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

sacrifices—past, present, and future—that are made by our men and women in uniform and their families. We can and should do more for our veterans to ensure that they have a decent standard of living and access to adequate health care.

For those reasons, I am deeply concerned about a memorandum that was sent to Veterans Integrated Service Network Directors by Deputy Under Secretary for Health for Operations and Management Laura Miller in July ordering them to ''ensure that no marketing activities to enroll new veterans occur within your networks.'' The memo continued, ''[i]t is important to attend veteran-focused events as part of our responsibilities, but there is a difference between providing general information and actively recruiting people into the system.''

Deputy Under Secretary Miller's memo states that the increased demand for VA health care services exceeds the VA's current resources. According to the memo, ''In this environment, marketing VA services with such activities as health fairs, veteran open houses to invite new veterans to the facilities, or enrollment displays at VSO, Veteran Service Officer meetings, are inappropriate.''

While it is clear that more funding should be provided for VA health care and other programs, what is inappropriate is for the VA to institute a policy to stop making veterans aware of the health care services for which they may be eligible.

Soon after this memo was issued, I joined with the Senator from Massachusetts (Mr. KERRY) and a number of colleagues to send a letter to the President that expressed concern about the memo and asked that the policy outlined in it be reversed. As of today, Mr. President, more than two months later, we have yet to receive a reply to that letter.

I call on the President and the Secretary of Veterans Affairs to reverse immediately this unacceptable policy.

After the 108th Congress convenes next year, I plan to introduce a comprehensive package of reforms that will help to ensure that our nation's veterans are treated in a fashion that respects and recognizes the contributions that they have made to protect generations of Americans.

I am working to build on two pieces of legislation that I introduced during the 107th Congress. The National I Owe You Act, which I introduced with the Senator from Missouri [Mr. BOND], would require the VA to take more aggressive steps to make veterans aware of the benefits that are owed to them. This legislation, which was inspired by the Wisconsin Department of Veterans Affairs' ''I Owe You'' program, would create programs that identify eligible veterans who are not receiving benefits, notify veterans of changes in benefit programs, and encourage veterans to apply for benefits. The bill also would direct the Secretary of Veterans Affairs to develop an outreach program that encourages veterans and dependents to apply, or to reapply, for federal benefits.

This legislation in no way duplicates the work of County Veterans Service Officers (CVSOs) in my state and other states. The work of CVSOs is indispensable for reaching out to veterans, particularly in rural areas. The I Owe You Act simply calls for the VA to develop a program that encourages veterans to apply for benefits, identify veterans who are eligible but not receiving benefits, and notify veterans of any modifications to benefit programs. The new VA policy that prohibits marketing of health programs underscores the need for legislation in this area.

In addition, I have heard from many Wisconsin veterans about the need to improve claims processing at the VA. They are justifiably angry and frustrated about the amount of time it takes for the Veterans Benefits Administration to process their claims. In some instances, veterans are waiting well over a year. Telling the men and women who served their country in the Armed Forces that they ''just have to wait'' is wrong and unacceptable.

In response to these concerns, I joined with the Senator from Utah (Mr. HATCH) to introduce the Veterans Benefits Administration Improvement Act, which would require the Secretary of Veterans Affairs to submit a comprehensive plan to Congress for the improvement of the processing of claims for veterans compensation and pensions. In addition, every six months afterwards, the Secretary must report to Congress about the status of the program. I remain concerned about claims processing, and will continue to work with the VA and with my colleagues to address this important issue.

I look forward to continuing to meet with veterans and their families around Wisconsin in order to hear directly from them what services they need and what gaps remain in the VA system.

And so, Mr. President, this coming Veterans Day, and throughout the year, let us continue to honor America's great veterans.

Thank you, Mr. President.

WORKPLACE SAFETY IN THE CHEMICAL PROCESSING INDUSTRY

Mr. WELLSTONE. Mr. President, I would like to bring to the Senate's attention a disturbing new Federal study related to chemical plant safety. This report, dated September 24th from the U.S. Chemical Safety and Hazard Investigation Board, describes the hazards of what are called reactive chemicals. These are substances that can react violently, decompose, burn or explode when managed improperly in industrial settings. Process accidents involving reactive chemicals are reported to be responsible for significant numbers of deaths and injuries and considerable property losses in U.S. industries.

The investigation by the independent, non-regulatory board points out significant deficiencies in federal safety regulations that are meant to control the dangers from chemical processes. As the result of these inadequacies, more than half of the serious accidents caused by reactive chemicals occurred in processes that were exempt from the major Federal process safety rules.

These regulations known as the OSHA Process Safety Management standard and the EPA Risk Management Program rule -were mandated in the landmark 1990 Clean Air Act Amendments. Unfortunately, OSHA chose to regulate just a small handful of reactive chemicals only 38 substances out of the many thousands of chemicals used in commerce. EPA for its part did not regulate any reactive chemicals at all.

The tragic results of these omissions now seem apparent. The Chemical Safety Board uncovered 167 serious reactive chemical incidents in the U.S. over the last 20 years. More than half of these occurred after OSHA's rules were adopted in 1992. Serious chemical explosions and fires continue to occur in states around the country. Recent fatal accidents in Texas, Georgia, Pennsylvania, and New Jersey are among those catalogued in the Chemical Safety Board's investigation.

Take the case, for example, of 45-year old Rodney Gott, a supervisor at the Phillips Chemical complex in Pasadena, Texas, outside of Houston. On numerous occasions Mr. Gott was spared as deadly accidents occurred at his plant and those nearby. On one occasion in 1989, 23 of his coworkers were killed during a chemical explosion at his plant. But eleven years later, as he worked next to a 12,000 gallon storage tank containing reactive chemical residues, he fell victim to a huge explosion. Sixty-nine of his colleagues were injured, including some who were burned almost beyond recognition. Rodney Gott never made it out.

As a result of the loophole in OSHA and EPA regulations, many industrial facilities that handle reactive chemicals are not required to follow basic good engineering and safety management practices practices such as hazard analysis, worker training, and maintenance of process equipment.

Frankly, this is hard to understand. These sound to me like practices that should be followed universally in the chemical industry. There should be little disagreement about the need to require these practices wherever dangerous reactive chemicals are in use.

Nonetheless, OSHA has failed to take action to improve its process safety standard. The last administration had regulation of reactive chemicals on its agenda, but did not complete work on the task before leaving office. In December 2001, the new OSHA administration inexplicably dropped rulemaking on reactive chemicals from their published regulatory agenda. I convened