sanctions are threatened or imposed. Keeping Congressional advisers in the monitoring and enforcement loop tends to be episodic. It should be systematic.

The Guidelines should provide for consultations with Congressional advisers on monitoring and enforcement at least every two months. These consultations should not just highlight problems. They should provide a complete picture of how the Executive Branch is deploying its monitoring and enforcement resources. They should identify where these efforts are succeeding, as well as where they require reenforcement.

In conclusion, the Trade Act of 2002 represents a watershed in relations between the Executive and Legislative Branches when it comes to trade policy and negotiations. Before the Trade Act, the Executive Branch generally took the lead, and the involvement of Congressional advisers tended to be cursory and episodic. In the Trade Act, Congress sent a clear message that the old way will not do.

From now on, the involvement of Congressional advisers in developing trade policy and negotiations must be in depth and systematic. Congress can no longer be an afterthought. The Trade Act establishes a partnership of equals. It recognizes that Congress's constitutional authority to regulate foreign trade and the President's constitutional authority to negotiate with foreign nations are interdependent. It requires a working relationship that reflects that interdependence.

Our first opportunity to memorialize this new, interdependent relationship is only weeks away. I am very hopeful that the Administration will work closely with us in developing the Guidelines to make the partnership of equals a reality.

EXHIBIT 1

TREATIES AND OTHER INTERNATIONAL AGREEMENTS: THE ROLE OF THE UNITED STATES SENATE

On occasion Senators or Representatives have served as members of or advisers to the U.S. delegation negotiating a treaty. The practice has occurred throughout American history. In September 1898, President William McKinley appointed three Senators to a commission to negotiate a treaty with Spain. President Warren G. Harding appointed Senators Henry Cabot Lodge and Oscar Underwood as delegates to the Conference on the Limitation of Armaments in 1921 and 1922 which resulted in four treaties, and President Hoover appointed two Senators to the London Naval Arms Limitation Conference in 1930.

The practice has increased since the end of the Second World War, in part because President Wilson's lack of inclusion of any Senators in the American delegation to the Paris Peace Conference was considered one of the reasons for the failure of the Versailles Treaty. Four of the eight members of the official U.S. delegation to the San Francisco Conference establishing the United Nations were Members of Congress: Senators Tom Connally and Arthur Vandenberg and Representatives Sol Bloom and Charles A. Eaton.

There has been some controversy over active Members of Congress serving on such delegations. When President James Madison appointed Senator James A. Bayard and Speaker of the House Henry Clay to the commission that negotiated the Treaty of Ghent in 1814, both resigned from Congress to undertake the task. More recently, as in the annual appointment of Senators or Members of Congress to be among the U.S. representatives to the United Nations General Assembly, Members have participated in delegations without resigning, and many observers consider it ''now common practice and no longer challenged.''

One issue has been whether service by a Member of Congress on a delegation violated Article I, Section 6 of the Constitution. This section prohibits Senators or Representatives during their terms from being appointed to a civil office if it has been created or its emoluments increased during their terms, and prohibits a person holding office to be a Member of the Senate or House. Some contend that membership on a negotiating delegation constitutes holding an office while others contend that because of its temporary nature it is not.

Another issue concerns the separation of powers. One view is that as a member of a negotiating delegation a Senator would be subject to the instructions of the President and would face a conflict of interest when later required to vote on the treaty in the Senate. Others contend that congressional members of delegations may insist on their independence of action and that in any event upon resuming their legislative duties have a right and duty to act independently of the executive branch on matters concerning the treaty.

A compromise solution has been to appoint Members of Congress as advisers or observers, rather than as members of the delegation. The administration has on numerous occasions invited one or more Senators and Members of Congress or congressional staff to serve as advisers to negotiations of multilateral treaties. In 1991 and 1992, for example, Members of Congress and congressional staff were included as advisers and observers in the U.S. delegations to the United Nations Conference on Environment and Development and its preparatory meetings. In 1992, congressional staff advisers were included in the delegations to the World Administrative Radio Conference (WARC) of the International Radio Consultative Committee (CCIR) of the International Telecommunications Union.

In the early 1990s, Congress took initiatives to assure congressional observers. The Senate and House each designated an observer group for strategic arms reductions talks with the Soviet Union that began in 1985 and culminated with the Strategic Arms Reduction Treaty (START) approved by the Senate on October 1, 1992. In 1991, the Senate established a Senate World Climate Convention Observer Group. As of late 2000, at least two ongoing groups of Senate observers existed:

1. Senate National Security Working Group.—This is a bipartisan group of Senators who ''act as official observers to negotiations * * * on the reduction or limitation of nuclear weapons, conventional weapons or weapons of mass destruction; the reduction, limitation, or control of missile defenses; or related export controls.''

2. Senate Observer Group on U.N. Climate Change Negotiations.—This is a ''bipartisan group of Senators, appointed by the Majority and Minority Leaders'' to monitor ''the status of negotiations on global climate change and report[ing] periodically to the Senate * * *.''

OUR LADY OF PEACE ACT

Mr. LEVIN. Mr. President, a sensible gun safety measure has been recently passed by our colleagues in the House of Representatives. The ''Our Lady of Peace Act'' was first introduced by Representative CAROLYN MCCARTHY after Reverend Lawrence Penzes and Eileen Tosner were killed at Our Lady of Peace church in Lynbrook, NY on March 12, 2002. These deaths may have been prevented if the assailant's misdemeanor and mental health records were part of an automated and complete background check system.

According to the House Judiciary Committee Report on the bill, 25 States have automated less than 60 percent of their felony criminal conviction records. While many States have the capacity to fully automate their background check systems, 13 States do not automate or make domestic violence restraining orders accessible through the National Instant Criminal Background Check System, otherwise known as NICS. Fifteen States do not automate domestic violence misdemeanor records or make them accessible through NICS. Since 1994, the Brady Law has successfully prevented more than 689,000 individuals from illegally purchasing a firearm. More ineligible firearm purchases could have been prevented, and more shooting deaths may have been avoided had state records been fully automated.

The Our Lady of Peace Act would require Federal agencies to provide any government records with information relevant to determining the eligibility of a person to buy a gun for inclusion in NICS. It would also require states to make available any records that would disqualify a person from acquiring a firearm, such as records of convictions for misdemeanor crimes of domestic violence and individuals adjudicated as mentally defective. To make this possible, this bill would authorize appropriations for grant programs to assist States, courts, and local governments in establishing or improving automated record systems. I hope we can move in this direction this Congress or next.

ASSISTANCE FOR SOUTH DAKOTA MEDICARE BENEFICIARIES AND PROVIDERS

Mr. JOHNSON. Mr. President, one of the key remaining issues of the 107th Congress that I believe must be addressed yet this year is Medicare relief for rural health care providers and beneficiaries. Recently, bipartisan legislation was introduced, called the Beneficiary Access to Care and Medicare Equity Act of 2002, S. 3018, that will provide definitive steps to strengthen South Dakota's rural health care delivery system. I am pleased to be a cosponsor of this bill.

The legislation will provide $43 billion over ten years for provider and beneficiary improvements in the Medicare and Medicaid programs. Earlier

this summer, the House passed a Medicare bill, which provides approximately $30 billion over ten years. The Senate legislation will provide South Dakota with nearly $84.2 million in Medicare improvements for rural hospitals, skilled nursing facilities, home health services, physicians, and beneficiaries alike. Although the Administration has expressed some resistance to working with Congress on Medicare legislation this year, I will continue to fight for passage of this critically important legislation.

As I travel throughout South Dakota, many health care providers and Medicare beneficiaries have expressed concerns regarding inequities with Medicare reimbursements in rural states like South Dakota. It is a travesty that nationwide, rural providers receive less Medicare reimbursement for providing the same services as their urban counterparts. Therefore, I remain committed to improving the equity in Medicare reimbursement levels for rural States, and increasing access to quality, affordable health care for the citizens of South Dakota.

As a member of the Senate Rural Health Caucus, I joined several of my fellow caucus members in sending a letter to the Senate Finance Committee expressing our rural health priorities as compiled from the input that I received from South Dakotans, such as yourself. I was pleased that many of my rural priorities were included in S. 3018, and would ask unanimous consent that the text of this letter be printed in the CONGRESSIONAL RECORD. As well, I ask unanimous consent that the summary of S. 3018 also be printed in the RECORD.

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

U.S. SENATE,
Washington, DC, September 16, 2002.

Hon. MAX BAUCUS, *Chairman,*
Hon. CHARLES GRASSLEY, *Ranking Member,*
Committee on Finance,
Washington, DC.

DEAR CHAIRMAN BAUCUS AND RANKING MEMBER GRASSLEY: As members of the Senate Rural Health Caucus, we write to urge you to take definitive steps this year to strengthen our nation's rural health care delivery system. We are particularly concerned about geographic inequities in Medicare spending, which are caused in part by disparities in current Medicare payment formulas. Related to this, we strongly urge the Committee to address needed rural payment improvements in its Medicare refinement bill.

Nationwide, rural providers receive less Medicare reimbursement for providing the same services as their urban counterparts. According to the latest Medicare figures, Medicare's annual inpatient payments per beneficiary by state of residence range from slightly more than $3,000 in predominately rural states like Wyoming, Idaho and Iowa to over $7,000 in other states.

This problem is compounded by the fact that rural Medicare beneficiaries tend to be poorer and have more chronic illnesses than urban beneficiaries. This inherent vulnerability of rural providers combined with historic funding shortfalls and rising costs has placed additional burdens on an already strained rural health care system.

It is due to these unique circumstances that rural providers and beneficiaries deserve to be the Committee's top priority as it writes legislation to strengthen the Medicare system. We encourage the Committee to give special consideration to those states that are experiencing the lowest aggregate negative Medicare margins. We request the following rural specific provisions be included in the Committee's final Medicare provider legislation:

1. RURAL HOSPITALS

Market Basket Update: Under current law, all hospitals will receive a Medicare payment update in FY2003 of hospital cost inflation minus approximately one-half percent. However, hospitals in rural areas and smaller urban areas have Medicare profit margins far lower than those of hospitals in large urban areas. Therefore, we urge the Committee to provide hospitals located in rural or smaller urban areas with a full inflation update.

Equalize Medicare Disproportionate Share Hospital Payment (DSH) Formula: Hospitals receive add-on payments to help cover the costs of serving a high proportion of uninsured patients. While urban facilities can receive unlimited add-ons corresponding with the amount of patients served, rural add-on payments are capped at 5.25 percent of the total amount of the inpatient payment. We urge the Committee to remove this cap for rural hospitals, bringing their payments in line with the benefits urban facilities receive.

Close Gap Between Urban and Rural ''Standardized Payment'' Levels: Inpatient hospital payments are calculated by multiplying several different factors, including a standardized payment amount. Under current law, hospitals located in cities with more than 1 million people receive a base payment among 1.6 percent higher than those serving smaller populations. We urge the Committee to address this disparity by bringing the rural base payment up to the urban payment level.

Low-Volume Hospital Payment: According to recent data, the current hospital inpatient payment rate has placed low-volume hospitals at a disadvantage because it does not adequately account for the fact that smaller facilities have difficulty achieving the economies of scale of their larger counterparts. To address this problem, we request the Committee create a low-volume inpatient payment adjustment for hospitals that have less than 1,000 annual discharges per year and are located more than 15 miles from another hospital.

Outpatient Payment Improvements: Rural Hospitals are highly dependent on outpatient services for revenue; however, the Medicare Outpatient Prospective Payment System sets payments at 16 percent below costs. We urge the Committee to take the following actions to ensure outpatient stability for rural hospitals.

1. Increase emergency room and APC payments by 10 percent.

2. Limit the pro rata reduction in pass-through payments to 20 percent.

3. Limit the budget neutrality adjustment to no more than 2 percent.

4. Extend current provision that holds small, rural hospitals harmless from the current Outpatient PPS for three more years.

5. Improve and extend transitional corridor payments to rural hospitals.

Wage Index Issues: Medicare's current inpatient hospital payments fail to accurately reflect today's labor costs in rural areas. The Caucus has long been concerned about this issue and its impact on rural hospitals as they strive to recruit and retain key health care personnel. We strongly urge the Committee to address the area wage index disparities with new money.

Current law allows rural facilities located near urban area to receive the higher wage index available to the facilities located in the metropolitan area. However, this wage index ''reclassification'' is available only for inpatient and outpatient services. We believe re-classification should extend to other services offered by hospitals, such as home care and skilled nursing services.

2. CRITICAL ACCESS HOSPITAL PROGRAM IMPROVEMENTS

The Balanced Budget Act of 1997 created the Critical Access Hospital program (CAH) to ensure access to essential health services in underserved rural communities that cannot support a full service hospital. This program has proven to be critically important to rural areas as 667 hospitals across the nation have converted to Critical Access Hospital status. We urge the Committee to include the following modifications to strengthen this critical program.

- Reinstate Periodic Interim Payments (PIP), which provide facilities with a steadier stream of payment in order to improve their cash flow.
- Eliminate the current requirement that CAH-based ambulance services be at least 35 miles from another ambulance service in order to receive cost-based payment.
- Allow for home health services operated by CAHs to be reimbursed on a cost basis, as other CAH services already are.
- Provide cost-based reimbursement for certain clinical diagnostic lab tests furnished by a CAH.
- Provide Medicare coverage to CAHs for certain emergency room on-call providers.
- Allow CAHs to interchange the number of their acute and swing beds as necessary, but still maintain the current 25 bed limit.
- Alleviate payment reductions that will occur as a result of recent cost report changes made by CMS related to the amount of allowable beneficiary coinsurance payments.

3. RURAL HOME HEALTH IMPROVEMENTS

Home health care is a critical element of the continuum of care, allowing Medicare beneficiaries to remain in their homes rather than being hospitalized. Current law provides for a 10 percent payment boost for patients residing in rural areas, to reflect the higher costs due to distance, as well as the reality that there is often only one provider in rural areas. However, this special payment will expire with the current fiscal year.

4. RURAL HEALTH CLINICS

Under current law, rural health clinics receive an all-inclusive payment rate that is capped at approximately $63. Various analyses have suggested that this cap does not appropriately cover the cost of services for more than 50 percent of rural health clinics that the cap should be raised by 25 percent to address this shortfall. We request that the Committee raise the rural health clinic cap to $79.

Certain provider services, such as those offered by physicians, nurse practitioners, physician assistants, and qualified psychologists are excluded from the consolidated payments made to skilled nursing facilities (SNFs) under the prospective payment system. However, the same services provided to SNFs by physicians and other providers employed by rural health clinics are not excluded from the consolidated SNF payment. We request the Committee ensure skilled nursing services offered by rural health clinic providers will receive the same payment treatment as services offered by providers employed in other settings.

5. RURAL PROVIDERS

Rural Physicians: There are several ways to improve the current Medicare Incentive

Payment program to increase payments to rural physicians. Such changes include: placing the burden for determining eligibility for the current 10 percent rural physician bonus payment on the Medicare carrier rather than the individual physician; creating a Medicare Incentive Payment Education program at CMS; and establishing an on-going analysis of the program's ability to improve Medicare beneficiaries' access to physician services. We urge the Committee to make these critical changes to the Medicare Inventive Payment program.

Mental Health Providers: The majority of rural and frontier areas are federally designated mental health professional shortage areas. In many of these underserved communities, a Marriage and Family Therapist or a Licensed Professional Counselor is the only mental health provider available to seniors, but is not able to bill Medicare for their services. We strongly urge the Committee to provide Medicare reimbursement for Licensed Professional Counselors and Marriage and Family Therapists at the rate that Social Workers are paid.

6. OTHER RURAL ISSUES

Ambulance Services: The Balanced Budget Act of 1997 directed the Secretary of Health and Human services to establish a fee schedule payment system for ambulance services. The negotiated rule making committee that was utilized in the regulatory process instructed the Secretary to account for geographic differences and develop a more appropriate coding system. However, the current ambulance payment system does not recognize the unique circumstances of low-volume, rural providers. We strongly urge the Committee to address these issues to ensure access to critical ambulance services in rural and frontier communities.

Pathology Labs: Currently, independent labs can bill Medicare directly for all services. After January 1, 2003 labs will only be able to bill for diagnosis of slides prepared by the lab. The costs of slide preparation must be recovered separately from the hospital. Small, rural hospitals that do not have their own pathology departments and independent labs face increased administrative costs and complexity in this new billing arrangement. We request that the Committee make permanent the grandfather clause enacted in BIPA to allow independent labs to receive direct reimbursement from Medicare.

National Health Service Corps Taxation: The National Health Service Corps program (NHSC) provides either scholarships or loan-repayments to clinicians who agree to serve for at least three years in a designated health professional shortage area. Last year's tax cut exempted NHSC scholarships from taxation, but loan-repayments are still considered taxable income. As a result, almost half of the current NHSC appropriation is spent in the form of stipends to clinicians to offset the tax liability on loan repayments. We strongly urge the Committee to exempt the NHSC loan repayments from taxation.

Flex Reauthorization: As you know, the Balanced Budget Act of 1997 created the Rural Hospital Flexibility program (known as the ''flex'' program) to assist small rural hospitals in making the switch to Critical Access Hospital status (CAH). This program has proven to be very successful in rural areas as it has maintained access to critical care in small communities. Program funds are used by states for Critical Access Hospital designation and assistance, rural health planning and network development, and rural emergency medical services. We urge the Committee to reauthorize this important rural health program.

We greatly appreciate the Committee's past efforts on behalf of our nation's rural health care delivery system. We look forward to continuing to work with you to ensure that all rural providers receive the necessary resources to provide quality health care services to rural seniors.

Sincerely,

Craig Thomas (Co-Chair), Sam Brownback, ——, Byron L. Dorgan, Ben Nelson, ——, Fred H. Thompson, Conrad R. Burns, Jesse Helms, Wayne Allard, Michael Crapo, Chris Bond, James Inhofe, Patrick Leahy, Jeff Sessions, Debbie Stabenow, Paul Wellstone, Mike DeWine, Carl Levin, Ben Nighthorse Campbell, Jean Carnahan.

Tom Harkin (Co-Chair), Tim Johnson, Jeff Bingaman, Maria Cantwell, Mary Landrieu, Larry Craig, Pat Roberts, John Edwards, Blanche Lincoln, Susan Collins, Patty Murray, Mark Dayton, Gordon Smith, Tom Daschle, Tim Hutchinson, Jim Jeffords, ——, Ernest Hollings, Thad Cochran, Kay Bailey Hutchison, Ron Wyden, Orrin Hatch.

THE BENEFICIARY ACCESS TO CARE AND MEDICARE EQUALITY ACT OF 2002

TOTAL COST OVER 10 YEARS: APPROXIMATELY $43 BILLION

NOTE: subtotals below do not sum to $42 billion due to Part B premium and Medicaid interactions and rounding. Part B premium and Medicaid interactions total approximately −$2.5 billion over 10 years.

Title I—Rural Health Care Improvements

(Approx. $12.8 billion over 10 years)

Sec. 101. Full standardized amount for rural and small urban hospitals by FY04 and thereafter.

Sec. 102. Wage index changes: labor-related share for hospitals with a wage index below 1.0 is 68% for FY03 through FY05; labor-related share for hospital with a wage index above 1.0 is held harmless (i.e. remains at current level of 71%).

Sec. 103. Medicare disproportionate share (DSH) payments: increases the maximum DSH adjustment for rural hospitals and urban hospitals with under 100 beds to 10% (phased-in over ten years).

Sec. 104. 1-year extension of hold harmless from outpatient PPS for small rural hospitals.

Sec. 105. 5% add-on for clinic and ER visits for small rural hospitals.

Sec. 106. 2-year extension of reasonable cost payments for diagnostic lab tests in Sole Community Hospitals.

Sec. 107. Critical Access Hospital improvements: (a) Reinstatement of periodic interim payments; (b) Condition for application of special physician payment adjustment; (c) Coverage of costs for certain emergency room on-call providers; (d) Prohibition on retroactive recoupment; (e) Increased flexibility for states with respect to certain frontier critical access hospitals; (f) Permitting hospitals to allocate swing beds and acute care inpatient beds subject to a total limit of 25 beds; (g) Provisions related to certain rural grants; (h) Coordinated survey demonstration program.

Sec. 108. Temporary relief for certain non-teaching hospital for FY03 through FY05 (same as House-passed provision).

Sec. 109. Physician work Geographic Practice Cost Index at 1.0 for CY03 through CY05, holding harmless those areas with work GPCIs over 1.0.

Sec. 110. Make existing Medicare Incentive Payment 10% bonus payments on claims by physicians serving patients in rural Health Professional Shortage Areas automatic, rather than requiring special coding on such claims.

Sec. 111. GAP study on geographic differences in physician payments.

Sec. 112. Extension of 10% rural add-on for home health through FY04.

Sec. 113. 10% add-on for frontier hospice for CY03 through CY07.

Sec. 114. Exclude services provided by Rural Health Clinic-based practitioners from Skilled Nursing Facility consolidated billing.

Sec. 115. Rural Hospital Capital Loan Authorization.

Title II—Provisions Relating to Part A

(Approx. $9.0 billion over 10 years)

Subtitle A—Inpatient Hospital Services

Sec. 201. FY03 inflation adjustment of market basket minus −0.25% for PPS hospitals; full market basket for Sole Community Hospitals.

Sec. 202. Update hospital market basket weights more frequently.

Sec. 203. IME Adjustment: 6.5% in FY03, 6.5% in FY04, 6.0% in FY05.

Sec. 204. Puerto Rico: 75%–25% Federal-Puerto Rico blend beginning in FY 03.

Sec. 205. Geriatric GME programs: certain geriatric residents do not count against caps.

Sec. 206. DSH increase for Pickle hospitals from 35% to 40%.

Subtitle B—Skilled Nursing Facility Services

Sec. 211. Increase to nursing component of RUGs: 15% in FY03, 13% in FY04, 11% in FY05; increase in payment for AIDS patients cared for by SNFs; GAO study.

Sec. 212. Require collection of staffing data; require staffing measure in CMS quality initiative.

Subtitle C—Hospice

Sec. 221. Allow payment for hospice consultation services based on fee schedule set by Secretary; remove one-time limit set by House.

Sec. 222. Authorize use of arrangements with other hospice programs.

Title III—Provisions Relating to Part B

(Approx. $10.0 billion over 10 years)

Subtitle A—Physicians' Services

Sec. 301. Physician payment increase (same as House-passed version); GAO study; MedPAC report.

Sec. 302. Extension of treatment of certain physician pathology services through FY05.

Subtitle B—Other Services

Sec. 311. Competitive bidding for DME: begin national phase-in CY03 for MSAs with over 500,000 people.

Sec. 312. 2-year extension of moratorium on therapy caps.

Sec. 313. Acceleration of reduction of beneficiary copayment for hospital outpatient department services.

Sec. 314. End-Stage Renal Disease: Increase composite rate to 1.2% in CY03 and CY04; composite rate exceptions for pediatric facilities.

Sec. 315. Improved payment for certain mammography services.

Sec. 316. Waiver of Part B late enrollment penalty for certain military retirees and special enrollment period.

Sec. 317. Coverage of cholesterol and blood lipid screening.

Sec. 318. 5% payment increase for rural ground ambulance service, 2% increase for urban ground ambulance services.

Sec. 319. Medical necessity criteria for air ambulance services under ambulance fee schedule.

Sec. 320. Improved payment for thin prep pap tests.

Sec. 321. Coverage of immunsuppressive drugs.

Sec. 322. Geriatric care assessment demonstration program.

Sec. 323. CMS study and recommendations to Congress on revisions to outpatient payment methodology for drugs, devices and biologicals.

Title IV—Provisions Relating to Parts A and B

(Approx. $0.0 billion over 10 years)

Subtitle A—Home Health Services

Sec. 401. Eliminate 15% reduction in payments for home health services.

Sec. 402. Reduce inflation updates in FY03 through FY05; full market basket increases thereafter.

Subtitle B—Other Provisions

Sec. 411. Information technology demonstration project.

Sec. 412. Modifications to the Medicare Payment Advisory Commission.

Sec. 413. Requires CMS to maintain a carrier medical director and carrier advisory committee in every state to ensure access to the local coverage process.

Title V—Medicare+Choice and Related Provisions

(Approx. $2.3 billion over 10 years, including M+C interactions)

Sec. 501. Increase minimum updates to 4% in CY03 and 3% in CY04.

Sec. 502. Clarify Secretary's authority to disapprove certain cost-sharing

Sec. 503. Extend cost contracts for 5 years.

Sec. 504. Extend the Social HMO Demonstration through 2006.

Sec. 505. Extend specialized plans for special needs beneficiaries for 5 years (Evercare).

Sec. 506. Extend 1% entry bonus for M+C for 2 years; bonus does not apply for private fee-for-service or demonstration plans.

Sec. 507. PACE technical fix regarding services furnished by non-contract providers.

Sec. 508. Reference to implementation of certain M+C provisions in 2003.

Title VI—Medicare Appeals, Regulator, and Contracting Improvements

(Approx. $0.0 billion over 10 years)

Subtitle A—Regulatory Reform

Sec. 601. Require status report on interim final rules; limit effectiveness of interim final rules to 12 months with one extension permitted under certain circumstances.

Sec. 602. Requires only prospective compliance with regulation changes.

Sec. 603. Secretary report on legal and regulatory inconsistencies in Medicare.

Subtitle B—Appeals Process Reform

Sec. 611. Requires Secretary to submit detailed plan for transfer of responsibility for medicare appeals from SSA to HHS; GAO evaluation of plan.

Sec. 612. Allows expedited access to judicial review for Medicare appeals involving legal issues that the DAB does not have the authority to decide.

Sec. 613. Allows expedited appeals for certain provider agreement determinations, including terminations.

Sec. 614. Tightens eligibility requirements for QICs and reviewers; ensures notice and improved explanation on determination and redetermination decisions; delays implementation of Section 521 of BIPA for 14 months, but continues implementation of expedited redeterminations; expands CMS discretion on the number of QICs.

Sec. 615. Creates hearing rights in cases of denial or nonrenewal of enrollment agreements; requires consultation before CMS changes provider enrollment forms.

Sec. 616. Permits provider to appeal determinations relating to services rendered to an individual who subsequently dies if there is no other party available to appeal.

Sec. 617. Permits providers to seek appeal of local coverage decisions and to request development of local coverage decisions under certain circumstances.

Subtitle C—Contracting Reform

Sec. 621. Authorizes Medicare contractor reform beginning in October 2004.

Subtitle D—Education and Outreach Improvements

Sec. 631. New education and technical assistance requirements.

Sec. 632. Requires CMS and contractors to provide written responses to health care providers' and beneficiaries' questions with 45 days.

Sec. 633. Suspends penalties and interest payments for providers that have followed incorrect guidance.

Sec. 634. Creates new ombudsmen offices for health care providers and beneficiaries.

Sec. 635. Authorizes beneficiary outreach demonstration.

Subtitle E—Review, Recovery, and Enforcement Reform

Sec. 641. Requires CMS to establish standards for random prepayment audits.

Sec. 642. Requires CMS to enter into overpayment repayment plans. Prevents CMS from recovering overpayments until the second level of appeal is exhausted.

Sec. 643. Establishes a process for the correction of incomplete or missing data without pursuing the appeals process.

Sec. 644. Expands the current waiver of program exclusions in cases where the provider is a sole community physician or sole source of essential health care.

Title VII—Medicaid-SCHIP

(Approx. $10.8 billion over 10 years)

Sec. 701. Extend Medicaid disproportionate share hospital (DSH) inflation updates (for 2001 and 2002) to 2003, 2004 and 2005 allotments; update District of Columbia DSH allotment.

Sec. 702. Raise cap from 1% to 3% for states classified as low Medicaid DSH in FY03 through FY05.

Sec. 703. Five year extension of QI–1 Program.

Sec. 704. Enable public safety net hospitals to access discount drug pricing for inpatient drugs.

Sec. 705. CHIP Redistribution: give states an additional year to spend expiring funds that would otherwise return to the Treasury; continue BIPA arrangement for SCHIP redistribution; establish caseload stabilization pool beginning in FY04; allow certain states to use a portion of unspent SCHIP funds to cover specified Medicaid beneficiaries; GAO study to evaluate program implementation and funding.

Sec. 706. Improvements to Section 1115 waiver process for Medicaid and State Children's Health Insurance Program (SCHIP) waiver.

Sec. 707. Increase the federal medical assistance percentage in Medicaid (FMAP) by 1.3% for 12 months for all states; ''hold harmless'' states scheduled to have a lower FMAP in FY03; $1 billion increase in Social Services Block Grant for FY03.

Title VIII—Other Provisions

(Approx. $0.9 billion over 10 years)

Sec. 801. Extend funding for Special Diabetes Programs for FY04, FY05, and FY06 at $150 million per program per year.

Sec. 802. Disregard of certain payments under the Emergency Supplemental Act, 2000 in the administration of Federal programs and federally assisted programs.

Sec. 803. Create Safety Net Organizations and Patient Advisory Commission.

Sec. 804. Guidance on prohibitions against discrimination by national origin.

Sec. 805. Extend grants to hospitals for EMTALA treatment of undocumented aliens.

Sec. 806. Extend Medicare Municipal Health Services Demonstration for 1 year.

Sec. 807. Provides for delayed implementation of certain provisions.

VETERANS DAY 2002

Mr. FEINGOLD. Mr. President, as the Senate prepares to recess until after the November elections, I would like to take a moment to express my thanks and the thanks of the people of Wisconsin to our Nation's veterans and their families.

The Senate will not be in session on Veterans Day, November 11th. I urge my colleagues and all Americans to take a moment on that day to reflect upon the meaning of that day and to remember those who have served and sacrificed to protect our country and the freedoms that we enjoy as Americans.

Webster's Dictionary defines a veteran as ''one with a long record of service in a particular activity or capacity,'' or ''one who has been in the armed forces.'' But we can also define a veteran as a grandfather or a grandmother, a father or a mother, a brother or a sister, a son or a daughter. Veterans live in all of our communities, and their contributions have touched all of our lives.

November 11 is a date with special significance in our history. On that day in 1918—at the eleventh hour of the eleventh day of the eleventh month—World War I ended. In 1926, a joint resolution of Congress called on the President to issue a proclamation to encourage all Americans to mark this day by displaying the United States flag and by observing the day with appropriate ceremonies.

In 1938, ''Armistice Day'' was designated as a legal holiday ''to be dedicated to the cause of world peace'' by an Act of Congress. This annual recognition of the contributions and sacrifices of our Nation's veterans of World War I was renamed ''Veterans Day'' in 1954 so that we might also recognize the service and sacrifice of those who had fought in World War II and the veterans of all of America's other wars.

Mr. President, our Nation's veterans and their families have given selflessly to the cause of protecting our freedom. Too many have given the ultimate sacrifice for their country, from the battlefields of the Revolutionary War that gave birth to the United States to the Civil War that sought to secure for all Americans the freedoms envisioned by the Founding Fathers. In the last century, Americans fought and died in two world wars and in conflicts in Korea, Vietnam, and the Persian Gulf. They also participated in peacekeeping missions around the globe, some of which are still going on. Today, our men and women in uniform are waging a fight against terrorism. And in the future, our military personnel could be asked to undertake a campaign in Iraq.

As we prepare to commemorate Veterans Day 2002, we should reflect on the