NOMINATIONS DISCHARGED

The following nomination was discharged from the Committee on Finance pursuant to the order of March 22, 2002:

DEPARTMENT OF THE TREASURY

Randal Quarles, of Utah, to be Deputy Under Secretary of the Treasury.

The following nomination was discharged from the Committee on Agriculture, Nutrition, and Forestry pursuant to the order of March 22, 2002:

DEPARTMENT OF AGRICULTURE

Nancy Southard Bryson, of the District of Columbia, to be General Counsel of the Department of Agriculture.

The following nomination was discharged from the Committee on Health, Education, Labor, and Pensions pursuant to the order of March 22, 2002:

DEPARTMENT OF LABOR

Victoria A. Lipnic, of Virginia, to be an Assistant Secretary of Labor.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BAYH:

S. 2066. A bill to prohibit United States assistance and commercial arms exports to countries and entities supporting international terrorism; to the Committee on Foreign Relations.

By Mr. BINGAMAN (for himself, Mr. BOND, and Mr. INOUYE):

S. 2067. A bill to amend title XVIII of the Social Security Act to enhance the access of medicare beneficiaries who live in medically underserved areas to critical primary and preventive health care benefits, to improve the Medicare+Choice program, and for other purposes; to the Committee on Finance.

By Mr. McCAIN (for himself, Mr. BAYH, Mr. CLELAND, Mrs. CARNAHAN, and Mr. LIEBERMAN):

S. 2068. A bill to further encourage and facilitate service in the Armed Forces of the United States, and for other purposes; to the Committee on Armed Services.

By Mr. NELSON of Florida (for himself, Mr. GRAHAM, Mr. CLELAND, and Mr. MILLER):

S. 2069. A bill to direct the Secretary of Veterans Affairs to establish a national cemetery for veterans in the Jacksonville, Florida, metropolitan area; to the Committee on Veterans' Affairs.

By Mr. BINGAMAN (for himself and Mr. KERRY):

S. 2070. A bill to amend part A of title IV to exclude child care from the determination of the 5-year limit on assistance under the temporary assistance to needy families program, and for other purposes; to the Committee on Finance.

By Mr. SMITH of New Hampshire:

S. 2071. A bill to amend title 23, United States Code, to prohibit the collection of tolls from vehicles or military equipment under the actual physical control of a uniformed member of the Armed Forces, and for other purposes; to the Committee on Environment and Public Works.

By Mr. CORZINE (for himself, Mr. BINGAMAN, and Mr. BREAUX):

S. 2072. A bill to amend title XIX of the Social Security Act to provide States with the option of covering intensive community mental health treatment under the Medicaid Program; to the Committee on Finance.

By Mr. CRAIG:

S. 2073. A bill to provide for the retroactive entitlement of Ed W. Freemen to Medal of Honor special pension; to the Committee on Veterans' Affairs.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. CONRAD:

S. Con. Res. 100. An original concurrent resolution setting forth the congressional budget for the United States Government for fiscal year 2003 and setting forth the appropriate budgetary levels for each of the fiscal years 2004 through 2012; from the Committee on the Budget; placed on the calendar.

ADDITIONAL COSPONSORS

S. 940

At the request of Mr. DODD, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 940, a bill to leave no child behind.

S. 960

At the request of Mr. BINGAMAN, the name of the Senator from South Carolina (Mr. HOLLINGS) was added as a cosponsor of S. 960, a bill to amend title XVIII of the Social Security Act to expand coverage of medical nutrition therapy services under the medicare program for beneficiaries with cardiovascular diseases.

S. 1343

At the request of Mr. CHAFEE, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of S. 1343, a bill to amend title XIX of the Social Security Act to provide States with options for providing family planning services and supplies to individuals eligible for medical assistance under the medicaid program.

S. 1409

At the request of Mr. SMITH of New Hampshire, his name was added as a cosponsor of S. 1409, a bill to impose sanctions against the PLO or the Palestinian Authority if the President determines that those entities have failed to substantially comply with commitments made to the State of Israel.

S. 1777

At the request of Mrs. CLINTON, the name of the Senator from Iowa (Mr. HARKIN) was added as a cosponsor of S. 1777, a bill to authorize assistance for individuals with disabilities in foreign countries, including victims of landmines and other victims of civil strife and warfare, and for other purposes.

S. 1924

At the request of Mr. LIEBERMAN, the name of the Senator from New Jersey (Mr. TORRICELLI) was added as a cosponsor of S. 1924, a bill to promote charitable giving, and for other purposes.

S. 2040

At the request of Mr. ROBERTS, the name of the Senator from Idaho (Mr. CRAPO) was added as a cosponsor of S. 2040, a bill to provide emergency agricultural assistance to producers of the 2002 crop.

S. 2058

At the request of Mrs. LINCOLN, the name of the Senator from Florida (Mr. GRAHAM) was added as a cosponsor of S. 2058, a bill to replace the caseload reduction credit with an employment credit under the program of block grants to States for temporary assistance for needy families, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BINGAMAN (for himself, Mr. BOND, and Mr. INOUYE):

S. 2067. A bill to amend title XVIII of the Social Security Act to enhance the access of Medicare beneficiaries who live in medically underserved areas to critical primary and preventive health care benefits to improve the Medicare+Choice program, and for other purposes; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, the legislation I am introducing today with Senators BOND and INOUYE entitled the ''Medicare Safety Net Access Act of 2002,'' or ''Access 2002,'' would improve services for Medicare beneficiaries and protect a critical mission of health centers, to provide access to care to underserved rural, frontier, and inner-city communities.

Community health centers, CHC's, provide primary and preventive care to more than 700,000 medically underserved Medicare beneficiaries, including over 20,000 in New Mexico. Health centers also provide critical support services that help seniors more easily access care. In many cases, the local health center may be the only source of primary and preventive care for Medicare beneficiaries in a community.

While hundreds of thousands of Medicare beneficiaries turn to health centers for care, many centers struggle to provide services to these patients. Current Medicare regulations cause health centers significant financial losses that have a direct impact on access to care. In addition, the Medicare federally qualified health center, FQHC, benefit has not been modernized to include many of the new preventive and other services added to the Medicare package by Congress in recent years again undermining the critical role that health centers play in providing access to care.

To address these and other issues, Senators BOND, INOUYE, and I are introducing the ''Medicare Safety Net Access Act of 2002'', also known as ''Access 2002.'' The legislation would address the following problems.

With respect to payment issues, the bill ensures that Medicare covers the cost of providing care to Medicare beneficiaries at CHC's. Congress provides more than $1.3 billion in section 330 funding to CHC's to provide care to

the uninsured. When Medicare fails to cover the costs of care for Medicare beneficiaries, CHC's must make up for the shortfall through a variety of mechanisms including drawing from the section 330 grants, which are supposed to be dedicated for care to the uninsured.

Medicare has historically provided such cost-based reimbursement to other safety net providers, such as certain rural hospitals, cancer hospitals, and children's hospitals. Moreover, Congress passed legislation in 2000 to protect health centers from the same problem in Medicaid.

The legislation assures that CHC's are afforded the same protections through the Medicare program so that Federal funding for the uninsured is not redirected to pay for shortfalls from Medicare patients. It does so by eliminating the per visit payment cap on health centers' Medicare payments. In the Medicare statute, Congress clearly intended to cover the cost of a health centers' Medicare patients, but the Centers for Medicare and Medicaid Services, CMS, applies an arbitrary ''payment cap'' that is not in the Federal statute. For many health centers, the cap has significantly reduced their Medicare payments, particularly for patients that have chronic illnesses, and forced them to reduce care they would have otherwise provided for their uninsured patients. Our bipartisan legislation prevents the imposition of the Medicare payment cap for health centers, and again, mirrors cost-based reimbursement that a number of other safety-net providers receive through Medicare.

The bill also extends payment protections to Medicare+Choice. This is achieved by establishing a supplemental or ''wrap-around'' payment much like the one that currently exists in the Medicaid program for FQHC's contracting with managed care organizations. As this has worked so well in the Medicaid program, Congress should also enact a ''wrap-around'' payment in the Medicare+Choice program to ensure CHC's are having their reasonable costs appropriately covered.

In addition, the legislation eliminates regulatory hurdles that impair health centers' ability to provide preventive ambulatory services to Medicare patients. While CHC's provide primary care services to their patients, Medicare does not cover anything other than the most basic services provided at CHC's. Such services that health centers may provide that Medicare does not pay on a cost basis, include: mammograms, nutrition services, or laboratory or x-ray services. Some of these services have been recently been added by Congress but the Medicare FQHC benefit has not been updated to reflect those changes. This legislation would expand the services that health centers could provide to medically underserved Medicare beneficiaries.

Furthermore, the bill ensures the availability of these services to those enrolling in Medicare managed care but requiring Medicare+Choice plans to contract with a sufficient number of FQHC's to make FQHC services accessible to plan enrollees.

And finally, the ''Medicare Safety Net Access Act of 2002'' establishes a safe harbor in the federal anti-kickback statute for arrangements between health centers and other providers that improve access to services for low-income patients in underserved communities. Health centers and other providers often participate in arrangements designed to expand their ability to provide care in the poor communities they serve. However, these arrangements can potentially expose health centers under the federal anti-kickback laws.

For nine years, a proposed ''safe harbor'' has been pending before the U.S. Department of Health and Human Services' Office of the Inspector General, HHS IOG, that would allow health centers to contract with other providers to improve health services to low-income patients without fear of being in violation of the anti-kickback law. To qualify under the proposed safe harbor, the arrangement would have to meet strict criteria to protect against fraud and abuse, including the demonstration of a community benefit through the savings of grant dollars intended for care for the uninsured or an increase in the availability of services to a medically underserved community. There are additional requirements, such as assurances that the arrangement to not limit a patient's freedom of choice, in addition to any others that the IOG deems are needed as long as they are consistent with congressional intent.

Community health centers enjoy strong bipartisan support in Congress because they are cost-effective providers of services that keep patients healthy and out of costly specialty and emergency settings. As more people prepare to enter the Medicare program, it is vital that beneficiaries in rural, frontier, and inner-city areas have access to the full range of Medicare benefits. Health centers are the vehicle to make that happen. I urge passage of this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2067

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Safety Net Access Act of 2002''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. SUPPLEMENTAL REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS PARTICIPATING IN MEDICARE MANAGED CARE.

(a) SUPPLEMENTAL REIMBURSEMENT.—

(1) IN GENERAL.—Section 1833(a)(3) of the Social Security Act (42 U.S.C. 1395*l*(a)(3)) is amended to read as follows:

''(3) in the case of services described in section 1832(a)(2)(D)—

''(A) except as provided in subparagraph (B), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; or

''(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a Medicare+Choice organization under part C pursuant to a written agreement described in section 1853(j), the amount by which—

''(i) the amount of payment that would have otherwise been provided under subparagraph (A) (calculated as if '100 percent' were substituted for '80 percent' in such subparagraph) for such services if the individual had not been so enrolled; exceeds

''(ii) the amount of the payments received under such written agreement for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds),

less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(C);''.

(b) CONTINUATION OF MEDICARE+CHOICE MONTHLY PAYMENTS.—

(1) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(j) SPECIAL PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with a Medicare+Choice organization under this part receives a service from a Federally qualified health center that has a written agreement with such organization for providing such a service (including any agreement required under section 1857(e)(3))—

''(1) the Secretary shall pay the amount determined under section 1833(a)(3)(B) directly to the Federally qualified health center not less frequently than quarterly; and

''(2) the Secretary shall not reduce the amount of the monthly payments to the Medicare+Choice organization made under section 1853(a) as a result of the application of paragraph (1).''.

(2) CONFORMING AMENDMENTS.—

(A) Paragraphs (1) and (2) of section 1851(i) of the Social Security Act (42 U.S.C. 1395w–21(i)(1)) are each amended by inserting ''1853(j),'' after ''1853(h),''.

(B) Section 1853(c)(5) is amended by striking ''subsections (a)(3)(C)(iii) and (i)'' and inserting ''subsections (a)(3)(C)(iii), (i), and (j)(1)''.

(c) ADDITIONAL MEDICARE+CHOICE CONTRACT REQUIREMENTS.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is

amended by adding at the end the following new paragraph:

''(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

''(A) ENSURING EQUAL ACCESS TO SERVICES OF FQHCS.—A contract under this part shall require the Medicare+Choice organization to enter into (and to demonstrate to the Secretary that it has entered into) a sufficient number of written agreements with Federally qualified health centers providing Federally qualified health center services for which payment may be made under this title in the service area of each Medicare+Choice plan offered by such organization so that such services are reasonably available to individuals enrolled in the plan.

''(B) ENSURING EQUAL PAYMENT LEVELS AND AMOUNTS.—A contract under this part shall require the Medicare+Choice organization to provide a level and amount of payment to each Federally qualified health center for services provided by such health center that are covered under the written agreement described in subparagraph (A) that is not less than the level and amount of payment that the organization would make for such services if the services had been furnished by a provider of services that was not a Federally qualified health center.

''(C) COST-SHARING.—Under the written agreement described in subparagraph (A), a Federally qualified health center must accept the Medicare+Choice contract price plus the Federal payment as payment in full for services covered by the contract, except that such a health center may collect any amount of cost-sharing permitted under the contract under this part, so long as the amounts of any deductible, coinsurance, or copayment comply with the requirements under section 1854(e) and do not result in a total payment to the center in excess of the amount determined under section 1833(a)(3)(A) (calculated as if '100 percent' were substituted for '80 percent' in such section).''.

(d) SAFE HARBOR FROM ANTIKICKBACK PROHIBITION.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) in subparagraph (E), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (F), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(G) any remuneration between a Federally qualified health center (or an entity controlled by such a health center) and a Medicare+Choice organization pursuant to the written agreement described in section 1853(j).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided on or after January 1, 2003, and contract years beginning on or after such date.

SEC. 3. REVISION OF FEDERALLY QUALIFIED HEALTH CENTER PAYMENT LIMITS.

(a) PER VISIT PAYMENT REQUIREMENTS FOR FQHCS.—Section 1833(a)(3)(A) of the Social Security Act (42 U.S.C. 1395*l*(a)(3)(A)), as amended by section 2(a), is amended by adding ''(which regulations may not limit the per visit payment amount, or a component of such amount, for services described in section 1832(a)(2)(D)(ii))'' after ''the Secretary may prescribe in regulations''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services provided on or after January 1, 2003.

SEC. 4. COVERAGE OF ADDITIONAL FEDERALLY QUALIFIED HEALTH CENTER SERVICES.

(a) COVERAGE FOR FQHC AMBULATORY SERVICES.—Section 1861(aa)(3) of the Social Security Act (42 U.S.C. 1395x(aa)(3)) is amended to read as follows:

''(3) The term 'Federally qualified health center services' means—

''(A) services of the type described in subparagraphs (A) through (C) of paragraph (1), and such other services furnished by a Federally qualified health center for which payment may otherwise be made under this title if such services were furnished by a health care provider or health care professional other than a Federally qualified health center; and

''(B) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act, when furnished to an individual as a patient of a Federally qualified health center.''.

(b) OFFSITE FQHC SERVICES.—

(1) PATIENTS OF HOSPITALS AND CRITICAL ACCESS HOSPITALS.—Section 1862(a)(14) of the Social Security Act (42 U.S.C. 1395y(a)) is amended by inserting ''Federally qualified health center services,'' after ''qualified psychologist services,''.

(2) EXCLUSION OF FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PPS FOR SKILLED NURSING FACILITIES.—Section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) is amended—

(A) in paragraph (2)(A)(i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii) through (iv)''; and

(B) by adding at the end of paragraph (2)(A) the following new clause:

''(iv) EXCLUSION OF FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are Federally qualified health center services (as defined in section 1861(aa)(3)).''.

(c) TECHNICAL CORRECTIONS.—

(1) Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''subsection (hh)(1)),,'' and inserting ''subsection (hh)(1)),''.

(2) Clauses (i) and (ii)(II) of section 1861(aa)(4)(A) of the Social Security Act (42 U.S.C. 1395x(aa)(4)(A)) are each amended by striking ''(other than subsection (h))''.

(d) EFFECTIVE DATES.—The amendments made—

(1) by subsections (a) and (b) shall apply to services furnished on or after January 1, 2003; and

(2) by subsection (c) shall take effect on the date of enactment of this Act.

SEC. 5. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7(b)(3)), as amended by section 2(d), is amended—

(1) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(H) any remuneration between a public or nonprofit private health center entity described under clauses (i) and (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement produces a community benefit that will be used by the health center entity to maintain or increase the availability or accessibility, or enhance the quality, of services provided to a medically underserved population served by the health center entity.''.

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, on an expedited basis, standards relating to the exception for health center entity arrangements to the antikickback penalties described in section 1128B(b)(3)(F) of the Social Security Act, as added by subsection (a).

(B) FACTORS TO CONSIDER.—In establishing standards relating to the exception for health center entity arrangements under subparagraph (A), the Secretary—

(i) shall extend the exception where the arrangement between the health center entity and the other party—

(I) results in savings of Federal grant funds or increased revenues to the health center entity;

(II) does not limit or restrict a patient's freedom of choice; and

(III) does not interfere with a health care professional's independent medical judgment regarding medically appropriate treatment; and

(ii) may include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this subsection.

(2) INTERIM FINAL EFFECT.—No later than 60 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to change and revision after public notice and opportunity (for a period of not more than 60 days) for public comment, provided that any change or revision shall be consistent with this subsection.

By Mr. NELSON of Florida (for himself, Mr. GRAHAM, Mr. CLELAND, and Mr. MILLER):

S. 2069. A bill to direct the Secretary of Veterans Affairs to establish a national cemetery for veterans in the Jacksonville, Florida, metropolitan area; to the Committee on Veterans' Affairs.

Mr. NELSON of Florida. Mr. President, this Nation honors in many ways the service of those who have worn the uniform of our Armed Forces and placed themselves in harm's way to defend our freedom and way of life. This Nation raises great monuments to commemorate the many battles and the countless heroes of those battles fought throughout our history. This Nation sets aside special days to remember the sacrifice of generations of Americans who have stepped forward in America's defense.

This Nation hallows ground where we lay to rest those who have served us in our hour of greatest need. Our National Cemetery System is not only hallowed ground, national cemeteries are monuments to military service, the places where we go on those special days to pay tribute to the sacrifice of so many in our history.

Today I offer legislation to establish a national cemetery near Jacksonville, FL, to meet the needs of thousands of veterans who have chosen to live out their lives in northeast Florida and southeast Georgia. Florida's veteran population is the second largest in the Nation. Right now in northern Florida and southern Georgia, there are nearly half-a-million veterans. Florida has the Nation's oldest veteran population and one of the largest remaining populations of World War II veterans. We are all aware that this greatest of generations is passing away at higher and higher rates.

Unfortunately for these hundreds of thousands of veterans in Florida and Georgia, the nearest national cemetery is located in Bushnell, FL, which is 3-hour drive from Jacksonville. The national cemetery in St. Augustine is full and closed. The nearest national cemetery in Georgia is in Marietta just north of Atlanta.

Our veterans have made great sacrifices to protect our country in her days of peril, and certainly deserve to rest in honored respect in a national cemetery. To honor the veterans of northeast Florida and southeast Georgia, we must act now, in order to have this facility established by 2006 when our World War II veterans' deaths are expected to reach their peak.

Senators GRAHAM and CLELAND and I are honored and proud to sponsor this important bill, and we look forward to the support of our colleagues as we provide for our veterans who have given so much for our country.

I ask unanimous consent that the text of this bill be printed in the RECORD.

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

S. 2069

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

SECTION 1. ESTABLISHMENT.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall establish, in accordance with chapter 24 of title 38, United States Code, a national cemetery in the Jacksonville, Florida, metropolitan area to serve the needs of veterans and their families.

(b) CONSULTATION IN SELECTION OF SITE.—Before selecting the site for the national cemetery established under subsection (a), the Secretary shall consult with—

(1) appropriate officials of the State of Florida and local officials of the Jacksonville metropolitan area, and

(2) appropriate officials of the United States, including the Administrator of General Services, with respect to land belonging to the United States in that area that would be suitable to establish the national cemetery under subsection (a).

(c) REPORT.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the establishment of the national cemetery under subsection (a). The report shall set forth a schedule for such establishment and an estimate of the costs associated with such establishment.

By Mr. BINGAMAN (for himself and Mr. KERRY):

S. 2070. A bill to amend part A of title IV to exclude child care from the determination of the 5-year limit on assistance under the temporary assistance to needy families program, and for other purposes; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I rise today to introduce the Children First Act. Since 1996, federal funding for child care assistance under the Child Care and Development Block Grant, CCDBG, has significally increased, making it possible for states to provide more low-income families with child care assistance and expand initiatives to improve the quality of child care. This has been an extremely important endeavor. Access to quality childcare helps families to work and children to succeed. Yet, we must do more. Only one out of seven children eligible for assistance through the CCDBG program receives a subsidy, approximately 12.9 million eligible children without assistance. In March 2000, a family earning as little as $25,000 could not qualify for child care assistance in most States. The need for child care assistance is likely to significantly increase in the near future. Many States are currently faced with serious budget shortfalls that threaten the progress they have made in the provision of child care in recent years. The administration's recently proposed welfare plan would increase work-related requirements for welfare recipients, which if passed will create an even greater demand for child care. Even if this aspect of the administration's welfare proposal is rejected as unworkable, which I believe is the case, we must make providing high-quality child care to low-income families a priority in this Congress. The Children First Act will do just that.

Increased availability of child care enables low-income parent on welfare, and parents trying to stay off welfare, to work and support their families. According to a recent administration report, employment among single mothers with young children grew in recent years fro 58 percent to 73 percent. The administration noted: ''These employment increased by single mothers and former welfare mothers are unprecedented.'' Most people agree that employment gains among single mothers can only be sustained if families have access to dependable child care. Studies show that when child care is available, and when families get help paying for care, they are more likely to work.

When I talk to people in my home State of New Mexico about welfare reform, they identify access to childcare as the most important work support we can provide. In New Mexico, 57 percent of children under 6 live in households in which all parents work. Approximately 67 percent of these households have income less than 200 percent of the Federal poverty threshold. Yet less than 25 percent of children under the age of 6 eligible under federal law for childcare assistance are receiving assistance in New Mexico. Families with both parent working aen earning he minimum wage must pay 49 percent of their income on childcare for one child. Without subsidized care, many of these families can not afford to work.

When I talk to people in New Mexico about improving our education system, the need for improved school readiness is often theotp concern. Improved quality of child care is an important component in that effort as well. Quality child care provides low-income children with the early learning experiences that they need to do well in school. We know that children in high-quality early care score higher on reading and math tests, are more likely to complete high school and go onto college, and are less likely to repeat a grade or get charged in juvenile court. In contrast, children in poor quality child care have been found to be more likely to be referred to special education, delayed in language and reading skills and to display more aggression toward other children and adults.

In the recently enacted No Child Left Behind Act, Congress and the President signaled a new commitment to improving educational outcomes in our schools. The legislation required states, school districts, and communities to close achievement gaps between disadvantaged students and their peers. In his State of the Union Address earlier this year, President Bush acknowledged the important of early learning and made it a priority for his administration. Increased federal support for child care is critical to supporting high-quality early learning programs. We should work on a bipartisan basis—as we did with respect to the No Child Left Behind Act—towards this goal.

We must increase access to child car, but we must also do more to ensure the improved quality of child care. Many families in New Mexico, even those receiving assistance, cannot provide their children with a high quality child car setting. In part, this is caused by the low reimbursement rates provided due to limited funding. For example, in New Mexico the reimbursement rate is $396, while the market rate averaged $470. As a result the higher quality provider often do not accept state-subsidized children into their programs.

A lack of qualified care provider also make the provision of high quality care difficult. Childcare workers in New Mexico make, on average, $6.24 per hour, less than half the average weekly wage. Less than 20 percent of these workers receive employee benefits such as health insurance and paid sick leave.

The Children First Act will address these issues by increasing funding for the Child Care Development Block Grant by $11.2 billion over five years. With these funds, states will be able to serve approximately 1 million more children nationally. The bill also contains an increase in the quality set-aside in CCDBG, which will provide funds specifically for efforts to improve quality. States can use these funds to provide training to care providers and create and enforce standards of care. The bill also makes common sense changes to the TANF program that support work by enabling states to increase the availability and improve the quality of child care.

I urge my colleagues to support this important piece of legislation. It will help low-income families work and help prepare our children to succeed.

By Mr. SMITH of New Hampshire:

S. 2071. A bill to amend title 23, United States Code, to prohibit the collection of tolls form vehicles or military equipment under the actual physical control of a uniformed member of the Armed Forces, and for other purposes; to the Committee on Environment and Public Works

Mr. SMITH of New Hampshire. Mr. President, I rise today to offer a bill that will exempt our Nation's military vehicles and equipment from being subject to paying tolls on America's roads, bridges and ferries. As the Ranking Member of Environment & Public Works Committee, which has jurisdiction over our highway system, and as a senior member of the Armed Services Committee, I believe that this an appropriate action long overdue. In this time of war and heightened threat to America's shores, the thought of all units in an Army troop convoy digging into their pockets to drop quarters into the nets at tollbooths on the Jersey turnpike is absurd. When we created the interstate highway system in the 1950's under the strong leadership of President Eisenhower, a primary motivation of the former General of the Army was to facilitate the movement of men and material in times of crisis. Yet in the intervening years, as toll roads have been established, no one at the Federal level has thought to exempt the armed forces form being slowed down to pay these levies. While the Federal Government has not acted, many States, most notably my State of New Hampshire, has seen fit to exempt those who are protecting us from paying these tolls. America's armed forces deserve all the help we can give them. The shortsighted among us might say that all we need to do is to provide some expedited form of payment, so that the tolls can be collected faster. I say that our troops deserve better. There is just no reason to subject our military to paying tolls in order to use America's roads when their only reason for being on those roads is to protect America. Therefore, my bill provides for a complete exemption from tolls, and not just half-way measures to simplify the payment. But my bill goes even further. In the same vein, I believe that it is essential, should a crisis arise, or God forbid, should America again be attacked, to speed our troops through the toll facilities. Accordingly, I have written the bill a provision to require a toll facility, in times of an emergency declared by the President, to reserve a dedicated support for America's military by voting for this important bill.

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

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

S. 2071

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

SECTION 1. PROHIBITION ON COLLECTION OF TOLLS FROM VEHICLES AND EQUIPMENT USED BY THE ARMED FORCES.

Section 129 of title 23, United States Code, is amended by adding at the end the following:

''(d) PROHIBITION ON COLLECTION OF TOLLS FROM VEHICLES AND EQUIPMENT USED BY THE ARMED FORCES.—

''(1) IN GENERAL.—No tolls shall be collected from any vehicle or military equipment owned by the Department of Defense for the use of any toll facility described in paragraph (3) when the vehicle or military equipment is under the actual physical control of a uniformed member of the Armed Forces.

''(2) PERIODS OF NATIONAL EMERGENCY.—During a period of national emergency declared by the President, upon request of the Secretary of Defense, a toll facility described in paragraph (3)(A) shall reserve a lane of the toll facility for the exclusive use of a vehicle or military equipment described in paragraph (1).

''(3) TOLL FACILITIES.—A toll facility described in this paragraph is—

''(A) a toll highway, bridge, or tunnel located on a public road; or

''(B) a toll ferry boat that operates on a route classified as a public road.''.

By Mr. CORZINE (for himself, Mr. BINGAMAN, and Mr. BREAUX):

S. 2072. A bill to amend title XIX of the Social Security Act to provide States with the option of covering intensive community mental health treatment under the Medicaid Program, to the Committee on Finance.

Mr. CORZINE. Mr. President, I am very pleased to introduce today a critical piece of mental health legislation with my colleagues Senators BINGAMAN and BREAUX. This legislation, the Medicaid Intensive Community Mental Health Act, will assist and encourage States to provide comprehensive intensive mental health services through the Medicaid Program.

Since deinstitutionalization, too many people with severe mental illnesses have fallen through the cracks of our mental health system in part because too many States and localities have not established intensive community-based programs to assist those with severe mental illness.

In 1999, the Supreme Court rules in its Olmstead decision that individuals with disabilities, including mental illness, who are capable of living in a community setting, must be placed in less restrictive settings. Two years after this decision, my State of New Jersey and States nationwide are struggling to improve and expand community-based mental health services in order to ensure that the appropriate services are in place for the mentally ill so that they can lead productive lives outside of the institution. And, let me be clear that this applies to children just as it applies to adults. I know my colleague from New Mexico, Senator BINGAMAN, has expressed deep concern about the hundreds of youth with mental illness in his State who are being held at detention centers because there are very limited community-based mental health treatment options.

These children do not deserve to be treated as criminals, they need and deserve access to treatment, counseling, and other rehabilitative and supportive services. We need to give States the flexibility and the resources they need to make these options available. Currently, Federal financing for community-based mental health care is so complex and burdensome that States are unable to offer a comprehensive, coordinated set of community-based intensive mental health services with a single point of access. Rather, those in dire need of these services are forced to rely on a patchwork of uncoordinated programs with missing service components.

Currently, States must apply for six optional Medicaid waivers in order to provide these services. This legislation would help fill the cracks in our mental health care system by allowing States, through a single policy decision, to finance the entire array of community-based services that individuals with severe mental illness need. The Medicaid Intensive Community Mental Health Act would allow States to choose the ''intensive community mental health treatment'' option under Medicaid, which would allow States to provide services such as psychiatric rehabilitation, crisis residential treatment, medication education and management, integrated treatment services for individuals with co-occurring mental illness and substance abuse disorders, and family psycho-education services, among others, in a coordinated manner.

In my home State of New Jersey, there are about 3,000 people residing in psychiatric hospitals. About half of these people, or 1,500 people, are eligible to be released, but, due to a lack of intensive community-based treatment, they continue to remain needlessly institutionalized. If passed, this legislation would help States to create an integrated system of intensive community-based mental health care for those with severe mental illness. Not only would this option improve community-based services for the mentally ill, but it would also give states a mechanism to assist people who otherwise require costly hospitalization.

Far too often in our Nation, individuals with severe mental illness are either unable to access appropriate mental health care or have repeated but ultimately unsuccessful hospitalizations. And unfortunately, untreated mental illness has led many sufferers to become homeless. It has also led many to commit crimes. Ultimately, this legislation will help States respond to the problems associated with deinstitutionalization, homelessness, and the criminalization of mental illness, and in doing so, it will help people with severe mental illness to live better lives in their communities and with their families.

I want to thank my colleagues, Mr. BINGAMAN and Mr. BREAUX, for joining me today to introduce this important legislation.