliation Act of 1966 (Public Law 104-193; 110 Stat. 2105) and the amendments made by such Act, or any Federal or Federally assisted program.

SEC. 6. TECHNICAL AMENDMENT TO EXTEND THE AUTHORIZATION PERIOD UNDER THE INDIAN HEALTH CARE IMPROVEMENT ACT.

The authorization of appropriations for, and the duration of, each program or activity under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is extended through fiscal year 2001.

SEC. 7. TECHNICAL AMENDMENT TO EXTEND THE AUTHORIZATION PERIOD UNDER THE INDIAN ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND TREATMENT ACT OF 1986.

The authorization of appropriations for, and the duration of, each program or activity under the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (25 U.S.C. 2401 et seq.) is extended through fiscal year 2001.

By Mr. SMITH of New Hampshire (for himself, Mr. WARNER, and Mr. L. CHAFEE):

S. 3032. A bill to reauthorize the Junior Duck Stamp Conservation and Design Program Act of 1994, and for other purposes; to the Committee on Environment and Public Works.

JUNIOR DUCK STAMP REAUTHORIZATION ACT OF 2000

Mr. SMITH of New Hampshire. Mr. President, I would like to introduce the Junior Duck Stamp Reauthorization Act of 2000.

The Junior Duck Stamp Program is a wonderful program that allows children from kindergarten through twelfth grade to participate in an integrated art and science curriculum that is designed to teach environmental science and habitat conservation. It also raises awareness for wetlands and waterfowl conservation. Students and teachers work together through a set curriculum that incorporates ecological and wildlife management principles, allowing students to learn about conserving wildlife habitat while they explore the esthetic qualities of wildlife and nature.

As part of the curriculum, each student is encouraged to focus his or her efforts on a particular waterfowl species. The culmination of the curriculum is an artistic depiction of that species. Each state selects a Best-of-Show winner and that piece of artwork competes to become the national winner of the Junior Duck Stamp contest. The winning depiction is chosen as the Federal Junior Duck Stamp, and the student receives $2,500. Revenues from selling the stamp are used for conservation awards and scholarships to the participants.

By all accounts the Junior Duck Stamp Program has been extremely successful. Last year alone more than 44,000 students entered the state competitions. The Fish and Wildlife Service and educators estimate that for every child who enters the state program, ten others are exposed to the curriculum. The program has also been very successful in introducing urban children to nature, allows all children to develop an important connection to the environment, and motivates students to take an active role in conservation of waterfowl species.

This legislation is a simple reauthorization of the program through 2005. The U.S. Fish and wildlife Service would be authorized to receive $250,000 a year for the administration of the Junior Duck Stamp Program. In addition, the Junior Duck Stamp Conservation and Design Program Act of 1994 would be amended to allow schools in the District of Columbia and the U.S. territories to participate in the program.

Mr. President, I strongly urge the passage of this legislation. The Junior Duck Stamp Program has played an important role in the education of children and the conservation of our natural resources, and it should continue to do so. I ask that the full text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 3032

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 ''Junior Duck Stamp Reauthorization Act of 2000''.

SEC. 2. REAUTHORIZATION OF JUNIOR DUCK STAMP CONSERVATION AND DESIGN PROGRAM ACT OF 1994.

Section 5 of the Junior Duck Stamp Conservation and Design Program Act of 1994 (16 U.S.C. 719c) is amended by striking ''for each of the fiscal years 1995 through 2000'' and inserting ''for each of fiscal years 2001 through 2005''.

SEC. 3. EXPANSION OF PROGRAM TO INSULAR AREAS.

The Junior Duck Stamp Conservation and Design Program Act of 1994 is amended—

(1) by redesignating sections 2 through 6 (16 U.S.C. 719 through 719c; 16 U.S.C. 668dd note) as sections 3 through 7, respectively;

(2) by inserting after section 1 (16 U.S.C. 719 note) the following:

''SEC. 2. DEFINITION OF STATE.

''In this Act, the term 'State' means a State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Virgin Islands, and any other territory or possession of the United States.'';

(3) in section 3(c) (16 U.S.C. 719(c)) (as redesignated by paragraph (1)), by striking ''50 States'' each place it appears and inserting ''States''; and

(4) in section 5 (16 U.S.C. 719b) (as redesignated by paragraph (1)), by striking ''section 3(c)(1) (A) and (B)'' and inserting ''subparagraphs (A) and (B) of section 4(c)(1)''.

By Mr. BOND:

S. 3033. A bill to delegate the Primary Responsibility for the Preservation and Expansion of Affordable Low-Income Housing to States and Localities; to the Committee on Banking, Housing, and Urban Affairs.

HOUSING NEEDS ACT OF 2000

Mr. BOND. Mr. President. I rise today to introduce an important piece of housing legislation that addresses the affordable-housing needs of needy Americans. The Housing Needs Act of 2000 is a direct response to the affordable housing crisis being experienced by millions of Americans today. By working with State and localities, this legislation will produce thousands of affordable housing units and ensure that existing federally-assisted housing properties are maintained for lower income families.

As Chairman of the Appropriations Subcommittee on VA, HUD, and Independent Agencies, I have become increasingly alarmed by the news reports and housing studies that have shown that lower income Americans are having a difficult time finding decent, safe, and affordable housing. The Administration's response to this problem has been to provide section 8 tenant-based assistance or vouchers. However, I have heard from communities in Missouri to here in the Washington, D.C. area that it is becoming increasingly difficult to use vouchers to find affordable housing. It has also come to my attention that despite the resources given to the Department of Housing and Urban Development (HUD), the Federal government has lost thousands of scarce affordable housing that were once subsidized by the Federal government. Instead of preserving these scarce and valuable housing resources, the Department has replaced these units with vouchers. While some families have been able to locate replacement housing, many have experienced displacement and hardship, resulting in returning the voucher unused or becoming homeless.

Due to these well-publicized problems, I instructed my subcommittee staff to conduct a review of the section 8 program and to provide recommendations on how to meet better the housing needs of lower income Americans. The recommendations of the report are captured in the Housing Needs Act of 2000, which I am introducing today.

Before I discuss the contents of the bill, I summarize the key findings of the Subcommittee Staff report entitled ''Empty Promises—Subcommittee Staff Report on HUD's Failing Grade on the Utilization of Section 8 Vouchers.'' The key findings of the report are (1) housing units for low-income families are disappearing; (2) worse case housing needs are worsening; and (3) section 8 vouchers are proving to be less and less effective in meeting the housing needs of low-income families.

Specifically, the staff reported that over the past 4 years, nearly 125,000 housing units have been lost to the national inventory of affordable housing. These units have been lost due to the decision of landlords to leave or opt-out of the section 8 program, HUD's policy to voucher out properties that they have acquired title to and those that the Department actually owns.

The staff also found that a record high of 5.4 million households have major housing needs. Based on HUD's Worst Case Housing Needs study, many of these households are our most vulnerable individuals such as the elderly, disabled, and children.

Lastly, the staff reported that about 1 out of every 5 families that received a voucher are unable to find housing and thus, the voucher remains unused. The report also found not enough landlords were participating in the voucher program, the payment standard of the vouchers were too low for the market area, and voucher holders had personal problems which affected the utilization of vouchers.

Mr. President, the staffs' findings were disturbing to me. As a result, I am here today to introduce the Housing Needs Act of 2000 to address the report's findings.

Briefly, the legislation creates a new affordable housing block grant production program that would allocate funds to state housing agencies. States currently administer other federal programs such as the Low-Income Housing Tax Credit program, HOME block grant program, and the Community Development Block Grant program, which have expanded and increased the capacity of states to create affordable housing units. Thus, state housing finance agencies have the tools to make this program work effectively. I am a big believer in local decision-making. States and localities know and understand their housing problems and needs and are in the best position to make decisions on their housing needs.

The legislation would also create a new section 8 success program that would allow public housing agencies (PHA) to raise the payment standard for vouchers up to 150 percent of the fair market rent. This will greatly improve the ability of voucher holders to use the vouchers in economically strong markets. As the Subcommittee Staff report found, 19 percent or one in five families that receive a voucher cannot use it. I believe that this new success program will improve greatly the number of voucher holders actually to use the voucher.

Lastly, the bill includes a number of smaller provisions that would enhance the ability of state and local housing entities to produce low-income housing and ensure that HUD maintains section 8 assistance on properties that it has acquired through foreclosure.

I urge my colleagues to support this critical piece of legislation. Families all over the country are experiencing hardships never before seen. It is clear that vouchers alone do not adequately address the housing needs of our vulnerable populations. I believe strongly that the Housing Needs Act of 2000 provides a much-needed, flexible, balanced approach to ensure that the affordable-housing problems can be solved.

By Mr. KERRY:

S. 3034. A bill to amend title XVIII of the Social Security Act with respect to payments made under the prospective payment system for home health services furnished under the Medicare Program; to the Committee on Finance.

HOME HEALTH REFINEMENT AMENDMENTS OF 2000

Mr. KERRY. Mr. President, I am pleased to introduce the Home Health Refinement Amendments of 2000. This legislation will protect patient access to home health care under Medicare, and ensure that providers are able to continue serving seniors who reside in medically underserved areas, have medically complex conditions, or require non-routine medical supplies.

Medicare was enacted in 1965, under the leadership of President Lyndon Johnson, as a promise to the American people that, in exchange for their years of hard work and service to our country, their health care would be protected in their golden years. Today, over 30 million seniors rely on the Medicare home health benefit to receive the care they need to maintain their independence and remain in their own homes, and to avoid the need for more costly hospital or nursing home care. Home health care is critical. It is a benefit to which all eligible Medicare beneficiaries should be entitled. But, this benefit is being seriously undermined. Since enactment of the Balanced Budget Act, BBA, of 1997, federal funding for home health care has plummeted. According to the Congressional Budget Office, CBO, Medicare spending on home health care dropped 48 percent in the last two fiscal years—from $17.5 billion in 1998 to $9.7 billion in 1999—far beyond the original amount of savings sought by the BBA. Across the country, these cuts have forced over 2,500 home health agencies to close and over 900,000 patients to lose their services.

In my own State of Massachusetts—a state that, because of economic efficiency, sustained a disproportionate share of the BBA cuts in Medicare home health funding—28 home health agencies have closed, 6 more have turned in their Medicare provider numbers and chosen to opt out of the Medicare program, and 12 more have been forced to merge in order to consolidate their limited resources. The home health agencies that have continued to serve patients despite the deep cuts in Medicare funding reported net operating losses of $164 million in 1998. The loss of home health care providers in Massachusetts has cost 10,000 patients access to home health services. Consequently, many of the most vulnerable residents in my state are being forced to enter hospitals and nursing homes, or going without any help at all.

To compound the problem, without Congressional action, Medicare payments for home health care will be automatically cut by an additional 15 percent next year. It is critical that we defend America's seniors against future cuts in home health services, and this bill will eliminate the additional 15 percent cut in Medicare home health payments mandated by the BBA. However, we must do more than attempt to stop future cuts. Indeed, it is equally as important that we begin to provide relief to home health providers who are already struggling to care for patients.

During the first year of implementation of the Interim Payment System, IPS, agencies were placed on precarious financial footing because of insufficient payments, particularly for high-cost and long-term patients. Accordingly, it is critical that we bolster the efforts of home health care providers to transcend their current operating deficits, especially as they transition from the Interim Payment System to the Prospective Payment System, PPS.

The Home Health Refinement Amendments of 2000 would ensure that providers are able to treat the sickest, most expensive patients who rely on home health care. Independent studies indicate that, under IPS, thousands of patients have been denied home health care benefits—while ''outlier'' patients (those who require the most intensive services) have been most at risk of losing access to care. To address the costs of treating the sickest homebound patients, this legislation provides additional funding for outliers under PPS. Specifically, this bill would set the funding level for outliers at 10 percent of the total payments projected or estimated to be made under PPS each year. This would double the current 5 percent allocation without reducing the PPS base payment.

In addition, the Home Health Refinement Amendments of 2000 would remove the costs of non-routine medical supplies from the PPS base payment and, instead, arrange for Medicare reimbursement for these supplies on the basis of a fee schedule. PPS rates include average medical supply costs, but some agencies' patient populations have greater or lesser supply needs than the average. Thus, current rates would underpay agencies that treat patients with high medical supply needs and overpay agencies that treat patients with low medical supply needs. Agencies that treat our most ill, frail, and vulnerable should not be punished with low payment rates.

Agencies that treat patients in medically underserved communities also deserve equitable reimbursement for the services they provide. In order to address the unique costs of treating patients in underserved areas, the Home Health Refinement Amendments of 2000 would establish a 10 percent add-on to the episodic base payment for patients in rural areas, to reflect the increasing costs of travel, and a ''reasonable cost'' add-on for security services utilized by providers in our urban areas. These add-ons ensure that patients in all types of communities across the country continue to receive the home care they need and deserve.

Finally, this legislation would encourage the incorporation of telehealth

technology in home care plans by allowing cost reporting of the telemedicine services utilized by agencies. Telemedicine has demonstrated tremendous potential in bringing modern health care services to patients who reside in areas where providers and technology are scarce. Cost reporting will provide the data necessary to develop a fair and reasonable Medicare reimbursement policy for telehomecare and bring the benefits of modern science and technology to our nation's underserved.

Unless we increase the federal commitment to the Medicare home health care benefit, we can only expect to continue to imperil the health of an entire generation. We must act to deliver on that promise that President Johnson made 25 years ago—our nation's seniors deserve no less.

Mr. BAUCUS (for himself, Mr. GRASSLEY, and Mr. JEFFORDS):

S. 3035. A bill to amend title XI of the Social Security Act to create an independent and nonpartisan commission to assess the health care needs of the uninsured and to monitor the financial stability of the Nation's health care safety net; to the Committee on Finance.

HEALTH CARE SAFETY NET OVERSIGHT ACT OF 2000

Mr. BAUCUS. Mr. President, it is often said that, ''Good health and good sense are two of life's greatest blessings.'' Senators GRASSLEY, JEFFORDS, and I hope to further the cause of good health and good sense today, through introduction of the Health Care Safety Net Oversight Act of 2000.

Mr. President, currently no entity oversees America's health care safety net. This means that all safety net providers—including rural health clinics, community heath centers and emergency rooms—are laboring on their own. They are like master musicians performing without a conductor. Each is trying their hardest and performing their part—but no one is coordinating their efforts. No one is able to tell an actor when his services will be needed, or when he can take a break.

This act changes that, by creating the Safety Net Organizations and Patient Advisory Commission, an independent and nonpartisan commission to monitor the stability of the health care safety net.

What does this mean?

The Safety Net is made up of providers that deliver health services to the uninsured and vulnerable populations across America. These providers are often a last resort for patients who are unable to afford the health care they need and have nowhere else to turn. In my state, we have about 30 community health centers and rural health clinics, serving an estimated 80,000 persons per year. That translates into about one in ten Montanans. Were it not for these clinics and health centers, many of these folks—the uninsured and underinsured—would have no place to turn.

According to the U.S. Census Bureau, nearly one in five Montanans were uninsured in 1998. This number has risen by 36 percent over the last ten years, and there are now only five states with a higher percentage of uninsured residents. When these uninsured seek medical treatment they are often not able to pay. Last year, Montana hospitals reported over $67 million in charity care and bad debt. And the problem is not going away. At current growth rates for the uninsured, as many as one in four Montanans will be uninsured by the year 2007.

But Mr. President, these people are not uninsured of their own volition. Eighty three percent of uninsured Montanans are in working families. And self-employed workers—including owners of small businesses—and their dependents account for one-fifth of the uninsured in our state. In fact, Montana ranks last in the nation with only 40 percent of firms offering a health insurance benefit.

So what do we do about this problem? How do we ensure that all Americans, irrespective of color, creed gender or geography, have access to quality health care?

Six or seven years ago, Congress and the administration worked on the problem of the uninsured. A tremendous amount of time and effort went into the Health Security Act, on both sides of the issue. As we know, passage of that bill failed. Since then, Congress has taken a more incremental approach to health care. Congress passed legislation in 1996 to ensure portability of health insurance. A year later, the CHIP program was signed into law, bipartisan legislation to cover children of working families. And last year, Congress passed the Work Incentives Improvement Act to allow disabled folks to continue working and not lose health care benefits.

But while these legislative actions are extremely important, they affect relatively few Americans. The fact remains, for most uninsured and underinsured Americans, the safety net is still the only place to turn.

Yet the safety net has been seriously damaged in recent years. According to a recent report by the Institute of Medicine, the health care safety net is ''intact but endangered.''

For instance, the 1997 Balanced Budget Act cut payments to Disproportionate Share Hospitals and Community health centers. It also cut reimbursement to rural health clinics, so critical to providing coverage to rural uninsured individuals. At the same time, Congress mandates that emergency departments care for anyone and everyone that darkens their door. Though not a reimbursement issue per se, the EMTALA dictates that all ER's care for all individuals, regardless of ability to pay.

Despite all these developments, there is no entity responsible for making changes to the safety net. And though SNOPAC will not solve the problem of America's uninsured, it will work to ensure that no holes develop in the Safety Net. An independent, nonpartisan commission, modeled on the Medicare Payment Advisory Commission (MedPAC), SNOPAC will include professionals from across the policy and practical spectrum of health care. And like MedPAC, SNOPAC will report to the relevant committees of Congress on the status of its mission: tracking the well-being of the health care safety net.

Though it's not a panacea, SNOPAC is a positive step toward a coordinated approach in caring for the uninsured. Absent large-scale improvements in the number of insured Americans, we should at least work to monitor and care for what we already have—an intact, but endangered, health care safety net.

I urge all my colleagues to join me in this effort towards good health and good sense.

By Mr. TORRICELLI:

S. 3036. A bill to assure that recreation and other economic benefits are accorded the same weight as hurricane and storm damage reduction benefits as well as environmental restoration benefits; to the Committee on Environment and Public Works.

NATIONAL BEACH ENHANCEMENT ACT

Mr. TORRICELLI. Mr. President, I rise today to introduce legislation which will ensure the preservation of our nation's coastal areas. Protection of our beaches is paramount; they are not only where we go to enjoy the sand and surf, but they also generate a significant portion of our nation's revenue.

Tourism and recreational activity are extremely important to New Jersey, especially to our small businesses and shore communities. New Jersey's $17 billion a year tourism industry is supported by the 160 million people who visit our 127 miles of beaches each year. This spending by tourists totaled $26.1 billion in New Jersey in 1998, a 2 percent increase from $25.6 billion in 1997.

My state is a microcosm of coastal tourism throughout the United States. Travel and tourism is our Nation's largest industry, employer, and foreign-revenue earner, and U.S. beaches are its leading tourist destination. In 1997, total tourism expenditures in U.S. coastal areas was over $185 billion, generating over 2.7 million jobs with a payroll of nearly $50 million.

Americans are not the only ones eager to enjoy our beaches and coastal regions. They are also the top destination for foreign tourists. Each year, the U.S. takes in $4 billion in taxes from foreign tourists, while state and local governments receive another $3.5 million.

In Florida alone, foreign tourists spent over $11 billion in 1992, $2 billion of that amount in the Miami Beach area. This Florida spending generated over $750 million in Federal tax revenues. A recent article by Dr. James R.

Houston, published in the American Shore and Beach Preservation Journal, shows that annual tax revenues from foreign tourists in Miami Beach are 17 times more than the Federal government spent on the entire Federal Shore Protection program from 1950 to 1993. If the Federal share of beach nourishment averages about $10 million a year, the Federal government collects about 75 times more in taxes from foreign tourists in Florida than it spends restoring that State's beaches.

Delaware, one of the smallest states in the Union, is visited by over 5 million people each year. This, in a state where just over 21,000 people actually live in beach communities and another 373,000 live within a several hours drive. Beach tourism generates over $173 million in expenditures each year for ''The First State.''

Equally significant, however, beach erosion results in an estimated loss of over 471,000 visitor days a year, a figure which is estimated to increase to over 516,000 after five years. A 1998 study by Jack Faucett Associates (Bethesda, MD) in cooperation with independent consultants for the Delaware Department of Natural Resources and Environmental Control shows that during this five-year period, beach erosion will cost an estimated $30.2 million in consumer expenditures, the loss of 625 beach area jobs, and the reduction of wages and salaries by $11.5 million. Business profits will drop by $1.6 million and State and local tax revenues will decrease by $2.3 million. Finally, beach erosion will reduce beach area property values by nearly $43 million. The situation in Delaware is indicative of beach erosion problems throughout the coastlines of our nation. Unless we increase our efforts to protect and renourish our coastline, we jeopardize a significant portion of our country's revenue.

The Federal government spends $100 million a year for the Federal Shore Protection program. While the U.S. Army Corps of Engineers does a benefit-cost analysis in connection with every shore protection project, that analysis suffers from its own myopia. It places its greatest emphasis on the value of the private property that is immediately adjacent to the coastline. It is not reasonable to assume that a healthy beach with natural dunes and vegetation will benefit only that first row of homes and businesses. Homeowners spend money in the region; hotels attract tourists, who also spend money; local residents who live inland come to the beach to recreate. They too, spend money. Countless businesses, from t-shirt vendors to restaurants, all depend on these expenditures.

Prior to the 1986 Water Resources Development Act, the Army Corps of Engineers viewed recreation as an equally important component of its cost-benefits analysis. However, the 1986 bill omitted recreation as benefit to be considered, and our coastal communities have suffered. Indeed, the economy of our nation has suffered. My legislation would make it clear that recreational benefits will be given the same budgetary priority as storm damage reduction and environmental restoration. Companion legislation has been introduced in the House of Representatives, by Congressmen LAMPSON and LOBIONDO, and enjoys bipartisan support.

Beach replenishment efforts ensure that our beaches are protected, property is not damaged, dunes are not washed away, and the resource that coastal towns rely on for their lifeblood, is preserved. It is imperative that federal policy base beach nourishment assistance on the entirety of the economic benefits it provides. To limit benefits to hurricane or storm damage reduction ignores the equally important economic impact of tourism.

By Mr. CONRAD (for himself, Mr. FRIST, Mr. DEWINE, Mr. BRYAN, and Mr. THOMPSON):

S. 2038. A bill to amend title XVIII of the Social Security Act to update the renal dialysis composite rate; to the Committee on Finance.

THE MEDICARE RENAL DIALYSIS PAYMENT FAIRNESS ACT OF 2000

Mr. CONRAD. Mr. President, today I am pleased to be joined by Senator FRIST and Representatives CAMP and THURMAN in introducing the Medicare Renal Dialysis Payment Fairness Act of 2000. This legislation takes important steps to help sustain and improve the quality of care for Medicare beneficiaries suffering from kidney failure.

Nationwide, more than 280,000 Americans live with end-stage renal disease (ESRD). In my State of North Dakota, the number of patients living with ESRD is relatively small, just over 600. However, for these patients and others across the country, access to dialysis treatments means the difference between life and death.

In 1972, the Congress took important steps to ensure that elderly and disabled individuals with kidney failure receive appropriate dialysis care. At that time, Medicare coverage was extended to include dialysis treatments for beneficiaries with ESRD.

Over the last three decades, dialysis facilities have provided services to increasing numbers of kidney failure patients under increasingly strict quality standards; however, during this same time frame reimbursement for kidney services has not kept pace with the increasing demands of providing dialysis care.

Last year, Senator FRIST and I introduced legislation to ensure dialysis facilities could continue providing quality dialysis services to Medicare beneficiaries. I am happy to say that, based on these efforts, dialysis providers received increased Medicare reimbursement in fiscal years 2000 and 2001 as part of the Medicare, Medicaid, and S–CHIP Refinement Act of 1999.

While these efforts were a step in the right direction, a recent Medicare Payment Advisory Commission (MedPAC) report suggests that we must take further action to sustain patients' access to dialysis services. In particular, MedPAC recommends a 1.2 percent payment adjustment for Medicare-covered dialysis services in the next fiscal year. In addition, MedPAC recommends that the Health Care Financing Administration provide an annual review of the dialysis payment rate—a review that most other Medicare-covered services receive each year.

I believe these recommendations represent critical adjustments that must be addressed this year. For this reason, I have worked with Senator FRIST, Representative CAMP and Representative THURMAN to develop the Medicare Renal Dialysis Payment Fairness Act of 2000. This legislation would provide the payment rate improvements recommended by MedPAC and would establish an annual payment review process for dialysis services. This proposal would help ensure all dialysis providers receive reimbursement that is in line with increasing patient load and quality requirements. This is particularly important for our Nation's smaller, rural dialysis providers that on average receive Medicare payments to do not adequately reflect costs.

As the Congress considers further improvements to the Medicare Program, I urge my colleagues to support this important effort to ensure patients with kidney failure continue to have access to quality dialysis services. I thank my colleagues for working together on this bipartisan and bicameral proposal.

Mr. FRIST. Mr. President, I am pleased to join Senators CONRAD, THOMPSON, BRYAN, and DEWINE this afternoon to introduce the Medicare Renal Dialysis Payment Fairness Act of 2000. This bipartisan legislation takes important steps to assure both the quality and availability of outpatient dialysis services for Medicare patients with end-stage renal disease (ESRD).

Almost 30 years ago, Congress recognized the pain and suffering patients with end-stage renal disease face, and thus moved to provide coverage for dialysis treatment to this population under the Medicare Program. Today, approximately 300,000 patients nationwide live with this disease and receive services through Medicare. Presently, there are 3,423 dialysis facilities throughout the Nation that serve the Medicare population, 93 of which are in my home State of Tennessee.

However, I fear that a lack of proper reimbursement may adversely impact the quality and availability of dialysis care for Medicare beneficiaries. As the Medicare Payment Advisory Commission (MedPAC) noted, the payment rate for the critical dialysis services received by Medicare beneficiaries was established in 1983, and had never been updated.

Last year, Senator CONRAD and I sought to remedy this situation by introducing S. 1449, the Medicare Renal

Dialysis Fair Payment Act of 1999, which provided an update to the Medicare reimbursement rate for dialysis services for Fiscal Year 2000. Thus, I was pleased to see the Balanced Budget Refinement Act of 1999 (BBRA) include a provision increasing the payment rate by 1.2 percent for Fiscal Year 2000 and 1.2 percent for Fiscal Year 2001.

However, the BBRA represented only the first step toward securing access to dialysis services for Medicare patients and ensuring they receive the highest quality of care. The legislation we are introducing today takes the necessary additional steps, as recommended by MedPAC this year, to assure proper reimbursement levels for dialysis services.

Specifically, the ''Medicare Renal Dialysis Payment Fairness Act of 2000'' provides a 1.2 percent increase in the payment rate for FY 2001, in addition to the 1.2 percent update included in the BBRA, providing a 2.4 percent total increase. This follows MedPAC's analysis of dialysis center costs that concluded that prices paid by dialysis centers would rise by 2.4 percent between Fiscal Year 2000 and 2001.

Second, the legislation ensure proper reimbursement in future years by requiring the Health Care Financing Administration (HCFA) to develop a market basket index for dialysis centers that measures input prices and other relevant factors and to annually review and update the payment rate based upon this index.

Overall, the Medicare Renal Dialysis Payment Fairness Act of 2000 will ensure that dialysis facilities receive the proper Medicare reimbursement to continue to provide high quality dialysis services to the ESRD population.

I am grateful to the National Kidney Foundation, the American Nephrology Nurses Association, the Renal Physicians Association, the National Renal Administrators Association, and the Renal Leadership Council for their support of the Medicare Renal Dialysis Payment Fairness Act of 2000, and I urge my colleagues to support this critical measure.

ADDITIONAL COSPONSORS

S. 577

At the request of Mr. HATCH, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 577, a bill to provide for injunctive relief in Federal district court to enforce State laws relating to the interstate transportation of intoxicating liquor.

S. 642

At the request of Mr. GRASSLEY, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 642, a bill to amend the Internal Revenue Code of 1986 to provide for Farm and Ranch Risk Management Accounts, and for other purposes.

S. 681

At the request of Mr. DASCHLE, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of S. 681, a bill to amend the Public Health Service Act and Employee Retirement Income Security Act of 1974 to require that group and individual health insurance coverage and group health plans provide coverage for a minimum hospital stay for mastectomies and lymph node dissections performed for the treatment of breast cancer.

S. 805

At the request of Mr. DURBIN, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of S. 805, a bill to amend title V of the Social Security Act to provide for the establishment and operation of asthma treatment services for children, and for other purposes.

S. 1020

At the request of Mr. GRASSLEY, the names of the Senator from New Mexico (Mr. DOMENICI), the Senator from Mississippi (Mr. LOTT), and the Senator from Rhode Island (Mr. L. CHAFEE) were added as cosponsors of S. 1020, a bill to amend chapter 1 of title 9, United States Code, to provide for greater fairness in the arbitration process relating to motor vehicle franchise contracts.

At the request of Mr. FEINGOLD, the name of the Senator from Hawaii (Mr. INOUYE) was added as a cosponsor of S. 1020, supra.

S. 1391

At the request of Mr. INOUYE, the names of the Senator from California (Mrs. BOXER) and the Senator from Maryland (Mr. SARBANES) were added as cosponsors of S. 1391, a bill to amend title 38, United States Code, to improve benefits for Filipino veterans of World War II, and for other purposes.

S. 1510

At the request of Mr. MCCAIN, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 1510, a bill to revise the laws of the United States appertaining to United States cruise vessels, and for other purposes.

S. 1810

At the request of Mrs. MURRAY, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 1810, a bill to amend title 38, United States Code, to clarify and improve veterans' claims and appellate procedures.

S. 1900

At the request of Mr. LAUTENBERG, the name of the Senator from Pennsylvania (Mr. SANTORUM) was added as a cosponsor of S. 1900, a bill to amend the Internal Revenue Code of 1986 to allow a credit to holders of qualified bonds issued by Amtrak, and for other purposes.

S. 1974

At the request of Mr. SCHUMER, the names of the Senator from Wisconsin (Mr. KOHL), the Senator from Illinois (Mr. DURBIN), and the Senator from Nevada (Mr. REID) were added as cosponsors of S. 1974, a bill to amend the Internal Revenue Code of 1986 to make higher education more affordable by providing a full tax deduction for higher education expenses and a tax credit for student education loans.

S. 1987

At the request of Mr. DURBIN, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of S. 1987, a bill to amend the Violence Against Women Act of 1994, the Family Violence Prevention and Services Act, the Older Americans Act of 1965, and the Public Health Service Act to ensure that older women are protected from institutional, community, and domestic violence and sexual assault and to improve outreach efforts and other services available to older women victimized by such violence, and for other purposes.

S. 2003

At the request of Mr. JOHNSON, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of S. 2003, a bill to restore health care coverage to retired members of the uniformed services.

S. 2264

At the request of Mr. JOHNSON, his name was added as a cosponsor of S. 2264, a bill to amend title 38, United States Code, to establish within the Veterans Health Administration the position of Advisor on Physician Assistants, and for other purposes.

S. 2274

At the request of Mr. GRASSLEY, the names of the Senator from Wisconsin (Mr. KOHL) and the Senator from Wisconsin (Mr. FEINGOLD) were added as cosponsors of S. 2274, a bill to amend title XIX of the Social Security Act to provide families and disabled children with the opportunity to purchase coverage under the medicaid program for such children.

S. 2308

At the request of Mr. MOYNIHAN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 2308, a bill to amend title XIX of the Social Security Act to assure preservation of safety net hospitals through maintenance of the Medicaid disproportionate share hospital program.

S. 2399

At the request of Mr. DURBIN, the names of the Senator from South Dakota (Mr. JOHNSON), the Senator from California (Mrs. BOXER), and the Senator from Maryland (Ms. MIKULSKI) were added as cosponsors of S. 2399, a bill to amend title XVIII of the Social Security Act to revise the coverage of immunosuppressive drugs under the medicare program.

S. 2612

At the request of Mr. GRAHAM, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of S. 2612, a bill to combat Ecstasy trafficking, distribution, and abuse in the United States, and for other purposes.