the Inspectors General on Integrity and Efficiency, and for other purposes.

S. 2335

At the request of Ms. LANDRIEU, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 2335, a bill to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to provide adequate case management services.

S. 2348

At the request of Mr. CORNYN, the name of the Senator from New Hampshire (Mr. GREGG) was added as a cosponsor of S. 2348, a bill to ensure control over the United States border and to strengthen enforcement of the immigration laws.

S. 2356

At the request of Mr. COLEMAN, the name of the Senator from Kentucky (Mr. BUNNING) was added as a cosponsor of S. 2356, a bill to enhance national security by restricting access of illegal aliens to driver's licenses and State-issued identification documents.

S. 2358

At the request of Mr. BROWNBACK, the names of the Senator from Georgia (Mr. CHAMBLISS) and the Senator from Texas (Mr. CORNYN) were added as cosponsors of S. 2358, a bill to amend title 18, United States Code, to prohibit human-animal hybrids.

S. 2365

At the request of Mr. GRAHAM, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. 2365, a bill to require educational institutions that receive Federal funds to obtain the affirmative, informed, written consent of a parent before providing a student information regarding sex, to provide parents the opportunity to review such information, and for other purposes.

S.J. RES. 22

At the request of Mr. BAUCUS, the name of the Senator from Delaware (Mr. BIDEN) was added as a cosponsor of S.J. Res. 22, a joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Centers for Medicare & Medicaid Services within the Department of Health and Human Services relating to Medicare coverage for the use of erythropoiesis stimulating agents in cancer and related neoplastic conditions.

S. RES. 356

At the request of Mr. DURBIN, the name of the Senator from North Dakota (Mr. DORGAN) was added as a cosponsor of S. Res. 356, a resolution affirming that any offensive military action taken against Iran must be explicitly approved by Congress before such action may be initiated.

S. RES. 367

At the request of Mr. GRASSLEY, his name was added as a cosponsor of S. Res. 367, a resolution commemorating the 40th anniversary of the mass movement for Soviet Jewish freedom and the 20th anniversary of the Freedom Sunday rally for Soviet Jewry on the National Mall.

S. RES. 380

At the request of Mr. STEVENS, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. Res. 380, a resolution recognizing Hostelling International USA for 75 years of service to intercultural understanding and to youth travel.

AMENDMENT NO. 3538

At the request of Mr. AKAKA, the name of the Senator from Washington (Ms. CANTWELL) was added as a cosponsor of amendment No. 3538 intended to be proposed to H.R. 2419, a bill to provide for the continuation of agricultural programs through fiscal year 2012, and for other purposes.

AMENDMENT NO. 3613

At the request of Mr. STEVENS, the name of the Senator from Texas (Mrs. HUTCHISON) was added as a cosponsor of amendment No. 3613 intended to be proposed to H.R. 2419, a bill to provide for the continuation of agricultural programs through fiscal year 2012, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DURBIN (for himself and Mr. BURR):

S. 2376. A bill to establish a demonstration project to provide for patient-centered medical homes to improve the effectiveness and efficiency in providing medical assistance under the Medicaid program and child health assistance under the State Children's Health Insurance Program; to the Committee on Finance.

Mr. DURBIN. Mr. President, we are all aware of the current healthcare crisis in our nation. Health care spending continues to rise at an unsustainable rate, constituting 16 percent of the Federal budget. Health care costs have increased 78 percent since 2001, more than 4 times the pace of prices and wages.

One reason for the rise in costs and spending is the increase in chronic disease. Heart disease, cancer, and diabetes are the leading causes of death and disability in the U.S. They also account for 70 percent of all deaths in the U.S., or 1.7 million people each year. These diseases also make life harder for the 1 of 10 Americans who are living with them. The irony, of course, is that chronic diseases are both preventable and manageable.

The quality of our healthcare has not changed substantially despite the fact that we live in the wealthiest country in the world with the best researchers and medical doctors at our fingertips. At a time when both health care costs and chronic illnesses are on the rise, we need a better way to provide care.

Changing the delivery of care is a controversial topic, but it is a topic that has gained more traction in recent months. Last week, the New York Times published an article titled, ''A Model for Health Care That Pays for Quality.'' The article described a new model for healthcare, and I quote here, ''to identify the best primary care doctors and to steer patients their way. Those doctors, in turn, would be paid for more services than are currently reimbursed under typical health plan payments for office visits. The idea is to encourage doctors to meet with patients for more than a few minutes during an office visit and to also compensate them, or nurse coordinators, for communicating with patients by phone and e-mail outside office hours.'' This is an approach to delivering care that national physician groups and patient advocacy organizations call the medical home.

A medical home is something that those of us who have it take for granted. We see the same doctor, in the same setting, for extended periods of time. Our medical history is in one place, and even if we are seeing specialists or different doctors in the same practice, there is continuity in decisions about our health care. This is a medical home.

But many people do not have this luxury. Think about people who move from place to place, whose home lives are less than stable, who don't have health insurance, whose medical care is sporadic. For these members of our community, each visit to a clinic or an emergency room means starting over again.

So, everyone should have access to a medical home. A medical home is not only a place, but an approach to providing comprehensive primary care that respects, and responds to, individual patient preferences and needs and helps patients develop relationships with their providers.

It sounds easy, but it requires some changes and creative thinking and, perhaps most importantly, it requires a commitment by local providers to work together. The medical home model makes sense for improving health care for everyone. It is a model of care that makes sense for stretching our limited Federal health care dollars.

States like Illinois and North Carolina are already seeing progress with implementing the medical home model. Illinois Health Connect is a new program at the Illinois Department of Healthcare and Family Services that uses the medical home model to deliver primary and preventive care for children and adults covered through the All Kids program. This emphasis on coordinated and ongoing care is leading to better health outcomes, and it's saving money.

Community Care of North Carolina launched a medical home model in 1998, through nine physician-led networks. North Carolina started by creating medical homes for 250,000 Medicaid enrollees. Today, it is a State-wide program that has saved the state at least $60 million in Medicaid costs in 2003 and $120 million in 2004.

Cost savings is not the only benefit. Several studies show that the medical home approach improves quality of care. Early analyses are finding that having regular access to a particular physician through the medical home is associated with earlier and more accurate diagnoses, fewer emergency room visits, fewer hospitalizations, lower costs, better care, and increased patient satisfaction. Many studies conclude that having both health insurance and a medical home leads to improved overall health for the entire population, which brings down the cost of care and reduces health care disparities.

Today, I am proud to be joined by my colleague Senator RICHARD BURR of North Carolina to introduce the Medical Homes Act of 2007. This bill would make it easier for other states to implement a medical home model, much like Illinois and North Carolina have. Congress passed a medical home demonstration project for Medicare last year. The Medical Homes Act of 2007 would do this for Medicaid and SCHIP beneficiaries by making Federal funding available for a demonstration project in 8 States to provide care through patient-centered medical homes.

The approach we propose requires a per-member, per-month care management fee to help pay for participating doctors and provides initial start-up funding for participating States. The startup funds are used for the purchase of health information technology, primary care case managers, and other uses appropriate for the delivery of patient-centered care.

If patients, provider, payers, and the government work together to create a system that values the patient more than payments and the health outcome of the patient more than the number of patients seen, we can really change the way primary care is provided. I urge my colleagues to support the Medical Homes Act of 2007 and help stabilize healthcare delivery for low-income and elderly Americans.

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

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

S. 2376

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medical Homes Act of 2007''.

SEC. 2. FINDINGS.

Congress finds the following:

(1) Medical homes provide patient-centered care, leading to better health outcomes and greater patient satisfaction. A growing body of research supports the need to involve patients and their families in their own health care decisions, to better inform them of their treatment options, and to improve their access to information.

(2) Medical homes help patients better manage chronic diseases and maintain basic preventive care, resulting in better health outcomes than those who lack medical homes. An investigation of the Chronic Care Model discovered that the medical home reduced the risk of cardiovascular disease in diabetes patients, helped congestive heart failure patients become more knowledgeable and stay on recommended therapy, and increased the likelihood that asthma and diabetes patients would receive appropriate therapy.

(3) Medical homes also reduce disparities in access to care. A survey conducted by the Commonwealth Fund found that 74 percent of adults with a medical home have reliable access to the care they need, compared with only 52 percent of adults with a regular provider that is not a medical home and 38 percent of adults without any regular source of care or provider.

(4) Medical homes reduce racial and ethnic differences in access to medical care. Three-fourths of Caucasians, African Americans, and Hispanics with medical homes report getting care when they need it in a medical home.

(5) Medical homes reduce duplicative health services and inappropriate emergency room use. In 1998, North Carolina launched the Community Care of North Carolina (CCNC) program, which employs the medical home concept. Today CCNC includes 14 networks, that include all Federally qualified health centers in the State, covering 740,000 recipients across the entire State. An analysis conducted by Mercer Human Resources Consulting Group found that CCNC resulted in $244,000,000 in savings to the Medicaid program in 2004, with similar results in 2005 and 2006.

(6) Health information technology is a crucial foundation for medical homes. While many doctor's offices use electronic health records for billing or other administrative functions, few practices utilize health information technology systematically to measure and improve the quality of care they provide. For example, electronic health records can generate reports to ensure that all patients with chronic conditions receive recommended tests and are on target to meet their treatment goals. Computerized ordering systems, particularly with decision-support tools, can prevent medical and medication errors, while e-mail and interactive Internet websites can facilitate communication between patients and providers and patient education.

SEC. 3. MEDICAID AND SCHIP DEMONSTRATION PROJECT TO SUPPORT PATIENT-CENTERED PRIMARY CARE.

(a) DEFINITIONS.—In this section:

(1) CARE MANAGEMENT MODEL.—The term ''care management model'' means a model that—

(A) uses health information technology and other innovations such as the chronic care model, to improve the management and coordination of care provided to patients;

(B) is centered on the relationship between a patient and their personal primary care provider;

(C) seeks guidance from—

(i) a steering committee; and

(ii) a medical management committee; and

(D) has established, where practicable, effective referral relationships between the primary care provider and the major medical specialties and ancillary services in the region.

(2) HEALTH CENTER.—The term ''health center'' has the meaning given that term in section 330(a) of the Public Health Service Act (42 U.S.C. 254b(a)).

(3) MEDICAID.—The term ''Medicaid'' means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(4) MEDICAL MANAGEMENT COMMITTEE.—The term ''medical management committee'' means a group of local practitioners that—

(A) reviews evidence-based practice guidelines;

(B) selects targeted diseases and care processes that address health conditions of the community (as identified in the National or State health assessment or as outlined in ''Healthy People 2010'', or any subsequent similar report (as determined by the Secretary));

(C) defines programs to target diseases and care processes;

(D) establishes standards and measures for patient-centered medical homes, taking into account nationally-developed standards and measures; and

(E) makes the determination described in subparagraph (A)(iii) of paragraph (5), taking into account the considerations under subparagraph (B) of such paragraph.

(5) PATIENT-CENTERED MEDICAL HOME.—

(A) IN GENERAL.—The term ''patient-centered medical home'' means a physician-directed practice or a health center that—

(i) incorporates the attributes of the care management model described in paragraph (1);

(ii) voluntarily participates in an independent evaluation process whereby primary care providers submit information to the medical management committee of the relevant network;

(iii) the medical management committee determines has the capability to achieve improvements in the management and coordination of care for targeted beneficiaries (as defined by Statewide quality improvement standards and outcomes); and

(iv) meets the requirements imposed on a covered entity for purposes of applying part C of title XI of the Public Health Service Act (42 U.S.C. 300b–1 et seq.) and all regulatory provisions promulgated thereunder, including regulations (relating to privacy) adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(B) CONSIDERATIONS.—In making the determination under subparagraph (A)(iii), the medical management committee shall consider the following:

(i) ACCESS AND COMMUNICATION WITH PATIENTS.—Whether the practice or health center applies both standards for access to care for and standards for communication with targeted beneficiaries who receive care through the practice or health center.

(ii) MANAGING PATIENT INFORMATION AND USING INFORMATION MANAGEMENT TO SUPPORT PATIENT CARE.—Whether the practice or health center has readily accessible, clinically useful information on such beneficiaries that enables the practice or health center to comprehensively and systematically treat such beneficiaries.

(iii) MANAGING AND COORDINATING CARE ACCORDING TO INDIVIDUAL NEEDS.—Whether the practice or health center—

(I) maintains continuous relationships with such beneficiaries by implementing evidence-based guidelines and applying such guidelines to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries;

(II) assists in the early identification of health care needs;

(III) provides ongoing primary care; and

(IV) coordinates with a broad range of other specialty, ancillary, and related services.

(iv) PROVIDING ONGOING ASSISTANCE AND ENCOURAGEMENT IN PATIENT SELF-MANAGEMENT.—Whether the practice or health center—

(I) collaborates with targeted beneficiaries who receive care through the practice or health center to pursue their goals for optimal achievable health;

(II) assesses patient-specific barriers; and

(III) conducts activities to support patient self-management.

(v) RESOURCES TO MANAGE CARE.—Whether the practice or health center has in place the resources and processes necessary to achieve improvements in the management and coordination of care for targeted beneficiaries who receive care through the practice or health center.

(vi) MONITORING PERFORMANCE.—Whether the practice or health center—

(I) monitors its clinical process and performance (including process and outcome measures) in meeting the applicable standards under paragraph (4)(D); and

(II) provides information in a form and manner specified by the steering committee and medical management committee with respect to such process and performance.

(6) PERSONAL PRIMARY CARE PROVIDER.—The term ''personal primary care provider'' means—

(A) a physician, nurse practitioner, or other qualified health care provider (as determined by the Secretary), who—

(i) practices in a patient-centered medical home; and

(ii) has been trained to provide first contact, continuous, and comprehensive care for the whole person, not limited to a specific disease condition or organ system, including care for all types of health conditions (such as acute care, chronic care, and preventive services); or

(B) a health center that—

(i) is a patient-centered medical home; and

(ii) has providers on staff that have received the training described in subparagraph (A)(ii).

(7) PRIMARY CARE CASE MANAGEMENT SERVICES; PRIMARY CARE CASE MANAGER.—The terms ''primary care case management services'' and ''primary care case manager'' have the meaning given those terms in section 1905(t) of the Social Security Act (42 U.S.C. 1396d(t)).

(8) PROJECT.—The term ''project'' means the demonstration project established under this section.

(9) SCHIP.—The term ''SCHIP'' means the State Children's Health Insurance Program established under title XXI of the Social Security Act (42 U.S.C. 1396aa et seq.).

(10) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(11) STEERING COMMITTEE.—The term ''steering committee'' means a local management group comprised of collaborating local health care practitioners or a local not-for-profit network of health care practitioners—

(A) that implements State-level initiatives;

(B) that develops local improvement initiatives;

(C) whose mission is to—

(i) investigate questions related to community-based practice; and

(ii) improve the quality of primary care; and

(D) whose membership—

(i) represents the health care delivery system of the community it serves; and

(ii) includes physicians (with an emphasis on primary care physicians) and 1 representative from each part of the collaborative or network (such as a representative from a health center, a representative from the health department, a representative from social services, and a representative from each public and private hospital in the collaborative or the network).

(12) TARGETED BENEFICIARY.—

(A) IN GENERAL.—The term ''targeted beneficiary'' means an individual who is eligible for benefits under a State plan under Medicaid or a State child health plan under SCHIP.

(B) PARTICIPATION IN PATIENT-CENTERED MEDICAL HOME.—Individuals who are eligible for benefits under Medicaid or SCHIP in a State selected to participate in the project shall receive care through a patient-centered medical home when available.

(C) ENSURING CHOICE.—In the case of such an individual who receives care through a patient-centered medical home, the individual shall receive guidance from their personal primary care provider on appropriate referrals to other health care professionals in the context of shared decisionmaking.

(b) ESTABLISHMENT.—The Secretary shall establish a demonstration project under Medicaid and SCHIP for the implementation of a patient-centered medical home program that meets the requirements of subsection (d) to improve the effectiveness and efficiency in providing medical assistance under Medicaid and child health assistance under SCHIP to an estimated 500,000 to 1,000,000 targeted beneficiaries.

(c) PROJECT DESIGN.—

(1) DURATION.—The project shall be conducted for a 3-year period, beginning not later than October 1, 2009.

(2) SITES.—

(A) IN GENERAL.—The project shall be conducted in 8 States—

(i) four of which already provide medical assistance under Medicaid for primary care case management services as of the date of enactment of this Act; and

(ii) four of which do not provide such medical assistance.

(B) APPLICATION.—A State seeking to participate in the project shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(C) SELECTION.—In selecting States to participate in the project, the Secretary shall ensure that urban, rural, and underserved areas are served by the project.

(3) GRANTS AND PAYMENTS.—

(A) DEVELOPMENT GRANTS.—

(i) FIRST YEAR DEVELOPMENT GRANTS.—The Secretary shall award development grants to States participating in the project during the first year the project is conducted. Grants awarded under this clause shall be used by a participating State to—

(I) assist with the development of steering committees, medical management committees, and local networks of health care providers; and

(II) facilitate coordination with local communities to be better prepared and positioned to understand and meet the needs of the communities served by patient-centered medical homes.

(ii) SECOND YEAR FUNDING.—The Secretary shall award additional grant funds to States that received a development grant under clause (i) during the second year the project is conducted if the Secretary determines such funds are necessary to ensure continued participation in the project by the State. Grant funds awarded under this clause shall be used by a participating State to assist in making the payments described in paragraph (B). To the extent a State uses such grant funds for such purpose, no matching payment may be made to the State for the payments made with such funds under section 1903(a) or 2105(a) of the Social Security Act (42 U.S.C. 1396b(a); 1397ee(a)).

(B) ADDITIONAL PAYMENTS TO PERSONAL PRIMARY CARE PROVIDERS AND STEERING COMMITTEES.—

(i) PAYMENTS TO PERSONAL PRIMARY CARE PROVIDERS.—

(I) IN GENERAL.—Subject to subsection (d)(6)(B), a State participating in the project shall pay a personal primary care provider not less than $2.50 per month per targeted beneficiary assigned to the personal primary care provider, regardless of whether the provider saw the targeted beneficiary that month.

(II) FEDERAL MATCHING PAYMENT.—Subject to subparagraph (A)(ii), amounts paid to a personal primary care provider under subclause (I) shall be considered medical assistance or child health assistance for purposes of section 1903(a) or 2105(a), respectively, of the Social Security Act (42 U.S.C. 1396b(a); 1397ee(a)).

(III) PATIENT POPULATION.—In determining the amount of payment to a personal primary care provider per month with respect to targeted beneficiaries under this clause, a State participating in the project shall take into account the care needs of such targeted beneficiaries.

(ii) PAYMENTS TO STEERING COMMITTEES.—

(I) IN GENERAL.—Subject to subsection (d)(6)(B), a State participating in the project shall pay a steering committee not less than $2.50 per targeted beneficiary per month.

(II) FEDERAL MATCHING PAYMENT.—Subject to subparagraph (A)(ii), amounts paid to a steering committee under subclause (I) shall be considered medical assistance or child health assistance for purposes of section 1903(a) or 2105(a), respectively, of the Social Security Act (42 U.S.C. 1396b(a); 1397ee(a)).

(III) USE OF FUNDS.—Amounts paid to a steering committee under subclause (I) shall be used to purchase health information technology, pay primary care case managers, support network initiatives, and for such other uses as the steering committee determines appropriate.

(4) TECHNICAL ASSISTANCE.—The Secretary shall make available technical assistance to States, physician practices, and health centers participating in the project during the duration of the project.

(5) BEST PRACTICES INFORMATION.—The Secretary shall collect and make available to States participating in the project information on best practices for patient-centered medical homes.

(d) PATIENT-CENTERED MEDICAL HOME PROGRAM.—

(1) IN GENERAL.—For purposes of this section, a patient-centered medical home program meets the requirements of this subsection if, under such program, targeted beneficiaries designate a personal primary care provider in a patient-centered medical home as their source of first contact, comprehensive, and coordinated care for the whole person.

(2) ELEMENTS.—

(A) MANDATORY ELEMENTS.—

(i) IN GENERAL.—Such program shall include the following elements:

(I) A steering committee.

(II) A medical management committee.

(III) A network of physician practices and health centers that have volunteered to participate as patient-centered medical homes to provide high-quality care, focusing on preventive care, at the appropriate time and place in a cost-effective manner.

(IV) Hospitals and local public health departments that will work in cooperation with the network of patient-centered medical homes to coordinate and provide health care.

(V) Primary care case managers to assist with care coordination.

(VI) Health information technology to facilitate the provision and coordination of health care by network participants.

(ii) MULTIPLE LOCATIONS IN THE STATE.—In the case where a State operates a patient-centered medical home program in 2 or more areas in the State, the program in each of those areas shall include the elements described in clause (i).

(B) OPTIONAL ELEMENTS.—Such program may include a non-profit organization that—

(i) includes a steering committee and a medical management committee; and

(ii) manages the payments to steering committees described in subsection (c)(3)(B)(ii).

(3) GOALS.—Such program shall be designed—

(A) to increase—

(i) cost efficiencies of health care delivery;

(ii) access to appropriate health care services, especially wellness and prevention care, at times convenient for patients;

(iii) patient satisfaction;

(iv) communication among primary care providers, hospitals, and other health care providers;

(v) school attendance; and

(vi) the quality of health care services (as determined by the relevant steering committee and medical management committee, taking into account nationally-developed standards and measures); and

(B) to decrease—

(i) inappropriate emergency room utilization, which can be accomplished through initiatives, such as expanded hours of care throughout the program network;

(ii) avoidable hospitalizations; and

(iii) duplication of health care services provided.

(4) PAYMENT.—Under the program, payment shall be provided to personal primary care providers and steering committees (in accordance with subsection (c)(3)(B)).

(5) NOTIFICATION.—The State shall notify individuals enrolled in Medicaid or SCHIP about—

(A) the patient-centered medical home program;

(B) the providers participating in such program; and

(C) the benefits of such program.

(6) TREATMENT OF STATES WITH A MANAGED CARE CONTRACT.—

(A) IN GENERAL.—In the case where a State contracts with a private entity to manage parts of the State Medicaid program, the State shall—

(i) ensure that the private entity follows the care management model; and

(ii) establish a medical management committee and a steering committee in the community.

(B) ADJUSTMENT OF PAYMENT AMOUNTS.—The State may adjust the amount of payments made under (c)(3)(B), taking into consideration the management role carried out by the private entity described in subparagraph (A) and the cost effectiveness provided by such entity in certain areas, such as health information technology.

(e) EVALUATION AND PROJECT REPORT.—

(1) IN GENERAL.—

(A) EVALUATION.—The Secretary, in consultation with appropriate health care professional associations, shall evaluate the project in order to determine the effectiveness of patient-centered medical homes in terms of quality improvement, patient and provider satisfaction, and the improvement of health outcomes.

(B) PROJECT REPORT.—Not later than 12 months after completion of the project, the Secretary shall submit to Congress a report on the project containing the results of the evaluation conducted under subparagraph (A). Such report shall include—

(i) an assessment of the differences, if any, between the quality of the care provided through the patient-centered medical home program conducted under the project in the States that provide medical assistance for primary care case management services and those that do not;

(ii) an assessment of quality improvements and clinical outcomes as a result of such program;

(iii) estimates of cost savings resulting from such program; and

(iv) recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(2) SENSE OF THE SENATE.—It is the sense of the Senate that, during the next authorization of SCHIP, titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq.; 1397aa et seq.) should be amended, based on the results of the evaluation and report under paragraph (1), to establish a patient-centered medical home program under such titles on a permanent basis.

(f) WAIVER.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall waive compliance with such requirements of titles XI, XIX, and XXI of the Social Security Act (42 U.S.C. 1301 et seq.; 1396 et seq.; 1397aa et seq.) to the extent and for the period the Secretary finds necessary to conduct the project.

(2) LIMITATION.—In no case shall the Secretary waive compliance with the requirements of subsections (a)(10)(A), (a)(15), and (bb) of section 1902 of the Social Security Act (42 U.S.C. 1396a) under paragraph (1), to the extent that such requirements require the provision of, and reimbursement for services described in section 1905(a)(2)(C) of such Act (42 U.S.C. 1396d(a)(2)(C)).

By Mr. DURBIN (for himself and Mr. OBAMA):

S. 2377. A bill to amend title 38, United States Code, to improve the quality of care provided to veterans in Department of Veterans Affairs medical facilities, to encourage highly qualified doctors to serve in hard-to-fill positions in such medical facilities, and for other purposes; to the Committee on Veterans' Affairs.

Mr. DURBIN. Mr. President, today I am introducing legislation along with Senator OBAMA that will address some serious deficiencies we have found in the Veterans Administration's health care quality assurance efforts. Over the past several months, we have learned of problems in the hiring practices and quality of care at the veterans hospital in Marion, IL. What we have learned suggests that there are flaws that could equally affect the hiring and quality assurance programs in other VA hospitals.

The problems at Marion first came to light in August after the VA became aware that there had been an abnormal spike in deaths at the hospital the previous winter. A doctor was practicing at Marion even though a year earlier he had agreed to stop practicing medicine in Massachusetts. This fact came to light only after he had resigned from Marion because he was being sued for malpractice involving a case at Marion. It turned out that he had been involved in at least nine other cases at Marion in which the patient died, and he had been the subject of at least two malpractice settlements and a disciplinary action in Massachusetts before moving to Illinois.

The VA initiated an investigation and has taken steps to protect the patients at Marion. All but the most simple outpatient surgeries have been suspended, one doctor has resigned, four others have had their privileges restricted, and four top staff members have been temporarily reassigned.

The VA's Inspector General is conducting a thorough investigation and I am looking forward to considering his conclusions. But we know enough to take action now. And we must take action now because what happened at Marion may not be an isolated case. The same problems may exist at other VA hospitals as well.

The legislation we are introducing has three main objectives. First, it would improve the process of vetting doctors applying to and working in the VA. Second, it would expand the quality control programs in the VA health care system. And third, it would create incentives to encourage high-quality doctors to practice at veterans hospitals.

The VA's standards for evaluating employment applicants must be strengthened. When the doctor whose problematic service brought this issue to light was hired by the VA, he had two malpractice payments on his record, but he had only disclosed one to the VA. He was also under investigation by the Massachusetts medical board for gross incompetence in several cases that led to the deaths of patients. This was not disclosed to the VA.

Our legislation will fix this problem. It will require all physician applicants to the VA, and all doctors practicing in the VA, to disclose any judgments, settlements, disciplinary actions, and open investigations involving them. In addition, each doctor would be required to make a written request to the State medical board of any State in which they have held a license, requesting that the board release this same information to the VA.

Now, as a lawyer, I understand the caution that must be used when dealing with investigations that are not complete and judgments that are not final. But doctors and hospitals understand and work with confidential information all the time. VA officials with hiring authority will keep this information confidential and will be able to differentiate between a frivolous lawsuit and a case that should raise real concern. Before we entrust our Nation's veterans to a doctor, the VA should know all the pertinent information about that individual. Before the VA hires a physician, it should be required to examine this kind of information to make sure the physician should not be disqualified from employment in the VA.

In addition, our bill requires doctors employed by the VA to be licensed in the state in which they practice.

The bill's second objective is to improve the VA's quality assurance program. Our legislation would establish a quality assure officer at each VA medical facility, in each Veterans Integrated Service Network, VISN, region,

and at the VA national headquarters. These officers would establish and carry out a quality assurance program at each VA medical facility.

Over the year and a half that this doctor practiced at Marion, at least a few of the nurses had concerns about his skills and competence and raised those concerns with the hospital leadership. They were ignored. This is absolutely unacceptable.

Concerns about the quality of care in a VA facility should never go unexamined. If local hospital officials will not listen, another avenue should be available for raising these concerns. Our legislation would allow employees to raise quality of care concerns to the local quality assurance officer and the regional quality assurance officer, ensuring that there is a place employees can go and know that their concerns will be considered.

In addition, we would require that the quality assurance program at each hospital include a mechanism for the peer review of physicians in the hospital. At Marion, it appears that any kind of peer review program that might have been present was either dormant or ignored. As a result, early warning signs were missed that might have saved lives.

Our measure would require that the quality assurance officers be licensed physicians, so that they will be qualified to monitor the performance of other doctors and ensure a fair but thorough peer review process is in place.

Finally, our legislation includes provisions to encourage talented doctors to practice in the VA system. We would direct each VA hospital to seek to affiliate with a nearby medical school so that our hospitals will have the benefit of the fresh, young minds of medical students and the more experienced judgments Of medical school faculty. These affiliations would introduce young doctors to the work of the VA, which might lead them to consider a career there. We also would create loan forgiveness and tuition reimbursement programs to encourage doctors to commit to practice in VA hospitals.

We also recognize that many experienced doctors might be willing to practice part-time in a VA hospital but would be unwilling to totally leave private practice. Our bill would instruct the VA to develop programs to increase the recruitment of experienced, quality doctors who might be willing to practice part-time in the VA health care system. It would also offer access to the federal employees health insurance program to doctors who are willing to practice at least five days per month in a VA medical facility.

This bill addresses very real issues that directly affect the health of our veterans. The VA's investigation of what went wrong at Marion may lead us to additional legislative initiatives, but the steps we have outlined in this bill are steps that need to be taken now to protect veterans in VA hospitals throughout the country.

This legislation has been endorsed by Veterans for America. I urge my colleagues to join in moving forward with this legislation to ensure that our veterans receive the quality of care they deserve.

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

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

S. 2377

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Veterans Health Care Quality Improvement Act''.

SEC. 2. STANDARDS FOR APPOINTMENT AND PRACTICE OF PHYSICIANS IN DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES.

(a) STANDARDS.—

(1) IN GENERAL.—Subchapter I of chapter 74 of title 38, United States Code, is amended by inserting after section 7402 the following new section:

''§ 7402A. Appointment and practice of physicians: standards

''(a) IN GENERAL.—The Secretary shall, acting through the Under Secretary for Health, prescribe standards to be met by individuals in order to qualify for appointment in the Administration in the position of physician and to practice as a physician in medical facilities of the Administration. The standards shall incorporate the requirements of this section.

''(b) DISCLOSURE OF CERTAIN INFORMATION BEFORE APPOINTMENT.—Each individual seeking appointment in the Administration in the position of physician shall do the following:

''(1) Provide the Secretary a full and complete explanation of the following:

''(A) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence (other than a lawsuit, action, or claim closed without any judgment against or payment by or on behalf of the individual).

''(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

''(C) Each investigation or disciplinary action taken against the individual relating to the individual's performance as a physician.

''(2) Submit a written request and authorization to the State licensing board of each State in which the individual holds or has held a license to practice medicine to disclose to the Secretary any information in the records of such State on the following:

''(A) Each lawsuit, civil action, or other claim brought against the individual for medical malpractice or negligence covered by paragraph (1)(A) that occurred in such State.

''(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

''(C) Each medical malpractice judgment against the individual by the courts or administrative agencies or bodies of such State.

''(D) Each disciplinary action taken or under consideration against the individual by an administrative agency or body of such State.

''(E) Any change in the status of the license to practice medicine issued the individual by such State, including any voluntary or nondisciplinary surrendering of such license by the individual.

''(F) Any open investigation of the individual by an administrative agency or body of such State, or any outstanding allegation against the individual before such an administrative agency or body.

''(c) DISCLOSURE OF CERTAIN INFORMATION FOLLOWING APPOINTMENT.—(1) Each individual appointed in the Administration in the position of physician after the date of the enactment of the Veterans Health Care Quality Improvement Act shall, as a condition of service under the appointment, disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

''(A) A judgment against the individual for medical malpractice or negligence.

''(B) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed under paragraph (1) or (2) of subsection (b).

''(C) Any disposition of or material change in a matter disclosed under paragraph (1) or (2) of subsection (b).

''(2) Each individual appointed in the Administration in the position of physician as of the date of the enactment of the Veterans Health Care Quality Improvement Act shall do the following:

''(A) Not later than the end of the 60-day period beginning on the date of the enactment of that Act and as a condition of service under the appointment after the end of that period, submit the request and authorization described in subsection (b)(2).

''(B) Agree, as a condition of service under the appointment, to disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

''(i) A judgment against the individual for medical malpractice or negligence.

''(ii) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed pursuant to subparagraph (A) or under this subparagraph.

''(iii) Any disposition of or material change in a matter disclosed pursuant to subparagraph (A) or under this subparagraph.

''(3) Each individual appointed in the Administration in the position of physician shall, as part of the biennial review of the performance of the physician under the appointment, submit the request and authorization described in subsection (b)(2). The requirement of this paragraph is in addition to the requirements of paragraph (1) or (2), as applicable.

''(d) INVESTIGATION OF DISCLOSED MATTERS.—(1) The Regional Director of the Veterans Integrated Services Network (VISN) in which an individual is seeking appointment in the Administration in the position of physician shall perform a comprehensive investigation (in such manner as the standards required by this section shall specify) of each matter disclosed under subsection (b) with respect to the individual.

''(2) The Regional Director of the Veterans Integrated Services Network in which an individual is appointed in the Administration in the position of physician shall perform a comprehensive investigation (in a manner so specified) of each matter disclosed under subsection (c) with respect to the individual.

''(3) The results of each investigation performed under this subsection shall be fully documented.

''(e) APPROVAL OF APPOINTMENTS BY REGIONAL DIRECTORS OF VISNs.—(1) An individual may not be appointed in the Administration in the position of physician without the approval of the Regional Director of the Veterans Integrated Services Network in which the individual will first serve under the appointment.

''(2) In approving the appointment under this subsection of an individual for whom

any matters have been disclosed under subsection (b), a Regional Director shall—

''(A) certify in writing the completion of the performance of the investigation under subsection (d)(1) of each such matter, including the results of such investigation; and

''(B) provide a written justification why any matters raised in the course of such investigation do not disqualify the individual from appointment.

''(f) BOARD CERTIFICATION.—(1) Except as provided in paragraph (2), an individual may not be appointed in the Administration in the position of physician unless the individual is board certified in the specialties in which the individual will practice under the appointment.

''(2) A Regional Director may waive the limitation in paragraph (1) with respect to any individual who has completed a residency program within the two-year period ending on the date of such waiver if the individual provides satisfactory evidence (as determined in accordance with the standards required by this section) of an intent to become board certified. The period of any waiver under this paragraph may not exceed one year.

''(g) STATE LICENSE REQUIRED FOR PRACTICE IN IN-STATE VA MEDICAL FACILITIES.—Each physician practicing at a medical facility of the Department in a State, whether under an appointment in the Administration or through the extension of privileges of practice, shall, as a condition of such practice, hold a license to practice medicine in the State within one year of appointment.

''(h) ENROLLMENT OF PHYSICIANS WITH PRACTICE PRIVILEGES IN PROACTIVE DISCLOSURE SERVICE.—Each medical facility of the Department at which physicians are extended the privileges of practice shall enroll each physician extended such privileges in the Proactive Disclosure Service of the National Practitioners Data Base.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 of such title is amended by inserting after the item relating to section 7402 the following new item:

''7402A. Appointment and practice of physicians: standards.''.

(b) EFFECTIVE DATE AND APPLICABILITY.—

(1) EFFECTIVE DATE.—Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) APPLICABILITY OF CERTAIN REQUIREMENTS TO PHYSICIANS PRACTICING ON EFFECTIVE DATE.—In the case of an individual appointed to the Veterans Health Administration in the position of physician as of the date of the enactment of this Act—

(A) the requirements of subsections (f) and (g) of section 7402A, United States Code, as added by subsection (a) of this section, shall take effect on the date that is one year after the date of the enactment of this Act; and

(B) the requirements of subsection (h) of such section 7402A, as so added, shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 3. ENHANCEMENT OF QUALITY ASSURANCE BY THE VETERANS HEALTH ADMINISTRATION.

(a) ENHANCEMENT OF QUALITY ASSURANCE THROUGH QUALITY ASSURANCE OFFICERS.—

(1) IN GENERAL.—Subchapter II of chapter 73 of title 38, United States Code, is amended by inserting after section 7311 the following new section:

''§ 7311A. Quality assurance officers

''(a) NATIONAL QUALITY ASSURANCE OFFICER.—(1) The Under Secretary of Health shall designate an official of the Administration to act as the principal quality assurance officer for the quality-assurance program required by section 7311 of this title. The official so designated may be known as the 'National Quality Assurance Officer of the Veterans Health Administration' (in this section referred to as the 'National Quality Assurance Officer').

''(2) The National Quality Assurance Officer shall report directly to the Under Secretary for Health in the discharge of responsibilities and duties of the Officer under this section.

''(3) The National Quality Assurance Officer shall be the official within the Administration who is principally responsible for the quality-assurance program referred to in paragraph (1). In carrying out that responsibility, the Officer shall be responsible for—

''(A) establishing and enforcing the requirements of that program; and

''(B) carrying out such other responsibilities and duties relating to quality assurance in the Administration as the Under Secretary for Health shall specify.

''(4) The requirements under paragraph (3) shall include requirements regarding the following:

''(A) A confidential system for the submittal of reports by Administration personnel regarding quality assurance at Administration facilities.

''(B) Mechanisms for the peer review of the actions of individuals appointed in the Administration in the position of physician.

''(C) Mechanisms for the accountability of the facility director and chief medical officer of each Administration medical facility for the actions of physicians in such facility.

''(b) QUALITY ASSURANCE OFFICERS FOR VISNS.—(1) The Regional Director of each Veterans Integrated Services Network (VISN) shall appoint an official of the Network to act as the quality assurance officer of the Network.

''(2) Each official appointed as a quality assurance officer under this subsection shall be a board-certified physician.

''(3) The quality assurance officer for a Veterans Integrated Services Network shall report to the Regional Director of the Veterans Integrated Services Network, and to the National Quality Assurance Officer, regarding the discharge of the responsibilities and duties of the officer under this section.

''(4) The quality assurance officer for a Veterans Integrated Services Network shall—

''(A) direct the quality assurance office in the Network; and

''(B) coordinate, monitor, and oversee the quality assurance programs and activities of the Administration medical facilities in the Network in order to ensure the thorough and uniform discharge of quality assurance requirements under such programs and activities throughout such facilities.

''(c) QUALITY ASSURANCE OFFICERS FOR MEDICAL FACILITIES.—(1) The director of each Administration medical facility shall appoint a quality assurance officer for that facility.

''(2) Each official appointed as a quality assurance officer under this subsection shall be a board-certified physician.

''(3) The official appointed as a quality assurance officer for a facility under this subsection shall be a practicing physician at the facility. If the official appointed as quality assurance officer for a facility has other clinical or administrative duties, the director of the facility shall ensure that those duties are sufficiently limited in scope so as to ensure that those duties do not prevent the officer from effectively discharging the responsibilities and duties of quality assurance officer at the facility.

''(4) The quality assurance officer for a facility shall report directly to the director of the facility, and to the quality assurance officer of the Veterans Integrated Services Network in which the facility is located, regarding the discharge of the responsibilities and duties of the quality assurance officer under this section.

''(5) The quality assurance officer for a facility shall be responsible for designing, disseminating, and implementing quality assurance programs and activities for the facility that meet the requirements established by the National Quality Assurance Officer under subsection (a).''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of such title is amended by inserting after the item relating to section 7311 the following new item:

''7311A. Quality assurance officers.''.

(b) BOARD-CERTIFIED PHYSICIAN REQUIREMENT FOR INDIVIDUALS APPOINTED AS UNDER SECRETARY FOR HEALTH.—Section 305(a)(2) of title 38, United States Code, is amended by inserting ''shall be a board-certified physician and'' before ''shall be''.

(c) REPORTS ON QUALITY CONCERNS UNDER QUALITY-ASSURANCE PROGRAM.—Section 7311(b) of such title is amended by adding at the end the following new paragraph:

''(4) As part of the quality-assurance program, the Under Secretary for Health shall establish mechanisms through which employees of Administration facilities may submit reports, on a confidential basis, on matters relating to quality of care in Administration facilities to the quality assurance officers of such facilities under section 7311A(c) of this title and to the quality assurance officers of the Veterans Integrated Services Networks (VISNs) in which such facilities are located under section 7311A(b) of this title. The mechanisms shall provide for the prompt and thorough review of any reports so submitted by the receiving officials.''.

(d) REVIEW OF CURRENT HEALTH CARE QUALITY SAFEGUARDS.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall conduct a comprehensive review of all current policies and protocols of the Department of Veterans Affairs for maintaining health care quality and patient safety at Department of Veterans Affairs medical facilities. The review shall include a review and assessment of the National Surgical Quality Improvement Program (NSQIP), including an assessment of—

(A) the efficacy of the quality indicators under the program;

(B) the efficacy of the data collection methods under the program;

(C) the efficacy of the frequency with which regular data analyses are performed under the program; and

(D) the extent to which the resources allocated to the program are adequate to fulfill the stated function of the program.

(2) REPORT.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the review conducted under paragraph (1), including the findings of the Secretary as a result of the review and such recommendations as the Secretary considers appropriate in light of the review.

SEC. 4. INCENTIVES TO ENCOURAGE HIGH-QUALITY PHYSICIANS TO SERVE IN THE VETERANS HEALTH ADMINISTRATION.

(a) INCENTIVES REQUIRED.—

(1) IN GENERAL.—Subchapter III of chapter 74 of title 38, United States Code, is amended by inserting after section 7431 the following new section:

''§ 7431A. Physicians: additional incentives for service in hard-to-fill positions

''(a) LOAN REPAYMENT FOR PHYSICIANS WHO SERVE IN HARD-TO-FILL POSITIONS.—(1) In

order to recruit and retain physicians in the Administration in hard-to-fill positions (as designated by the Secretary for purposes of this subsection), the Secretary shall repay, for each individual who agrees to serve as a physician for a period of not less than three years in an Administration facility in such a position, any loan of such individual as follows:

''(A) Any loan of the individual described in paragraphs (1) through (4) of section 16302(a) of title 10.

''(B) Any other loan of the individual designated by the Secretary for purposes of this subsection the proceeds of which were used by the individual to finance education leading to the medical degree of the individual.

''(2) Each individual seeking repayment of loans under paragraph (1) shall enter into an agreement with the Secretary regarding the repayment of loans. Under the agreement, the individual shall agree—

''(A) to perform satisfactory service in a physician position specified in the agreement in an Administration facility specified in the agreement for such period of years as the agreement shall specify; and

''(B) to possess and retain for the period of the agreement such professional qualifications as are necessary for the service specified under subparagraph (A).

''(3) Repayment of loans under this subsection shall be made on the basis of complete years of service under the agreement under this subsection. The amount to be repayed under an agreement under this subsection for a complete year of service specified in the agreement shall be such amount, not to exceed $30,000, for each complete year of service as the agreement shall specify.

''(b) TUITION REIMBURSEMENT FOR PHYSICIAN STUDENTS WHO AGREE TO SERVE IN HARD-TO-FILL POSITIONS.—(1) In order to recruit and retain physicians in the Administration in hard-to-fill positions (as designated by the Secretary for purposes of this subsection), the Secretary shall reimburse individuals who are enrolled in a course of education leading toward board certification as a physician for the tuition charged for pursuit of such course of education if such individuals agree to serve as a physician in an Administration facility in such a position.

''(2) Each individual seeking tuition reimbursement under paragraph (1) shall enter into an agreement with the Secretary regarding such tuition reimbursement. Under the agreement, the individuals shall agree—

''(A) to satisfactorily complete the course of education of the individual described in paragraph (1); and

''(B) upon completion of the course of education, to become board-certified as a physician; and

''(C) upon completion of the matters referred to in subparagraphs (A) and (B)—

''(i) to perform satisfactory service in a physician position specified in the agreement in an Administration facility specified in the agreement for such period of years as the agreement shall specify; and

''(ii) to possess and retain for the period of the agreement such professional qualifications as are necessary for the service specified under clause (i).

''(3) The amount of reimbursement payable to an individual under paragraph (1) for a year may not exceed $30,000.

''(4) Any individual receiving tuition reimbursement under paragraph (1) who does not satisfy the requirements of the agreement under paragraph (2) shall be subject to such repayment requirements as the Secretary shall specify in the agreement.

''(5) An individual receiving tuition reimbursement under paragraph (1) for pursuit of a course of education shall also be paid a stipend in the amount of $5,000 for each academic year of pursuit of such course of education after entry into an agreement under paragraph (2).

''(c) PARTICIPATION IN FEHBP OF PHYSICIANS WHO SERVE PART-TIME IN HARD-TO-FILL POSITIONS.—(1) In order to recruit and retain physicians in the Administration in hard-to-fill positions (as designated by the Secretary for purposes of this subsection), an individual not otherwise eligible for health insurance under chapter 89 of title 5 who agrees to serve as a physician in an Administration facility in such a position for not less than five days per month (of which two days must occur in each 14-day period) shall be eligible for enrollment in the health benefit plans under chapter 89 of title 5 on a self only or self and family basis (as applicable).

''(2) The Secretary shall administer this subsection in consultation with the Director of the Office of Personnel Management.

''(d) ADDITIONAL PROGRAMS.—It is the sense of Congress that the Secretary should undertake active and on-going efforts to establish additional incentive programs to encourage individuals to serve in the position of physician in the Administration, or otherwise practice in the Administration, in hard-to-fill positions, including, in particular, incentive programs to encourage more experienced physicians to serve or practice in such positions.

''(e) CONSTRUCTION.—The incentives required under this section are in addition to any other special pays or benefits to which the individuals covered by this section are eligible or entitled under law.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 of such title is amended by inserting after the item relating to section 731 the following new item:

''7431A. Physicians: additional incentives for service in hard-to-fill positions.''.

(b) AFFILIATION OF DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES WITH MEDICAL SCHOOLS.—The Secretary of Veterans Affairs shall, to the extent practicable, require each medical facility of the Department of Veterans Affairs to seek to establish an affiliation with a medical school within reasonable proximity of such medical facility.

SEC. 5. REPORTS TO CONGRESS.

(a) REPORT.—Not later than December 15, 2009, and each year thereafter through 2012, the Secretary of Veterans Affairs shall submit to the congressional veterans affairs committees a report on the implementation of this Act and the amendments made by this Act during the preceding fiscal year. Each report shall include, for the fiscal year covered by such report, the following:

(1) A comprehensive description of the implementation of this Act and the amendments made by this Act.

(2) Such recommendations as the Secretary considers appropriate for legislative or administrative action to improve the authorities and requirements in this Act and the amendments made by this Act or to otherwise improve the quality of health care and the quality of the physicians in the Veterans Health Administration.

(b) CONGRESSIONAL VETERANS AFFAIRS COMMITTEES DEFINED.—In this section, the term ''congressional veterans affairs committees'' means—

(1) the Committees on Veterans' Affairs and Appropriations of the Senate; and

(2) the Committees on Veterans' Affairs and Appropriations of the House of Representatives.

By Mr. ROBERTS:

S. 2378. A bill to authorize the voluntary purchase of certain properties in Treece, Kansas, endangered by the Cherokee County National Priorities List Site, and for other purposes; to the Committee on Environment and Public Works.

Mr. ROBERTS. Mr. President, I rise today to offer legislation to protect the residents of Treece, Kansas from the potential danger of remaining in an area that is undergoing a Superfund cleanup. I commend my fellow Kansas colleague, Congresswoman NANCY BOYDA, for introducing similar legislation in the House.

Treece is located in Cherokee County, Kansas. The Cherokee County site encompasses 115 square miles of former mining area. Mining in this area dates back to the early 1900s and at one time contained the richest lead and zinc ore production in the world. Although the drilling stopped in 1970, the effects of over 60 years of mining can be seen for miles around with mountains of milling left behind. Below these mountains, and surrounding areas, are enormous holes large enough to fit a football stadium, and they continually threaten the everyday safety of the residents of this community.

Cherokee County is part of a larger area known as the Tri-State Mining District that encompasses cities in southeastern Kansas, southwestern Missouri and northeastern Oklahoma. Within the Tri-State Mining District are two towns of particular importance, Treece, Kansas and Picher, Oklahoma. While these two towns are separated by a State line they are only a mere two miles away from one another. These two communities share more than a State line; they share a major highway, local stores, and most importantly the concerns of the aftermath of over 60 years of mining on their health, safety and the ultimate survival of their towns.

Currently Picher, part of the Tar Creek Superfund site, is undergoing a Federal buyout. The residents of Treece rely heavily on the services provided to them by Picher. Without that support the economic stability and ultimate survival of their town is in danger. Therefore, in order to assist the residents of Treece, I offer this legislation today to authorize the Environmental Protection Agency to make available to the state of Kansas $6,000,000, in 2009. This money will be used for the voluntary purchase of certain properties in Treece and will also allow for the relocation of community residents. This legislation will provide the residents of Treece an opportunity to relocate to another town of their choosing. An opportunity that they may not have without the Environmental Protection Agency's assistance.

By Mr. SALAZAR:

S. 2384. A bill to authorize the Chief of Engineers to conduct a feasibility study relating to the construction of a multipurpose project in the Fountain