to the Local Initiatives Support Corporation to carry out its Community Safety Initiative.

S. 2979

At the request of Mr. KERRY, the names of the Senator from Wisconsin (Mr. FEINGOLD) and the Senator from Maryland (Mr. CARDIN) were added as cosponsors of S. 2979, a bill to exempt the African National Congress from treatment as a terrorist organization, and for other purposes.

S. 3038

At the request of Mr. GRASSLEY, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 3038, a bill to amend part E of title IV of the Social Security Act to extend the adoption incentives program, to authorize States to establish a relative guardianship program, to promote the adoption of children with special needs, and for other purposes.

S. 3070

At the request of Mr. SESSIONS, the names of the Senator from Iowa (Mr. GRASSLEY) and the Senator from Maine (Ms. SNOWE) were added as cosponsors of S. 3070, a bill to require the Secretary of the Treasury to mint coins in commemoration of the centennial of the Boy Scouts of America, and for other purposes.

S. 3098

At the request of Mrs. DOLE, her name was added as a cosponsor of S. 3098, a bill to amend the Internal Revenue Code of 1986 to extend certain expiring provisions, and for other purposes.

At the request of Mr. CORNYN, his name was added as a cosponsor of S. 3098, supra.

S. 3101

At the request of Mr. BAUCUS, the name of the Senator from New Mexico (Mr. BINGAMAN) was added as a cosponsor of S. 3101, a bill to amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

S. 3103

At the request of Mr. BIDEN, the name of the Senator from Oklahoma (Mr. INHOFE) was added as a cosponsor of S. 3103, a bill to amend the Iran, North Korea, and Syria nonproliferation Act to allow certain extraordinary payments in connection with the International Space Station.

S. 3108

At the request of Mr. KERRY, the names of the Senator from New York (Mrs. CLINTON) and the Senator from Vermont (Mr. SANDERS) were added as cosponsors of S. 3108, a bill to require the President to call a White House Conference on Food and Nutrition.

S.J. RES. 37

At the request of Mrs. FEINSTEIN, the names of the Senator from Illinois (Mr. DURBIN) and the Senator from New Jersey (Mr. MENENDEZ) were added as cosponsors of S.J. Res. 37, a joint resolution expressing the sense of Congress that the United States should sign the Declaration of the Oslo Conference on Cluster Munitions and future instruments banning cluster munitions that cause unacceptable harm to civilians.

S. CON. RES. 82

At the request of Mrs. LINCOLN, the names of the Senator from Georgia (Mr. ISAKSON) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of S. Con. Res. 82, a concurrent resolution supporting the Local Radio Freedom Act.

S. RES. 273

At the request of Ms. MIKULSKI, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. Res. 273, a resolution expressing the sense of the Senate that the United States Postal Service should issue a semipostal stamp to support medical research relating to Alzheimer's disease.

S. RES. 300

At the request of Mr. MENENDEZ, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. Res. 300, a resolution expressing the sense of the Senate that the Former Yugoslav Republic of Macedonia (FYROM) should stop the utilization of materials that violate provisions of the United Nations-brokered Interim Agreement between FYROM and Greece regarding ''hostile activities or propaganda'' and should work with the United Nations and Greece to achieve longstanding United States and United Nations policy goals of finding a mutually-acceptable official name for FYROM.

S. RES. 576

At the request of Mr. HATCH, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. Res. 576, a resolution designating August 2008 as ''Digital Television Transition Awareness Month''.

S. RES. 580

At the request of Mr. BAYH, the name of the Senator from North Dakota (Mr. CONRAD) was added as a cosponsor of S. Res. 580, a resolution expressing the sense of the Senate on preventing Iran from acquiring a nuclear weapons capability.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. ENZI:

S. 3112. A bill to reauthorize the Javits-Wagner-O'Day Act and the Randolph-Sheppard Act, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. ENZI. Mr. President, I rise today to introduce the Javits-Wagner-O'Day and Randolph-Sheppard Modernization Act of 2008. This legislation was drafted after thousands of hours were spent listening to the concerns of persons with disabilities and other affected parties.

The Randolph-Sheppard Act, enacted in 1936, gives persons who are legally blind training, support and contracting priority to fulfill certain Government food service contracts.

The Wagner-O'Day Act, enacted in 1938, required the Federal Government to make certain commodities purchases from organizations, 75 percent of whose direct laborers were blind. In 1971, Senator Jacob Javits fought to include individuals with other severe disabilities in the law. The amended law—the Javits-Wagner-O'Day Act—now requires the Federal Government to purchase over 11,000 commodities from organizations, 75 percent of whose workers have a severe disability.

Javits-Wagner-O'Day and Randolph-Sheppard are the two main Federal employment and training programs for persons with significant disabilities. Congress has paid them little attention, and has not revised them, since their creation.

Beginning in 2003, Randolph-Sheppard and JWOD stakeholders approached Congress to seek our attention and help. Each group complained the other was getting too big a share of lucrative military dining contracts.

In 2003 and 2004, the offices of Senators GREGG, KENNEDY, ENSIGN and DODD tried to informally mediate. Neither the blind vendors nor the JWOD vendors would budge. The dispute intensified in the courts and in Congress, with each side accusing the other of waste, fraud and abuse.

When I assumed the chairmanship of the HELP Committee in 2005, I decided to honor the stakeholders' longstanding request, and investigate their claims. My staff's initial findings were troubling, so I worked with my good friend Senator KENNEDY to hold a bipartisan oversight hearing.

Our hearing, in October 2005, documented several troubling facts. First and foremost, we discovered that the programs had produced bad quantitative results for persons with disabilities. There are about 15 million unemployed persons with disabilities between the ages of 16 and 64. Javits-Wagner-O'Day and Randolph-Sheppard together had created only about 48,000 jobs. Clearly we can—and must—do much better.

Second, the programs had stayed the same while the law, technology, commercial customs and social norms had changed dramatically over the past decades. Since JWOD was enacted, Congress, through the Americans with Disabilities Act, ADA, Individuals with Disabilities Education Act, IDEA and Rehabilitation Act reauthorizations of 1992 and 1998, had mandated equal access, inclusion, choice, anti-discrimination and control by individuals with disabilities over their own lives. The Supreme Court in its Olmstead decision held that the unnecessary segregation of individuals with disabilities was an impermissible form of discrimination. Corporate good citizens such as Marriott had taken a leadership role in

the community to employ persons with severe disabilities in integrated work settings. New technologies made it possible for persons who were legally blind to use the Internet. These and countless other examples highlight how Randolph-Sheppard and JWOD had become ancient statutes. The world had changed dramatically since 1971. Persons with disabilities needed and deserved better treatment than the law was providing.

Third, regulatory neglect had given rise to waste, fraud and abuse. The Randolph-Sheppard program was supposed to create good jobs and increased opportunities for the many persons who are blind. Instead, we found that 38 blind vendors were taking the lion's share of profits from huge military cafeteria contracts with an approximate total dollar value of $1.203 billion. Just as troublesome was the fact that less than 5 percent of the employees hired to fulfill those contracts were actually blind. In addition, we found nonprofit executives were using JWOD to exploit persons with disabilities for improper financial gain. The FBI and other Federal law enforcement officials raided a Texas JWOD nonprofit and discovered some shocking abuses that underscored the need for Congress to act.

In 2006, I worked with Senators KENNEDY, ENSIGN, DODD, BURR, CLINTON, ISAKSON, REED, HATCH, HARKIN, ROBERTS, MIKULSKI, COBURN, BINGAMAN, COLLINS, and OBAMA to develop solutions to these problems. The HELP Committee staff spent thousands of hours meeting with hundreds of stakeholders, and listening to their ideas about how to fix these programs. Then we drafted this legislation.

In 2007, the momentum we had set in motion for a reauthorization bill stalled and other priorities began to take precedence. I continued to talk to and work with all of the stakeholders we could find, including those representing small business.

Recent events put these issues back on the front burner where they belong. On April 15, the Department of Defense and Department of Education Inspectors General collaborated on a report, ''Assessment of Contracting With Blind Vendors and Employers of Persons Who Are Blind or Have Other Severe Disabilities.'' In addition, the Committee for Purchase From People Who Are Blind or Severely Disabled—the principal regulator of the JWOD program—proposed modest tweaks to its authorizing statute. I sincerely applaud the Committee for their hard work in coming up with consensus fixes, but its proposal does not go nearly far enough.

As an alternative, I have updated the bill that the bipartisan HELP Committee produced in collaboration with stakeholder groups in 2006. It fulfills the promise I made to the disability community to try to solve the problems we found. The bill vitalizes and expands both programs. It creates much more flexibility to provide real job training and real skill development so persons with disabilities can develop marketable skills and make meaningful career choices. The bill also empowers a strong regulator to police both programs and make sure workers are no longer exploited.

Finally, I have tried to stay out of the military dining facility debate for years. But it has become a significant distraction to our military. Accordingly, this bill establishes an even playing field in a way that will be clear and easy for the military to administer and participants in the process to understand.

Our main goal here is to create more and better jobs for persons with disabilities. My bill moves us in the direction Congress should take to modify these two important programs. I look forward to continued discussions with my colleagues and the stakeholders on all these issues.

By Mr. GRASSLEY (for himself, Mr. MCCONNELL, Mr. KYL, Mr. HATCH, Mr. SUNUNU, Mr. BUNNING, Mr. CRAPO, Mr. BURR, Mr. ENSIGN, and Mr. ENZI):

S. 3118. A bill to amend titles XVIII and XIX of the Social Security Act to preserve beneficiary access to care by preventing a reduction in the Medicare physician fee schedule, to improve the quality of care by advancing value based purchasing, electronic health records, and electronic prescribing, and to maintain and improve access to care in rural areas, and for other purposes; read the first time.

Mr. GRASSLEY. Mr. President, I am pleased to introduce today the Preserving Access to Medicare Act of 2008.

If we do not act very quickly, the physicians who treat Medicare patients will face a 10.6 percent pay cut, effective July 1.

It is not in the best interest of America's seniors who depend on Medicare for their doctors to take such a significant cut.

Such a dramatic cut will affect access that seniors have to their doctors.

The bill we are introducing today provides a 0.5 percent physician update for the remainder of 2008 and a 1.1 percent update for 2009.

This increase is identical to the one the majority is looking to proceed to tomorrow.

Preserving access to health care for Medicare beneficiaries is a first priority, but it is not the only thing we are accomplishing in this bill.

The bill will also improve the quality of care in Medicare. It increases the physician quality reporting bonus from 1.5 percent to 2 percent for 2009 and 2010.

The bill retains the Physician Assistance and Quality Improvement (PAQI) fund to specifically help avert future physician cuts.

It promotes value-based purchasing, e-prescribing, and electronic health records.

It includes a responsible rural package, including a rural home health add-on payment.

It returns the ownership of oxygen equipment to the supplier, not the beneficiary.

The bill extends section 1011 of the Medicare Modernization Act for two years at a total of $400 million.

It phases out the duplicative Indirect Medical Education payments from Medicare Advantage.

The bill makes reforms to Medicare Advantage marketing practices to curb abusive activities. It requires all MA plans to report on quality.

I also want to devote a moment to what the bill we are introducing today does not do.

Unlike the bill the majority wants to proceed to tomorrow, the bill we are introducing today does not make cuts to payments for power wheelchairs.

Unlike the bill the majority wants to proceed to tomorrow, the bill we are introducing today does not reduce payments for oxygen.

Unlike the bill the majority wants to proceed to tomorrow, the bill we are introducing today does not make large, unwarranted cuts to Medicare Advantage, altering policy decisions designed to maximize patient choice.

Unlike the bill the majority wants to proceed to tomorrow, the bill we are introducing today does not eliminate the PAQI fund, which Congress specifically created to help avert future physician cuts.

Unlike the bill the majority wants to proceed to tomorrow, the bill we are introducing today does not expand eligibility for low-income Medicare programs, which would increase long-term entitlement spending and expand coverage under an already unsustainable program.

While well intentioned, this is not the right time for entitlement expansions like this.

The Medicare program is headed for a fiscal crisis that demands comprehensive reform.

Many would also like to add income-relating Part D subsidies to this bill as well. That change would make high income seniors shoulder a greater share of their Part D premium just like already happens today with premiums under Part B of Medicare.

These kind of changes need to be done. The other side has told us that they cannot support increasing premiums on high income seniors in order to provide greater assistance to lower income seniors.

Many on our side are disappointed by their position.

So it seems we will need to reserve those reforms on premiums until we are working on comprehensive Medicare reform in some future bill.

Finally, let me turn to the most critical difference between the bill we are introducing today and the bill the majority wants to proceed to tomorrow.

The bill we are introducing today can be signed into law. The President will sign our bill.

The bill the majority wants to proceed to tomorrow—if it somehow were

to make it to the President's desk—will be vetoed.

Republicans were not the ones that walked away from the negotiations and put a timely outcome of this effort in jeopardy.

I am ready to sit down on a bipartisan basis to find a compromise that protects seniors' access to Medicare and that can be signed into law.

Today we are introducing a bill that accomplishes that.

Tomorrow we are voting to proceed to a bill that does not.

I hope we can move beyond this political exercise soon to accomplish what seniors are counting on us to do.

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

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

PRESERVING ACCESS TO MEDICARE ACT OF 2008

TITLE I—MEDICARE IMPROVEMENTS

Subtitle A—Craig Thomas Rural Hospital and Provider Equity Act of 2008

SEC. 101. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS

In FY2009 hospitals that are located more than 15 road miles from another comparable hospital and have 2,000 discharges of individuals entitled to or enrolled for Medicare Part A benefits would receive a low-volume payment adjustment for Medicare inpatient hospital services. The Secretary would determine the applicable percentage increase using a linear sliding scale ranging from 25 percent for low-volume hospitals below a certain threshold to no adjustment for hospitals with greater than 2,000 discharges of individuals with Medicare Part A benefits.

SECTION 102. IMPROVEMENT TO THE MEDICARE DEPENDENT HOSPITAL (MDH) PROGRAM

For discharges in FY 2009, MDH payments would not be adjusted for area wages unless it would result in improved payments.

SECTION 103. AMBULANCE SERVICES

Provides for an add-on payment for ground ambulance services of 3 percent in rural areas and 2 percent in urban areas for the period July 1, 2008–December 31, 2009. Provides an 18 month hold harmless for air ambulance areas previously designated as rural and clarifies the medically necessary requirement for air ambulance services.

SECTION 104. EXTENSION AND IMPROVEMENT OF MEDICARE FLEX PROGRAM

The provision would extend the Medicare Rural Hospital Flexibility Grant Program through FY2010, increases authorization for appropriations and provides for grants for quality improvement and performance measurement activities.

SECTION 105. REBASING FOR SOLE COMMUNITY HOSPITALS (SCHS)

Starting for discharges on January 1, 2009, SCHs would be able to elect payment based on their FY2006 hospital-specific payment amount per discharge.

SECTION 106. EXTENSION AND EXPANSION OF THE MEDICARE HOSPITAL OUTPATIENT DEPARTMENT HOLD HARMLESS PROVISION FOR SMALL RURAL HOSPITALS

The provision would establish that in CY 2009, small rural hospitals, including Medicare Dependent Hospitals and Sole Community Hospitals under 100 beds, would receive 85 percent of the difference between payments made under the Medicare Hospital Outpatient Prospective Payment System and those made under the prior reimbursement system.

SECTION 107. CLARIFICATION OF PAYMENT FOR CLINICAL LABORATORY TESTS FURNISHED BY CRITICAL ACCESS HOSPITALS (CAHS)

Under this provision, clinical diagnostic laboratory services furnished by a CAH starting in July 1, 2009 would be reimbursed at 101 percent of costs as outpatient hospital services without regard to whether the specimen was collected from a patient of the CAH so long as the individual from whom the specimen was collected was in the same county as the CAH.

SECTION 108. EXTENSION OF FLOOR ON WORK GPCI

Extends for eighteen months the work geographic index (GPCI) floor of 1.0 through December 31, 2009.

SECTION 109. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES

Extends for eighteen months the provision that allows independent laboratories to continue to bill Medicare directly for the technical component of certain physician pathology services provided to hospitals as authorized by the Balanced Budget Act of 1997 through December 31, 2009.

SECTION 110. ADDING HOSPITAL-BASED RENAL DIALYSIS CENTERS AS ORIGINATING SITES FOR TELEHEALTH SERVICES

The provision would permit a hospital-based or critical access hospital-based renal dialysis center (including satellites) to be an originating site for the provision of telehealth services as of January 1, 2009.

SECTION 111. ADDING SKILLED NURSING FACILITIES AS ORIGINATING SITES FOR TELEHEALTH SERVICES

The provision would permit otherwise qualifying skilled nursing facilities to be an originating site for the provision of telehealth services as of January 1, 2009.

SECTION 112. APPLYING RURAL HOME HEALTH ADD-ON POLICY FOR 2009

Reinstates the five percent home health add-on payment for rural home health agencies in 2009.

Subtitle B—Other Provisions Related to Part A

SECTION 121. EXTENSION OF RECLASSIFICATION OF CERTAIN HOSPITALS UNDER THE MEDICARE PROGRAM

Extends until September 30, 2009, provisions that have allowed certain hospitals to be eligible for wage index reclassification that were otherwise unable to qualify for administrative wage index reclassification.

SECTION 122. INSTITUTE OF MEDICINE STUDY AND REPORT ON POST-ACUTE CARE

Requires the Secretary would enter into a contract with the Institute of Medicine (IOM) of the National Academy of Sciences to conduct a study on short-term and long-term steps to reform Medicare's current post-acute care payment and delivery system.

SECTION 123. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION

This provision would revoke the unique statutory authority granted to the Joint Commission of Healthcare Organizations (JCAHO) to accredit hospitals for participation in Medicare. Hospitals, like other Medicare provider entities, would be accredited by national accrediting organizations approved by the Secretary. The Secretary would have the authority to recognize JCAHO as a national accreditation body.

SECTION 124. MEDPAC STUDY AND REPORT ON HOSPICE CARE

The provision would require the Medicare Payment Advisory Commission (MedPAC) to submit a report to Congress on payments for hospice services. The report should include recommendations for potential changes in payment methodologies, including revisions to the aggregate cap.

SECTION 125. INTRODUCING THE PRINCIPLES OF VALUE-BASED HEALTH CARE INTO THE MEDICARE PROGRAM

The provision would require the Secretary to design and implement a system under which a portion of Medicare provider payments for hospitals would be based on the quality of provider performance.

Subtitle C—Other Provisions Relating to Part B

SECTION 131. PHYSICIAN PAYMENT UPDATE

Replaces the scheduled 10.1 percent cut to the Medicare physician reimbursement rate with an 18-month update. Continues the 0.5 percent increase through December 31, 2008 and provides an additional 1.1 percent update for 2009 as recommended by the Medicare Payment Advisory Commission (MedPAC). Revises the Physician Assistance and Quality Initiative fund in 2013 and deposits excess savings to help fund a physician update in subsequent years.

QUALITY IMPROVEMENTS

Extends and improves the physician quality reporting system through 2010 and increases PQRI incentive payments to 2.0 percent in 2009 and 2010. Requires Secretary to accept aggregate data from group practices on PQRI measures that target high-cost chronic conditions and preventive care. Includes changes enacted in MMSEA to allow reporting on groups of measures for certain conditions, alternative reporting periods, and reporting via registries. Includes audiologists as eligible professionals for PQRI. Requires the Secretary to establish a confidential physician feedback program regarding resource use as of 2009. Requires the Secretary to develop a value-based purchasing plan for physicians and other professionals and submit a report to Congress.

SECTION 132. INCENTIVES FOR ELECTRONIC PRESCRIBING

Provides positive incentive payments for the use of a qualified e-prescribing system by eligible professionals from 2009 through 2013. Requires the use of a qualified e-prescribing system in 2010 and reduces payment for eligible physicians who fail to use e-prescribing beginning in 2011. Incentive payments are based on allowed charges for all covered Medicare services. Allows for significant hardship exceptions, such as professionals in rural areas without sufficient Internet access, and excludes those who write a small number of prescriptions.

SECTION 133. INCREASING THE NUMBER OF SITES FOR ELECTRONIC HEALTH RECORDS DEMONSTRATION

Provides funding for a demonstration project on electronic health records.

SECTION 134. PRIMARY CARE IMPROVEMENTS

Establishes new Physician Scarcity Area incentive payments for primary care services furnished in Physician Scarcity Areas, as of January 1, 2011. Expands the Medicare Medical Home Demonstration Project established in the Tax Relief and Health Care Act of 2006. Authorizes the Secretary to expand the duration and scope of the project if certain quality of care or spending conditions are met and provides additional funding. Reapplies the budget-neutrality adjustment to the conversion factor rather than to work relative value units with respect to the most recent 5-year review of work RVUs, effective January 1, 2009.

SECTION 135. MEDICARE ANESTHESIA TEACHING PROGRAM IMPROVEMENTS

Eliminates the 50 percent teaching rule and requires CMS to provide 100 percent payment for teaching anesthesiologists. Requires payment for teaching certified registered nurse anesthetists to be consistent with adjustments made for teaching anesthesiologists.

SECTION 136. MEDICARE COORDINATED CARE PRACTICE RESEARCH NETWORK DEMONSTRATION

Requires the Secretary to establish a demonstration project to test best practices and innovative coordinated care projects for Medicare beneficiaries with multiple chronic conditions, no later than October 1, 2009. Sites include organizations which were participants in the Medicare Coordinated Care Demonstration project and may include other organizations as determined by the Secretary.

SECTION 137. IMAGING ACCREDITATION, APPROPRIATENESS, AND DISCLOSURE REQUIREMENTS

Requires that facilities and other providers who furnish the technical component of advanced diagnostic imaging services (MRI, CT, and nuclear medicine, including PET) be accredited as of January 1, 2012. Establishes an accreditation process and requires the Secretary to designate accreditation organizations as of January 1, 2010.

Establishes a two-year demonstration project to be implemented by January 1, 2010 to assess the appropriate use of advanced diagnostic imaging services by collecting data regarding physician compliance with clinical appropriateness criteria. Requires referring physician to disclose ownership interest and provide beneficiary with a list of providers.

SECTION 138. ACCOMMODATION OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED SERVICES.

Makes permanent a provision permitting physicians in the armed services to engage in substitute billing arrangements for longer than 60 days when they are ordered to active duty.

SECTION 139. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS

Ensures Medicare beneficiaries access to therapy services through December 31, 2009.

SECTION 140. SPEECH-LANGUAGE PATHOLOGY SERVICES

Allows speech-language pathologists practicing independently to bill Medicare directly for their services.

SECTION 141. COVERAGE OF ITEMS AND SERVICES UNDER CARDIAC PULMONARY REHABILITATION PROGRAMS

The provision would provide coverage for items and services furnished under a cardiac rehabilitation program or under a pulmonary rehabilitation program within the definition of covered medical and other health services, as of January 1, 2009.

SECTION 142. REPEAL OF TRANSFER OF OWNERSHIP OF OXYGEN EQUIPMENT

Repeals title transfer after 36 months and allows oxygen suppliers to retain ownership of oxygen equipment, effective January 1, 2009.

SECTION 143. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY AND RADIOPHARMACEUTICALS

Extends the current ''charges to cost'' methodology which provides a separate payment for brachytherapy services and therapeutic radiopharmaceuticals.

SECTION 144. CLINICAL LABORATORY TESTS

Repeals the competitive bidding demonstration program for clinical laboratory services. Reduces payments for clinical laboratory tests by −0.5% for 2009–2013.

SECTION 145. SENSE OF THE SENATE ON DELAYED IMPLEMENTATION OF DMEPOS COMPETITIVE BIDDING PROGRAM

Implementation of competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies should be delayed by 18 months to address concerns and ensure beneficiaries continued access to quality medical equipment and supplies.

Subtitle D—End Stage Renal Disease Program Reforms

SECTION 151. KIDNEY DISEASE EDUCATION AND AWARENESS PROVISIONS

Establishes pilot projects to increase awareness of chronic kidney disease in at least three states. Provides coverage of kidney disease patient education services furnished by qualified providers to those requiring dialysis or a kidney transplant consisting of comprehensive information on managing comorbidities, preventing complications, and explaining options for renal replacement therapy, including home dialysis.

SECTION 152. RENAL DIALYSIS PROVISIONS

Provides a 1.0 percent update to the composite rate for renal dialysis services as of January 1, 2009, and another 1.0 percent update as of January 1, 2010. Creates a site-neutral composite rate for dialysis services furnished on or after January 1,2009 to equalize payments for hospital outpatient departments providing dialysis services and freestanding dialysis facilities.

Establishes a fully bundled payment system for renal dialysis services, effective January 1, 2011, for dialysis and related drugs, laboratory tests, and other items and services furnished to individuals for the treatment of end stage renal disease (ESRD). Establishes an annual update for providers and renal dialysis facilities (of MB minus 1.0 percent) as of 2012. Requires case mix adjusters as well as additional payments for high cost outliers and costs incurred by rural, low volume providers and facilities. Allows other payment adjustments the Secretary determines appropriate, such as pediatric and rural add-on payments. Provides an optional four year phase-in to bundling for providers and facilities, trom 2011 to 2014.

Establishes a quality incentive program for providers and renal dialysis facilities, effective January 1, 2012. Requires that providers of ESRD services and renal dialysis facilities meet performance standards with respect to renal dialysis measures endorsed by a consensus-based organization.

Subtitle E—Provisions Relating to Part C

SECTION 161. PHASE-OUT OF INDIRECT MEDICARE EDUCATION PAYMENTS FROM PAYMENTS TO MEDICARE ADVANTAGE PLANS

Phases out inclusion of payments for indirect medical education (IME) in Medicare Advantage payments. The IME payments are phased out by reducing the Medicare Advantage payment rate by .6 percent each year until the amount accounted for by IME is exhausted.

SECTION 162. REVISIONS TO QUALITY IMPROVEMENT PROGRAMS

Requires Medicare Advantage private fee-for-service (PFFS) plans and MSA plans to submit data for quality analysis and reporting, whether the services are provided under contract or not. Specifies that to the extent services are provided by non-contracted providers, the data required for analysis and reporting on quality is limited to administrative data and beneficiary survey data.

SECTION 163. REVISIONS RELATING TO SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS

Extends the authority of specialized plans to target enrollment to certain populations through 2009. Lifts the moratorium on new plans and expanded service areas for special needs plans serving institutionalized populations and beneficiaries who are eligible for both Medicare and Medicaid (''dual-eligibles''). All special needs plans must meet additional requirements; 90 percent of new enrollment for all plans would have to be special needs individuals and special needs plans would have to have models of care targeted to the special needs populations they served. Special needs plans for dual Medicare- and Medicaid-eligibles would have three years to reach agreement with the states in which they operated. SNPs targeting dual-eligibles would have to protect enrollees from cost-sharing the state would have covered had these enrollees remained in fee-for-service Medicare. Retains the moratorium for special needs plans serving those with severe or disabling chronic conditions.

SECTION 164. ADJUSTMENT TO THE MEDICARE ADVANTAGE STABILIZATION FUND

Removes $1.3 billion from the stabilization fund for regional preferred provider organizations in 2013.

SECTION 165. ACCESS TO MEDICARE REASONABLE COST CONTRACT PLANS

Extends section 1876 authority for cost contracts through December 31, 2009. Requires that there be two unaffiliated Medicare Advantage plans in an area before the obligation for a cost plan to withdraw is triggered; clarifies that the minimum enrollment requirements for the MA plans would have to be met in the overlapping service area, not the MA plans' entire service area; and clarifies that a Medicare cost plan offered to beneficiaries in one MSA would not be forced to withdraw because of enrollment in Medicare Advantage plans in an adjoining MSA.

SECTION 166. MEDPAC STUDY AND REPORT ON MEDICARE ADVANTAGE PAYMENTS

Instructs MedPAC to study and report to Congress on ways to reimburse Medicare Advantage plans that do not rely on county-level Medicare payment area equivalents.

SECTION 167. MARKETING OF MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS

Prohibits Medicare Advantage and prescription drug plans from: paying cash for enrollment; offering gifts to potential enrollees; door-to-door sales, cold-calling, or other such personal contact; marketing non-health related products to potential enrollees; conducting a marketing appointment without an advance agreement; marketing in healthcare-provider offices; or any marketing activity prohibited by the Secretary. In addition, MA and prescription drug plans must confirm that individuals have enrolled in and understand the plan. MA and prescription drug plans must use state-licensed and appointed marketing representatives. MA and prescription drug plans must comply with state requests for information about licensed agent or brokers. Requires the Secretary to issue rules governing commissions and other compensation. Requires training and testing of marketing representatives. Effective for marketing for plan year 2009 and on.

Subtitle F—Other Provisions

SECTION 171. CONTRACT WITH A CONSENSUS-BASED ENTITY REGARDING PERFORMANCE MEASUREMENT

Requires the Secretary to contract with a consensus-based standards setting organization such as the National Quality Forum for four years to develop priorities for performance measurement, endorsement of measures, and maintenance of measures, and provides funding from 2009 through 2012.

SECTION 172. USE OF PART D DATA

Gives the Secretary authority to use Medicare Part D data for improving public health and conducting congressional oversight.

SECTION 173. INCLUSION OF MEDICARE PROVIDERS AND SUPPLIERS IN FEDERAL PAYMENT LEVY AND ADMINISTRATIVE OFFSET PROGRAM

Allows Treasury Department to levy a proportion of a Medicare provider's reimbursement against outstanding tax debt.

TITLE II—MEDICAID

SECTION 201. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE AND ABSTINENCE EDUCATION PROGRAMS

Extends the Transitional Medical Assistance program (TMA) through September 30, 2009. This program helps low-income individuals transition from welfare to work by maintaining healthcare for their children. Extends the current abstinence-only education program until September 30, 2009.

SECTION 202. EXTENSION OF QUALIFYING INDIVIDUAL (QI) PROGRAM

Provides assistance through Medicaid for low-income seniors and individuals who need help meeting their Medicare premiums. Extends this program through September 30, 2009 to continue serving current populations.

SECTION 203. MEDICAID DSH EXTENSION

Extends authority for disproportionate share hospital funding under section 1923 of the Social Security Act for Tennessee and Hawaii through December 31, 2009.

SECTION 204. EXTENSION OF SUPPLEMENTAL SECURITY INCOME (SSI) WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM

Extends the existing SSI Web-based asset demonstration program to Medicaid to all 50 States.

SECTION 205. APPLICATION OF MEDICARE PAYMENT ADJUSTMENT FOR CERTAIN HOSPITAL-ACQUIRED CONDITIONS TO PAYMENTS FOR INPATIENT HOSPITAL SERVICES UNDER MEDICAID

Requires states to develop Medicaid payment systems that reduce payments for certain hospital-acquired conditions consistent with the payment system used in Medicare.

SECTION 206. ELIMINATION OF DUPLICATIVE ADMINISTRATIVE COSTS

Reduces payments for Administrative costs to prevent duplication of payments under Title IV (the Temporary Assistance for Needy Families)

SECTION 207. CLARIFICATION OF TREATMENT OF REGIONAL MEDICAL CENTER

Clarifies that a regional medical center located on the border of multiple States may receive Medicaid reimbursement from any of those States.

SECTION 208. OUTREACH AND ENROLLMENT IN MEDICAID

Provides $25 million for outreach efforts to enroll eligible but uninsured children into Medicaid

TITLE III—MISCELLANEOUS

SECTION 301 EXTENSION OF TANF SUPPLEMENTAL GRANTS

Extends the Temporary Assistance for Needy Families (TANF) supplemental grants through September 30, 2009

SECTION 302. EXTENSION OF SPECIAL DIABETES PROGRAM

Extends the Special Diabetes Program through September 30, 2011 to fund type 1 diabetes research and type 2 treatment and prevention programs for Native Americans and Alaska Natives

SECTION 303. MEDICARE ENROLLMENT ASSISTANCE

Provides $19 million for grants to states for state health insurance assistance programs and $6 million for grants to states for area agencies on aging and to Aging and Disability Resource Centers. Such funds will be allocated to states based on a combination of the state's low-income beneficiaries and the state's rural beneficiaries. Most of the grant money must be used to provide outreach to beneficiaries who may be eligible for Medicare savings programs or low-income subsidies.

SECTION 304. EXTENSION OF FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Extends Federal reimbursement of emergency health services furnished to undocumented aliens under section 1011 of the MMA through FY 2010 for $200 million per year.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 591—RECOGNIZING THE NATIONAL AERONAUTICS AND SPACE ADMINISTRATION (NASA) FOR THE HISTORIC TOUCHDOWN OF THE PHOENIX MARS LANDER DURING ITS 50TH ANNIVERSARY YEAR

Mr. BROWN submitted the following resolution; which was referred to the Committee on Commerce, Science, and Transportation:

S. RES. 591

Whereas the Phoenix Mars Lander (Phoenix) touched down successfully on Mars on May 25, 2008;

Whereas the Phoenix landing was the first successful soft landing on Mars in over 30 years;

Whereas this achievement occurred during the National Aeronautics and Space Administration's (NASA) 50th year of scientific and technological excellence, and 47 years to the day after President Kennedy challenged the Nation to put a man on the moon;

Whereas the successful Phoenix landing is the result of years of planning, analyzing, and testing conducted by the dedicated men and women of NASA;

Whereas less than 50 percent of all previous lander missions have made it safely to the Mars planetary surface;

Whereas Phoenix is the first mission in NASA's Mars Scout program, a series of innovative and lower-cost spacecraft that will complement major missions;

Whereas Phoenix will be the first mission to collect meteorological data in the Martian arctic;

Whereas the mission will study the history of the planet in its water and ice, monitor weather of the polar region, and investigate whether the subsurface environment in the far-northern plains of Mars has ever been favorable for sustaining microbial life;

Whereas this data will allow scientists to accurately model Mars's past climate and predict future weather processes;

Whereas this data will increase our knowledge of the existence and nature of habitable zones on Mars;

While this data is instrumental in achieving the science goals of NASA's long-term Mars Exploration Program;

Whereas NASA Glenn Research Center's support to past Mars missions has enabled the continuing scientific exploration of Mars; and

Whereas the Glenn Research Center's contributions to NASA's Human Research Program play a vital role in providing solutions to critical problems that place human exploration missions and their crews at risk: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes the National Aeronautics and Space Administration (NASA) for 50 years of scientific and technological excellence;

(2) recognizes NASA for the historic landing of the Phoenix Mars Lander;

(3) recognizes the importance of the Phoenix mission to NASA's long-term Mars Exploration Program;

(4) recognizes the importance of contributions made by NASA Glenn Research Center to the NASA space program, including to Mars and moon missions; and

(5) recognizes the importance of NASA's Human Research Program, and Glenn Research Center's contributions to such program, to the health and safety of all NASA astronauts.

SENATE CONCURRENT RESOLUTION 89—AUTHORIZING FRANK WOODRUFF BUCKLES TO LIE IN HONOR IN THE ROTUNDA OF THE CAPITOL UPON HIS DEATH

Mr. BURR (for himself, Mr. BYRD, Mr. SPECTER, Mr. CRAIG, Mrs. DOLE, and Mr. ISAKSON) submitted the following conurrent resolution; which was referred to the Committee on Rules and Administration:

S. CON. RES. 89

Whereas the veterans of the First World War fought bravely and made heroic sacrifices for the Allied forces; and

Whereas past resolutions have sought authorization for American heroes to lie in honor in the rotunda of the Capitol upon an individual's passing, it is the Nation's collective desire to express its gratitude for the service of all World War I veterans by making it known to that war's last American survivor the honor it wishes to bestow on him before he passes: Now, therefore, be it

Resolved by the Senate (the House of Representatives concurring),

SECTION 1. HONORING FRANK WOODRUFF BUCKLES.

(a) IN GENERAL.—In recognition of the historic contributions of United States veterans who served in the First World War, Frank Woodruff Buckles, the last surviving United States veteran of the First World War, shall be permitted to lie in honor in the rotunda of the Capitol upon his death, so that the citizens of the United States may pay their last respects to this great American.

(b) IMPLEMENTATION.—The Architect of the Capitol, under the direction and supervision of the President pro tempore of the Senate and the Speaker of the House of Representatives, shall take the necessary steps to implement subsection (a).

Mr. BURR. Mr. President, I have sought recognition today to introduce a resolution honoring the last surviving member of a heroic group, the American World War I veterans. When the U.S. entered the First World War in 1917, 4.7 million Americans donned a military uniform and fought with the Allies struggling in an imperialistic battle of trench warfare. Now, 90 years after America's entry into the war, only one veteran remains.

Corporal Frank Woodruff Buckles, born in 1901, was sent to England and France during the First World War after exaggerating his age on Army paperwork. Eager to join the action, Buckles trained in the ambulance services and acted as a driver, remaining