(Mr. BUNNING) was added as a cosponsor of S. 2002, a bill to amend the Internal Revenue Code of 1986 to simplify certain provisions applicable to real estate investment trusts, and for other purposes.

S. 2035

At the request of Mr. SPECTER, the name of the Senator from Vermont (Mr. LEAHY) was added as a cosponsor of S. 2035, a bill to maintain the free flow of information to the public by providing conditions for the federally compelled disclosure of information by certain persons connected with the news media.

S. 2053

At the request of Mr. FEINGOLD, the name of the Senator from Oregon (Mr. WYDEN) was added as a cosponsor of S. 2053, a bill to amend part A of title I of the Elementary and Secondary Education Act of 1965 to improve elementary and secondary education.

S. 2063

At the request of Mr. GREGG, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 2063, a bill to establish a Bipartisan Task Force for Responsible Fiscal Action, to assure the economic security of the United States, and to expand future prosperity and growth for all Americans.

S. 2067

At the request of Mr. MARTINEZ, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. 2067, a bill to amend the Federal Water Pollution Control Act relating to recreational vessels.

S. 2088

At the request of Mr. FEINGOLD, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2088, a bill to place reasonable limitations on the use of National Security Letters, and for other purposes.

S. 2119

At the request of Mr. JOHNSON, the names of the Senator from Oregon (Mr. WYDEN) and the Senator from Mississippi (Mr. COCHRAN) were added as cosponsors of S. 2119, a bill to require the Secretary of the Treasury to mint coins in commemoration of veterans who became disabled for life while serving in the Armed Forces of the United States.

S. 2135

At the request of Mr. DURBIN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. 2135, a bill to prohibit the recruitment or use of child soldiers, to designate persons who recruit or use child soldiers as inadmissible aliens, to allow the deportation of persons who recruit or use child soldiers, and for other purposes.

S. 2140

At the request of Mr. DORGAN, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 2140, a bill to award a Congressional Gold Medal to Francis Collins, in recognition of his outstanding contributions and leadership in the fields of medicine and genetics.

S. 2152

At the request of Mr. MCCONNELL, the names of the Senator from Georgia (Mr. CHAMBLISS), the Senator from Kansas (Mr. BROWNBACK) and the Senator from South Carolina (Mr. GRAHAM) were added as cosponsors of S. 2152, a bill to amend title XXI of the Social Security Act to reauthorize the State Children's Health Insurance Program through fiscal year 2012, and for other purposes.

S. 2153

At the request of Mr. REED, the name of the Senator from Rhode Island (Mr. WHITEHOUSE) was added as a cosponsor of S. 2153, a bill to amend the Truth in Lending Act to enhance disclosure of the terms of home mortgage loans, and for other purposes.

S. 2166

At the request of Mr. CASEY, the name of the Senator from Minnesota (Mr. COLEMAN) was added as a cosponsor of S. 2166, a bill to provide for greater responsibility in lending and expanded cancellation of debts owed to the United States and the international financial institutions by low-income countries, and for other purposes.

S. 2172

At the request of Mr. MCCAIN, the names of the Senator from North Carolina (Mrs. DOLE) and the Senator from Connecticut (Mr. LIEBERMAN) were added as cosponsors of S. 2172, a bill to impose sanctions on officials of the State Peace and Development Council in Burma, to prohibit the importation of gems and hardwoods from Burma, to support democracy in Burma, and for other purposes.

S. RES. 348

At the request of Ms. MURKOWSKI, the names of the Senator from Mississippi (Mr. COCHRAN) and the Senator from Michigan (Ms. STABENOW) were added as cosponsors of S. Res. 348, a resolution supporting the goals and ideals of Red Ribbon Week.

AMENDMENT NO. 3320

At the request of Mr. COBURN, the names of the Senator from Arizona (Mr. MCCAIN) and the Senator from Oklahoma (Mr. INHOFE) were added as cosponsors of amendment No. 3320 intended to be proposed to H.R. 3043, a bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2008, and for other purposes.

AMENDMENT NO. 3321

At the request of Mr. COBURN, the name of the Senator from Arizona (Mr. MCCAIN) was added as a cosponsor of amendment No. 3321 intended to be proposed to H.R. 3043, a bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2008, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. HARKIN:

S. 2173. A bill to amend the Elementary and Secondary Education Act of 1965 to improve standards for physical education; to the Committee on Health, Education, Labor, and Pensions.

Mr. HARKIN. Mr. President, today I am introducing the FIT Kids Act. That first word, FIT, is an acronym for ''Fitness Integrated with Teaching''. The FIT Kids Act encourages schools to provide children with quality physical education that can help them lead healthier lives.

Since the 1970s, the incidence of obesity has more than doubled for preschool children aged 2–5 years and for young people aged 12–19 years, and has more than tripled for children aged 6–11 years. There are many reasons of this public health crisis, and addressing this crisis will require multiple solutions as well. One critical place to start is in our schools. The Centers for Disease Control and Prevention has found that fewer than 10 percent of our public schools at all levels offer daily physical education or its equivalent for the entire school year for all students.

The FIT Kids Act would amend the No Child Left Behind Act to support quality physical education for all public school children through grade 12, and ensure they receive important health and nutritional information. As a senior member of the Senate Health, Education, Labor and Pensions Committee, I have been working with Chairman KENNEDY and my other colleagues to reauthorize the No Child Left Behind Act in a way that improves on existing law, and gives schools and educators the resources they need to succeed.

It is truly alarming to see the discrepancies in achievement between children in the United States and children abroad. Here in the U.S., we have a wide and persistent achievement gap that is leaving behind children of color, young people from disadvantaged backgrounds, and children with disabilities. I believe that the No Child Left Behind Act gives us a framework to reduce, and hopefully close, this achievement gap to ensure that children from all walks of life are achieving at high levels. I believe that we can and will reauthorize the No Child Left Behind Act in a way that preserves its essential reforms and continues the progress we have made over the nearly 6 years since the act became law.

Unfortunately, despite the law's lofty goals, many educators have come to see it as a burden and a hindrance to effective classroom practices. I admit I share many of their concerns. I am particularly concerned about reports of imbalances and distortions that have come about as various States and the Federal Government have pushed for higher standards and greater accountability. Earlier this year, the Center on Education Policy, here in Washington,

released a study showing that, as a result of NCLB, many school districts have cut back on the time spent teaching subjects other than math and reading.

I am especially concerned by the finding that time spent on physical education has dropped by 9 percent, and recess by 6 percent. A new elementary school in Atlanta was actually built without a playground! This is just plain wrong-headed and short-sighted for two big reasons: one, we are fighting a childhood obesity epidemic of frightening proportions. Two, as any teacher or parent knows, kids have got to have time to play and burn off energy if they are going to be in a proper frame of mind to learn.

This legislation will provide parents with information on the time and resources devoted to giving their children a quality physical education. Specifically, the bill will amend the State, local education agency, and school report cards to include measures of physical education tied to nationally recognized guidelines and standards. It is important to note, however, that this legislation will not amend the school accountability process to include measures of physical education. However, by including this new information on report cards we will give parents the data they need in order to assess whether their children are receiving an appropriate physical education.

In addition, the bill promotes teacher professionalism in the field of physical education in order to promote healthy lifestyles and physical activity, and thereby to boost students' readiness to learn. The bill promotes physical activity in after-school programs. It amends the school counseling program to take into account students' emotional and physical wellbeing. It supports efforts to train parents to encourage healthy behaviors and physical activity.

Finally, this legislation authorizes research into the ways physical activity can be incorporated into all aspects of the school day, as well as research into the impact of physical activity on students' ability to learn, and into the best ways to measure student progress in increasing physical activity.

I am pleased that this bill is strongly supported by the American Heart Association, the National Parent Teacher Association, the American School Counselor Association, YMCA of the USA, National Association for Sport and Physical Education, the Campaign to End Obesity, and many other leading organizations in the fields of education and health.

The FIT Kids Act shines a spotlight on children's heath and how our schools can play a greater role in teaching our children healthy behaviors. As we move forward in reauthorizing the No Child Left Behind Act, we cannot neglect the importance of proper physical education. Students should be learning healthy behaviors and the importance of physical activity, and why these lessons will be important throughout their lives. The FIT Kids Act provides the framework to accomplish this. I urge my colleagues to support this bill.

By Mr. VOINOVICH (for himself and Mr. BROWN):

S. 2174. A bill to designate the facility of the United States Postal Service located at 175 South Monroe Street in Tiffin, Ohio, as the ''Paul E. Gillmor Post Office Building''; to the Committee on Homeland Security and Governmental Affairs.

Mr. VOINOVICH. Mr. President, I rise today to introduce legislation to name the Post Office in Tiffin, Ohio, after the late U.S. Representative Paul E. Gillmor. It is my honor to introduce this bill because of my close relationship with Congressman Gillmor, and the utmost respect I have for him and his service to the people of Ohio. I would like to thank Senator BROWN for his cosponsorship.

Paul and I met four decades ago in 1967 when we began our careers together, Paul as a State senator and I as a member of the Ohio House. Paul was immensely successful and well-respected because he treated others with dignity and respect.

During his tenure as president of the Ohio Senate, he was able to put partisan politics aside and work together with Governor Celeste for the best interests of the state.

Paul had a wonderful knack for being able to work with people to get things done. He led by example, and his enthusiasm and ability always made you want to be on his team. He left an indelible mark on the people he worked with which is a part of his wonderful, lasting legacy.

When I came to the Senate I knew I had a real friend in Paul Gillmor. My only regret is that I did not have more time to spend with him.

Because of Paul's diligent and devoted service to his country, it is fitting that the post office in Tiffin, Ohio, should soon bear his name. Not far from his small home town of Old Fort, Ohio; Tiffin was chosen in concurrence with the wishes of his wife, Karen Gillmor.

By Mrs. CLINTON:

S. 2175. A bill to amend the Public Health Service Act with regard to research on asthma, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mrs. CLINTON. Mr. President, I rise today to reintroduce the Family Asthma Act, legislation that would improve our federal government's response to this epidemic. The number of people with asthma has more than doubled in the past twenty years, and today, more than 32 million Americans, including more than 9 million children, have been diagnosed with asthma. By 2020, asthma is expected to strike 1 in 14 Americans and 1 in 5 families.

While deaths and hospitalizations from asthma are decreasing, the disease has a disproportionate impact among racial and ethnic minority populations. The emergency department visit rate for blacks seeking asthma treatment was 350 percent higher than that of the rates of whites, while the hospitalization rate for blacks with asthma was 240 percent higher than the rate of whites with asthma. Puerto Rican populations are 95 percent more likely to be diagnosed with asthma than white populations. Women are also disproportionately impacted, with asthma hospitalization rates approximately 35 percent higher among females than males.

Our legislation seeks to reverse these disparities. It would set up pilot projects to increase patient self-management, and allow for a better understanding of the environmental factors, like indoor and outdoor air pollution, that contribute to asthma. It would improve our surveillance and education efforts through the Centers for Disease Control and Prevention, so that we identify and target interventions to the populations with the highest burdens of asthma. And it would train providers to recognize the links between environmental pollution and asthma, in order to better treat and manage this condition.

This legislation contains the following components: it establishes pilot projects to improve asthma management and increase our knowledge of the environmental and genetic links to asthma. The Family Asthma Act establishes a $10 million annual grant program through the National Institutes of Health to establish pilot research projects that assist patients with asthma management. These projects will also allow scientists to engage in research on the environmental and genetic factors that contribute to severe, persistent asthma.

It directs our Government's asthma coordinating body to review and make recommendations for future directions in research and interventions. This legislation directs the National Asthma Education and Prevention Program to review current private and public sector efforts in combating asthma, and make recommendations as to how to strengthen those efforts in order to reduce the impact of this disease upon our health care system.

It increases funding to the CDC for education and surveillance. The bill provides $10 million annually to increase CDC's educational efforts, with state, local and nonprofit partners, to raise awareness of both asthma and ways to manage the disease. It also increases the scope of CDC's asthma surveillance activities to include hospitalization data, so as to better measure the impact of asthma at both the national and local level.

It creates a fellowship program to train providers about the links between the environment and asthma. Through this bill, the National Institutes of Environmental Health Sciences will set up a $2 million fellowship program to

help a broad spectrum of health care providers learn about the links between the environment and asthma, and increase their ability to address those links in clinical practice and asthma management programs.

I look forward to working with my colleagues in the Senate to move this legislation forward and address the growing incidence of asthma in our country.

I ask unanimous consent that a letter of support be printed in the RECORD.

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

AMERICAN LUNG ASSOCIATION,
Washington, DC, October 17, 2007.

Hon. HILLARY RODHAM CLINTON,
U.S. Senate,
Washington, DC.

DEAR SENATOR CLINTON: The American Lung Association strongly supports your Family Asthma Act. Once enacted into law, this measure will result in much-needed research into factors contributing to asthma and the alarming effects of asthma on the health of Americans, particularly children, minorities, women and the elderly.

As you know, over 22 million Americans currently have asthma, including more than six million children. Asthma is the leading cause of chronic illness among children in the U.S. and the third-leading cause of hospitalization among kids under 15 years of age. It also results in almost 13 million days of missed school annually. Asthma takes a significant toll on the public, increasing absenteeism from work, as well as the financial burden of asthma treatment. The Centers for Disease Control and Prevention (CDC) estimates that 11 million workdays are missed annually as a result of asthma and it is estimated to cost almost $15 billion in direct health care costs each year. Asthma also disproportionately affects women and minorities.

The introduction of this legislation comes at an important time: this week, the National Asthma Education and Prevention Program is issuing revised guidelines, emphasizing the importance of asthma control and suggesting new approaches for monitoring asthma. The new guidelines will help doctors and their patients select a treatment based on the patient's needs and level of asthma, emphasizing the importance of regularly monitoring the patient's asthma level so that treatments can be adjusted necessary.

However, despite these new guidelines, nationwide efforts to monitor asthma prevalence are hampered by a lack of consistent data. Your legislation will require that asthma surveillance activities be conducted so that critical information on the prevalence and severity of asthma, the effectiveness of public health asthma interventions and the quality of asthma management is collected. The Family Asthma Act will also require greater federal coordination to create a national plan to combat asthma.

Thank you for your leadership on this critical public health issue. The American Lung Association looks forward to working with you to see the Family Asthma Act become law.

Sincerely,

BERNADETTE A. TOOMEY,
President and CEO.

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

S. 2178. A bill to expedite the adjudication of employer petitions for aliens with extraordinary artistic ability; to the Committee on the Judiciary.

Mr. KERRY. Mr. President, one of the best ways that the United States can gain understanding and appreciation of other cultures is through the arts. Exposing children and adults alike to the creativity of other countries enriches our own artistic talents and helps bridge the gap between nations. It is for those reasons my colleague Senator HATCH and I have introduced the Arts Require Timely Service, ARTS, Act.

This legislation helps streamline the visa process and waive fees so that foreign artists and musicians can share their talents in the United States. Currently, the visa process for visiting artists is slow and costly, often times prohibiting artists from coming to the United States to share their talents. Breaking down these barriers is important and we shouldn't let the politics of immigration interfere with expanding our cultural horizons.

I am proud to stand with Senator HATCH and the Performing Arts Visa Task Force to try and help artists visit our country and inspire our communities. I hope our colleagues will join us and pass this sensible reform to expedite cultural exchanges and artistic expression.

Mr. HATCH. Mr. President, I rise today to join with Senator JOHN KERRY in introducing the Arts Require Timely Service, ARTS, Act. The ARTS Act would reduce the current processing times for ''O'' and ''P'' arts-related visa petitions filed by, or on behalf of, nonprofit arts-related organizations to a maximum of 45 days.

Unfortunately, delays by the U.S. Citizenship and Immigration Services are making it increasingly difficult for international artists to appear in the U.S. Nonprofit arts organizations confront long waits and uncertainty in gaining approval for visa petitions for foreign artists. Most nonprofit arts cannot afford the Premium Processing Service, guaranteeing processing within 15 days upon payment of an additional $1,000 fee per petition. This is burdensome for many nonprofit arts organizations leaving them to await the unpredictability of the regular visa process.

Performances and other cultural events are date, time and location-specific. The nature of scheduling, booking, and confirming highly sought-after guest soloists and performing groups requires that the timing of the visa process be efficient and reliable. There is a continuing risk that foreign guest artists will be unable to enter the U.S. in time for their engagements, causing burdens on nonprofit arts organizations, international artists, and the local artists who were scheduled to perform alongside the international guest.

In my home State of Utah, the Utah Symphony & Opera has witnessed firsthand how delays and unpredictability in artist visa processing have denied Utahns the opportunity to experience international artistry. To make matters worse, cancellations create high economic risks for these nonprofit arts institutions as they must sell tickets in advance, creating a financial obligation to their audiences.

Congress has already indicated strong, bipartisan support for the ARTS Act. In fact, the provision enjoys support from key House and Senate Judiciary Committee members and it was included in the 2006 Senate comprehensive immigration reform bill. I agree with Homeland Security Secretary Michael Chertoff when he said, ''Our heritage and our national character inspire us to create a more welcoming society for those who lawfully come to our shores to work, learn, and visit.'' Indeed, this noncontroversial improvement to the artist visa process will strengthen our ties with other countries, enrich our Nation's culture, and provide a wonderful opportunity to learn from foreign artists.

I encourage my colleagues to support the ARTS Act.

By Ms. COLLINS (for herself, Mr. CASEY, Mr. BOND, Ms. CANTWELL, Mr. ROBERTS, and Mr. REED):

S. 2181, A bill to amend title XVIII of the Social Security Act to protect Medicare beneficiaries' access to home health services under the Medicare program; to the Committee on Finance.

Ms. COLLINS. Mr. President, I am pleased to join Senators CASEY, BOND, CANTWELL, ROBERTS and REED in introducing legislation, the Home Health Care Access Protection Act, to prevent the devastating 11.75 percent cut that the Centers for Medicare and Medicaid Services, CMS, is planning to make in Medicare home health payment rates over the next 4 years.

Home health has become an increasingly important part of our health care system. The kinds of highly skilled and often technically complex services that our Nation's home health agencies provide have helped to keep families together and enabled millions of our most frail and vulnerable older and disabled persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes. Moreover, by helping these individuals to avoid more costly institutional care, they are saving Medicare millions of dollars each year.

That is why I find it so ironic that the Medicare home health benefit is once again under attack.

The House version of the SCHIP reauthorization bill proposed cutting Medicare home health spending by $2.6 billion over 5 years, and the Senate may soon be considering similar cuts.

To make matters worse, CMS has proposed additional administrative cuts that are estimated to total more than $6 billion over the next 5 years. If allowed to go forward, this ''double whammy'' for home care will result in

cuts in excess of $8.6 billion over 5 years from a program that costs less than $15 billion a year. This simply is not right, and it certainly is not in the best interest of our Nation's seniors who rely on home care to keep them out of hospitals, nursing homes and other institutions.

The administrative cuts proposed by CMS are based on the assertion that home health agencies have intentionally ''gamed the system'' by claiming that their patients have conditions of higher clinical severity than they actually have in order to receive higher Medicare payments. This unfounded allegation of ''case mix creep'' is based on what CMS contends to be an increase in the average clinical assessment ''score'' of home health patients over the last few years.

In fact, there are very real clinical and policy explanations for why the average clinical severity of home care patients' health conditions may have increased over the years. For example, the incentives built into the hospital DRG reimbursement system have led to the faster discharge of sicker patients. Advances in technology and changes in medical practice have also enabled home health agencies to treat more complicated medical conditions that earlier could only be treated in hospitals, nursing homes, or inpatient rehabilitation facilities.

These administrative cuts are proposed to go into effect on January 1. This would be devastating to home health agencies in Maine and across the Nation, particularly given that there is no evidence of intentional ''gaming'' on the part of home health agencies to warrant such a severe financial penalty.

Moreover, CMS has not made public any of the details of the research method, data and findings they used to justify the planned cuts, making it impossible for Congress or the public to evaluate the reliability or the validity of its actions.

What is of most concern to me, however, is that this unfair penalty is being assessed across the board, even for home health agencies that showed a decrease in their clinical assessment scores. If an individual home health agency is truly gaming the system, CMS should target that one agency, not penalize everyone.

The fact is that the Medicare home health benefit has already taken a larger hit in spending cuts over the past 10 years than any other Medicare benefit. In fact, home health as a share of Medicare spending has dropped from 8.7 percent in 1997 to 3.2 percent today, and is projected to decline to 2.6 percent of Medicare spending in 2015.

This downward spiral in home health spending began with provisions in the Balanced Budget Act of 1997, which resulted in a 50 percent cut in Medicare home health spending by 2001—far more than the Congress intended or the Congressional Budget Office projected.

And home health spending continues to be much lower than CBO projections. In 2000, the CBO projected that home health spending in 2006 would total $21.1 billion under the new home health prospective payment system. The actual total expenditures for home health last year were $13.2 billion. If home health agencies were engaging in the kind of widespread ''upcoding'' that CMS has alleged, home health spending would be exceeding CBO's projections. In fact, home health spending has been far less than expected.

Home health care has consistently proven to be a compassionate and cost-effective alternative to institutional care. Additional deep cuts will be completely counterproductive to our efforts to control overall health care costs. They will also place the quality of home health services at risk, particularly given ever-rising transportation, staffing, and technology costs. Cuts of this magnitude could leave some providers with no alternative but to reduce the number of home health visits or patient admissions, which would ultimately threaten seniors' access to care and clinical outcomes. Or they could cause them to close their doors altogether.

The legislation that we are introducing today will block the ''case mix creep'' cuts that were proposed by CMS as part of the final home health prospective payment system regulation in August. It will also establish a reliable and transparent process that the Department of Health and Human Services must use to justify that payment rate cuts are needed to account for improper changes in ''case mix scoring.'' A companion bill to our legislation is being introduced in the House by Representative JIM MCGOVERN.

The Home Health Care Access Protection Act of 2007 will help to ensure that our seniors and disabled Americans continue to have access to the quality home health services they deserve, and I encourage all of my colleagues to sign on as cosponsors.

By Mr. REED (for himself and Mr. SMITH):

S. 2182. A bill to amend the Public Health Service Act with respect to mental health services; to the Committee on Health, Education, Labor, and Pensions.

Mr. REED. Mr. President, today I introduce the Community Mental Health Services Improvement Act. For decades, we have known that people suffering from mental illness die sooner, on average 25 years sooner, and have higher rates of disability than the general population. People with mental illness are at greater risk of preventable health conditions such as heart disease and diabetes. With this legislation, we are taking steps to address these disturbing trends.

We know that mental health and physical health are inter-related: each contributes to the other. Yet historically mental health and physical health have been treated separately. The vision of this legislation is that the two should be integrated in a single medical home.

In a recent survey, 91 percent of community mental health centers said that improving the quality of health care is a priority. However, only one-third have the capacity to provide health care on site, and only one-fifth provide medical referrals off site. The centers identified a lack of financial resources as the biggest barrier to integrating treatment.

Accordingly, this legislation provides grants to integrate treatment for mental health, substance abuse, and primary and specialty care. Grantees can use the funds for screenings, basic health care services on site, referrals, or information technology.

This legislation is also a comprehensive response to the workforce crisis identified by the President's New Freedom Commission on Mental Health. It provides grants for a wide range of innovative recruitment and retention efforts, from loan forgiveness and repayment programs, to placement and support for new mental health professionals, to expanding mental health education and training programs.

Finally, this legislation provides grants for tele-mental health in medically-underserved areas, and invests in health IT for mental health providers. These proposals address the twin goals of improving the quality of mental health treatment while expanding access to that treatment in rural and underserved areas.

This bipartisan legislation, which I am introducing with my colleague Senator SMITH, has the overwhelming support of the mental health community. It has been endorsed by the National Council for Community Behavioral Healthcare, the National Alliance on Mental Illness, Mental Health America, the Campaign for Mental Health Reform, and the American Psychological Association. I am especially grateful for the support of the Rhode Island Council of Community Mental Health Organizations, whose members treat close to 15,000 Rhode Islanders of all ages.

Today Senator SMITH and I are also introducing the Community Mental Health Infrastructure Improvements Act. It should be obvious that this legislation is a necessary complement to the Community Mental Health Services Improvement Act: without community mental health centers, there can be no services to improve. Accordingly, this legislation provides grants to states for the construction and modernization of facilities that provide mental health services.

As a member of the Senate Committee on Health, Education, Labor, and Pensions, I will work to include

these important initiatives in legislation that renews and improves Substance Abuse and Mental Health Services Administration, SAMHSA, programs. It is my hope that with its passage, we can begin to address the challenge of improving and expanding access to mental health services in a comprehensive way.

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. 2182

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 ''Community Mental Health Services Improvement Act''.

SEC. 2. FINDINGS.

Congress finds that—

(1) almost 60,000,000 Americans, or one in four adults and one in five children, have a mental illness that can be diagnosed and treated in a given year;

(2) mental illness costs our economy more than $80,000,000,000 annually, accounting for 15 percent of the total economic burden of disease;

(3) alcohol and drug abuse contributes to the death of more than 100,000 people and costs society upwards of half a trillion dollars a year;

(4) individuals with serious mental illness die on average 25 years sooner than individuals in the general population; and

(5) community mental and behavioral health organizations provide cost-efficient and evidence-based treatment and care for millions of Americans with mental illness and addiction disorders.

SEC. 3. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by adding at the end the following:

''SEC. 520K. GRANTS FOR CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

''(a) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means a qualified community mental health program defined under section 1913(b)(1).

''(2) SPECIAL POPULATIONS.—The term 'special populations' refers to the following 3 groups:

''(A) Children and adolescents with mental and emotional disturbances who have co-occurring primary care conditions and chronic diseases.

''(B) Adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

''(C) Older adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.

''(b) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration and in coordination with the Director of the Health Resources and Services Administration, shall award grants to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.

''(c) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require. Each such application shall include—

''(1) an assessment of the primary care needs of the patients served by the eligible entity and a description of how the eligible entity will address such needs; and

''(2) a description of partnerships, cooperative agreements, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.

''(d) USE OF FUNDS.—

''(1) IN GENERAL.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—

''(A) the provision, by qualified primary care professionals on a reasonable cost basis, of—

''(i) primary care services on site at the eligible entity;

''(ii) diagnostic and laboratory services; or

''(iii) adult and pediatric eye, ear, and dental screenings;

''(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals as well as to other coordinators of care or, if permitted by the terms of the grant, for the provision, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity, of—

''(i) endocrinology services;

''(ii) oncology services;

''(iii) pulmonary/respiratory services; or

''(iv) cardiovascular services;

''(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or

''(D) facility improvements or modifications needed to bring primary and specialty care professionals on site at the eligible entity.

''(2) LIMITATION.—Not to exceed 15 percent of grant funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).

''(e) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that grants awarded under this section are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(f) EVALUATION.—Not later than 3 months after a grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.

''(g) REPORT.—Not later than 5 years after the date of enactment of this section, the Secretary shall prepare and submit to the appropriate committees of Congress a report that shall evaluate the activities funded under this section. The report shall include an evaluation of the impact of co-locating primary and specialty care in community mental and behavioral health settings on overall patient health status and recommendations on whether or not the demonstration program under this section should be made permanent.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $50,000,0000 for fiscal year 2009 and such sums as may be necessary for each of fiscal years 2010 through 2013.''.

SEC. 4. INTEGRATING TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE CO-OCCURRING DISORDERS.

Section 520I of the Public Health Service Act (42 U.S.C. 290bb-40) is amended—

(1) by striking subsection (i) and inserting the following:

''(j) FUNDING.—The Secretary shall make available to carry out this section, $14,000,000 for fiscal year 2009, $20,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2013. Such sums shall be made available in equal amount from amounts appropriated under sections 509 and 520A.''; and

(2) by inserting before subsection (j), the following:

''(i) COMMUNITY MENTAL HEALTH PROGRAM.—For purposes of eligibility under this section, the term 'private nonprofit organization' includes a qualified community mental health program as defined under section 1913(b)(1).''.

SEC. 5. IMPROVING THE MENTAL HEALTH WORKFORCE.

(a) NATIONAL HEALTH SERVICE CORPS.—Section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a)) is amended—

(1) in paragraph (1), by inserting after ''that meet the requirements of section 334'' the following: ''and qualified community mental health programs as defined in section 1913(b)(1),''; and

(2) in paragraph (2)(A), by striking ''community mental health center,''.

(b) RECRUITMENT AND RETENTION OF MENTAL HEALTH PROFESSIONALS.—Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. 256f et seq.) is amended by adding at the end the following:

''SEC. 340H. GRANTS FOR RECRUITMENT AND RETENTION OF MENTAL HEALTH PROFESSIONALS.

''(a) ESTABLISHMENT.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to States, territories, and Indian tribes or tribal organizations for innovative programs to address the behavioral and mental health workforce needs of designated mental health professional shortage areas.

''(b) USE OF FUNDS.—An eligible entity shall use grant funds awarded under this section for—

''(1) loan forgiveness and repayment programs (to be carried out in a manner similar to the loan repayment programs carried out under subpart III of part D) for behavioral and mental health professionals who—

''(A) agree to practice in designated mental health professional shortage areas;

''(B) are graduates of programs in behavioral or mental health;

''(C) agree to serve in community-based non-profit entities, or as public mental health professionals for the Federal, State or local government; and

''(D) agree to—

''(i) provide services to patients regardless of such patients' ability to pay; and

''(ii) use a sliding payment scale for patients who are unable to pay the total cost of services;

''(2) behavioral and mental health professional recruitment and retention efforts, with a particular emphasis on candidates from racial and ethnic minority and medically-underserved communities;

''(3) grants or low-interest or no-interest loans for behavioral and mental health professionals who participate in the Medicaid program under title XIX of the Social Security Act to establish or expand practices in designated mental health professional shortage areas, or to serve in qualified community mental health programs as defined in section 1913(b)(1);

''(4) placement and support for behavioral and mental health students, residents, trainees, and fellows or interns; or

''(5) continuing behavioral and mental health education, including distance-based education.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

''(2) ASSURANCES.—The application shall include assurances that the applicant will meet the requirements of this subsection and that the applicant possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

''(d) MATCHING REQUIREMENT.—The Secretary may not make a grant to an eligible entity under this section unless that entity agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant was awarded, the entity will provide non-Federal contributions in an amount equal to not less than 35 percent of Federal funds provided under the grant. The entity may provide the contributions in cash or in kind, fairly evaluated, including plant, equipment, and services, and may provide the contributions from State, local, or private sources.

''(e) SUPPLEMENT NOT SUPPLANT.—A grant awarded under this section shall be expended to supplement, and not supplant, the expenditures of the eligible entity and the value of in-kind contributions for carrying out the activities for which the grant was awarded.

''(f) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that grants awarded under this section are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(g) EVALUATION.—Not later than 3 months after a grant awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant.

''(h) REPORT.—Not later than 5 years after the date of enactment of this section, the Secretary shall prepare and submit to the appropriate committees of Congress a report containing data relating to whether grants provided under this section have increased access to behavioral and mental health services in designated mental health professional shortage areas.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2013.''.

(c) BEHAVIORAL AND MENTAL HEALTH EDUCATION AND TRAINING PROGRAMS.—Part A of title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

''SEC. 506C. GRANTS FOR BEHAVIORAL AND MENTAL HEALTH EDUCATION AND TRAINING PROGRAMS.

''(a) DEFINITION.—For the purposes of this section, the term 'related mental health personnel' means an individual who—

''(1) facilitates access to a medical, social, educational, or other service; and

''(2) is not a mental health professional, but who is the first point of contact with persons who are seeking mental health services.

''(b) ESTABLISHMENT.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, shall establish a program to increase the number of trained behavioral and mental health professionals and related mental health personnel by awarding grants on a competitive basis to mental and behavioral health nonprofit organizations or accredited institutions of higher education to enable such entities to establish or expand accredited mental and behavioral health education programs.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

''(2) ASSURANCES.—The application shall include assurances that the applicant will meet the requirements of this subsection and that the applicant possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

''(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to applicants that—

''(1) demonstrate a familiarity with the use of evidenced-based methods in behavioral and mental health services;

''(2) provide interdisciplinary training experiences; and

''(3) demonstrate a commitment to training methods and practices that emphasize the integrated treatment of mental health and substance abuse disorders.

''(e) USE OF FUNDS.—Funds awarded under this section shall be used to—

''(1) establish or expand accredited behavioral and mental health education programs, including improving the coursework, related field placements, or faculty of such programs; or

''(2) establish or expand accredited mental and behavioral health training programs for related mental health personnel.

''(f) REQUIREMENTS.—The Secretary may award a grant to an eligible entity only if such entity agrees that—

''(1) any behavioral or mental health program assisted under the grant will prioritize cultural competency and the recruitment of trainees from racial and ethnic minority and medically-underserved communities; and

''(2) with respect to any violation of the agreement between the Secretary and the entity, the entity will pay such liquidated damages as prescribed by the Secretary.

''(g) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that grants awarded under this section are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(h) EVALUATION.—Not later than 3 months after a grant awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant.

''(i) REPORT.—Not later than 5 years after the date of enactment of this section, the Secretary shall prepare and submit to the appropriate committees of Congress a report containing data relating to whether grants provided under this section have increased access to behavioral and mental health services in designated mental health professional shortage areas.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $4,000,0000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2013.''.

SEC. 6. IMPROVING ACCESS TO MENTAL HEALTH SERVICES IN MEDICALLY-UNDERSERVED AREAS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by inserting after section 520A the following:

''SEC. 520B. GRANTS FOR TELE-MENTAL HEALTH IN MEDICALLY-UNDERSERVED AREAS.

''(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, shall award grants to eligible entities to provide tele-mental health in medically-underserved areas.

''(b) ELIGIBLE ENTITY.—To be eligible for assistance under the program under subsection (a), an entity shall be a qualified community mental health program (as defined in section 1913(b)(1)).

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require.

''(2) ASSURANCES.—The application shall include assurances that the applicant will meet the requirements of this subsection and that the applicant possesses sufficient infrastructure to manage the activities to be funded through the grant and to evaluate and report on the outcomes resulting from such activities.

''(d) USE OF FUNDS.—An eligible entity shall use funds received under a grant under this section for—

''(1) the provision of tele-mental health services; or

''(2) infrastructure improvements for the provision of tele-mental health services.

''(e) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that grants awarded under this section are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(f) EVALUATION.—Not later than 3 months after a grant awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant.

''(g) REPORT.—Not later than 5 years after the date of enactment of this section, the Secretary shall prepare and submit to the appropriate committees of Congress a report that shall evaluate the activities funded under this section.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $20,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2013.''.

SEC. 7. IMPROVING HEALTH INFORMATION TECHNOLOGY FOR MENTAL HEALTH PROVIDERS.

Part A of title V of the Public Health Service Act (42 U.S.C. 290aa et seq.), as amended by section 5(c), is further amended by adding at the end the following:

''SEC. 506D. IMPROVING HEALTH INFORMATION TECHNOLOGY FOR MENTAL HEALTH PROVIDERS.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Veterans Affairs, shall collaborate with the Administrator of the Substance Abuse and Mental Health Services Administration and the National Coordinator for Health Information Technology to—

''(1) develop and implement a plan for ensuring that various components of the National Health Information Infrastructure, including data and privacy standards, electronic health records, and community and regional health networks, address the needs of mental health and substance abuse treatment providers; and

''(2) finance related infrastructure improvements, technical support, personnel training, and ongoing quality improvements.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 2009, and such sums as may be necessary for each of fiscal years 2010 through 2013.''.

SEC. 8. PAPERWORK REDUCTION STUDY.

(a) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Institute of Medicine shall submit to the appropriate committees of Congress a report that evaluates the combined paperwork burden of qualified community mental health programs as defined in section 1913(b)(1) of the Public Health Service Act.

(b) SCOPE.—In preparing the report under subsection (a), the Institute of Medicine shall examine licensing, certification, service definitions, claims payment, billing codes, and financial auditing requirements utilized by the Office of Management and Budget, the Centers for Medicare & Medicaid Services, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Office of the Inspector General, State Medicaid agencies, State departments of health, State departments of education, and State and local juvenile justice and social service agencies to—

(1) establish an estimate of the combined nationwide cost of complying with the requirements described in this paragraph, in terms of both administrative funding and staff time;

(2) establish an estimate of the per capita cost to each qualified community mental health program defined in section 1913(b)(1) of the Public Health Service Act to comply with the requirements of this paragraph, in terms of both administrative funding and staff time; and

(3) make administrative and statutory recommendations to Congress, which may include a uniform methodology, to reduce the paperwork burden experienced by qualified community mental health programs defined in section 1913(b)(1) of the Public Health Service Act.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $550,000 for each of fiscal years 2009 and 2010.

SEC. 9. WAGE STUDY.

(a) IN GENERAL.—Not later than 12 months after the date of enactment of this Act, the Institute of Medicine shall conduct a nationwide analysis, and submit a report to the appropriate committees of Congress, concerning the compensation structure of professional and paraprofessional personnel employed by qualified community mental health programs as defined under section 1913(b)(1) of the Public Health Service Act, as compared with the compensation structure of comparable health safety net providers and relevant private sector health care employers.

(b) SCOPE.—In preparing the report under subsection (a), the Institute of Medicine shall examine compensation disparities, if such disparities are determined to exist, by type of personnel, type of provider or private sector employer, and geographic region.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $550,000 for each of fiscal years 2009 and 2010.

By Mr. SMITH (for himself and Mr. REED):

S. 2183. A bill to amend the Public Health Service Act to provide grants for community-based mental health infrastructure improvement; to the Committee on Health, Education, Labor, and Pensions. '

Mr. SMITH. Mr. President, I rise today with my colleague, Senator JACK REED of Rhode Island, to introduce two bills, S. 2182 and S. 2183, that we hope will have a tremendous impact on the quality and accessibility of mental health care throughout the U.S. Our bills, the Community Mental Health Services Improvement Act and the Community-Based Mental Health Infrastructure Improvement Act, support those programs that serve as an important line of defense against mental illnesses and suicide.

Community mental health programs are the backbone of our mental health system by providing access to vital mental health care services to those in need. Unfortunately, community mental health centers are suffering under tremendous fiscal constraints to provide care in their communities. They operate, usually, on a small budget and with little resources to improve their facilities. Senator REED and I are introducing these two bills to help community mental health centers obtain the resources necessary to meet their needs.

The goal of the Community Mental Health Services Improvement Act is to provide funding to promote the provision of mental health services locally. The bill would establish a grant program for community mental health programs to provide health care services, screenings, referrals, information technology or facility improvements. The bill also establishes grants for programs that integrate treatment for individuals with a serious mental illness and a co-occurring substance abuse disorder. Grants also would be provided to mental health nonprofit organizations or accredited institutions to establish or expand accredited mental health education and training programs. Finally, this bill will provide grants to community mental health programs for tele-mental health in medically-underserved areas.

The second bill that we are introducing today is one that is very important to mental health programs in my home State of Oregon. Currently, patients are waiting for important mental health care due to lack of building capacity. Our bill, the Community-Based Mental Health Infrastructure Improvements Act, would provide funding for bricks and mortar infrastructure for mental health programs in our communities. There is no Federal funding currently available for construction of community mental health facilities. This bill ensures that individuals with mental illness are not turned away because a facility does not have the resources to keep their building up to code or because a building expansion could not occur to keep up with a growing population because no funds were available.

In developing this legislation, I worked with the Health Resources and Services Administration, HRSA, and the Substance Abuse and Mental Health Services Administration, SAMHSA, to determine how best to make funding available for community mental health programs. This bill would encourage a continuation of this important partnership between SAMHSA, HRSA and States to ensure that competitive grant funding is made available to community mental health programs throughout the country.

We know that mental illness can affect people of any age, of any race and of any income. As a parent with a son who struggled with mental illness, I know all too well the indiscriminate nature of the illness and the frightening statistics of its regular occurrence for those we love. In any given year, more than a quarter of our Nation's adults, 60 million people, suffer from a diagnosable mental disorder, many of whom suffer in silence. Mental disorders are the leading cause of disability for those aged 15–44 in the U.S. and in Canada.

Mental illness is just as deadly and serious as a physical illness. Suicide takes the lives of more than 30,000 people each year, with more than 700,000 attempts. Suicides outnumber homicides three to one each year. People who suffer from mental illness also suffer from much higher rates of other chronic conditions, such as cardiovascular disease. However, unlike heart attacks and strokes, mental illness is not something that we, as a Nation, want to talk about.

In a 2004 report by the Oregon Governor's Mental Health Taskforce, they found that in any given year 175,000 adults and 75,000 children under the age of 18 are in need of mental health services in my home State. Effective treatment exists for most people suffering. Help is out there, and these bills will help ensure that this help can be accessed effectively.

I urge my colleagues on both sides of the aisle to support the important work of community mental health centers by voting for these bills.

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 placed in the RECORD, as follows:

S. 2183

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 ''Community-Based Mental Health Infrastructure Improvements Act''.

SEC. 2. COMMUNITY-BASED MENTAL HEALTH INFRASTRUCTURE IMPROVEMENT.

Title V of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

''PART H—COMMUNITY-BASED MENTAL HEALTH INFRASTRUCTURE IMPROVEMENTS

''SEC. 560. GRANTS FOR COMMUNITY-BASED MENTAL HEALTH INFRASTRUCTURE IMPROVEMENTS.

''(a) GRANTS AUTHORIZED.—The Secretary may award grants to eligible entities to expend funds for the construction or modernization of facilities used to provide mental health and behavioral health services to individuals.

''(b) ELIGIBLE ENTITY.—In this section, the term 'eligible entity' means—

''(1) a State that is the recipient of a Community Mental Health Services Block Grant under subpart I of part B of title XIX and a Substance Abuse Prevention and Treatment Block Grant under subpart II of such part; or

''(2) an Indian tribe or a tribal organization (as such terms are defined in sections 4(b) and 4(c) of the Indian Self-Determination and Education Assistance Act).

''(c) APPLICATION.—A eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing—

''(1) a plan for the construction or modernization of facilities used to provide mental health and behavioral health services to individuals that—

''(A) designates a single State or tribal agency as the sole agency for the supervision and administration of the grant;

''(B) contains satisfactory evidence that such agency so designated will have the authority to carry out the plan;

''(C) provides for the designation of an advisory council, which shall include representatives of nongovernmental organizations or groups, and of the relevant State or tribal agencies, that aided in the development of the plan and that will implement and monitor any grant awarded to the eligible entity under this section;

''(D) in the case of an eligible entity that is a State, includes a copy of the State plan under section 1912(b) and section 1932(b);

''(E)(i) includes a listing of the projects to be funded by the grant; and

''(ii) in the case of an eligible entity that is a State, explains how each listed project helps the State in accomplishing its goals and objectives under the Community Mental Health Services Block Grant under subpart I of part B of title XIX and the Substance Abuse Prevention and Treatment Block Grant under subpart II of such part;

''(F) includes assurances that the facilities will be used for a period of not less than 10 years for the provision of community-based mental health or substance abuse services for those who cannot pay for such services, subject to subsection (e); and

''(G) in the case of a facility that is not a public facility, includes the name and executive director of the entity who will provide services in the facility; and

''(2) with respect to each construction or modernization project described in the application—

''(A) a description of the site for the project;

''(B) plans and specifications for the project and State or tribal approval for the plans and specifications;

''(C) assurance that the title for the site is or will be vested with either the public entity or private nonprofit entity who will provide the services in the facility;

''(D) assurance that adequate financial resources will be available for the construction or major rehabilitation of the project and for the maintenance and operation of the facility;

''(E) estimates of the cost of the project; and

''(F) the estimated length of time for completion of the project.

''(d) SUBGRANTS BY STATES.—

''(1) IN GENERAL.—A State that receives a grant under this section may award a subgrant to a qualified community program (as such term is used in section 1913(b)(1)).

''(2) USE OF FUNDS.—Subgrants awarded pursuant to paragraph (1) may be used for activities such as—

''(A) the construction, expansion, and modernization of facilities used to provide mental and behavioral health services to individuals;

''(B) acquiring and leasing facilities and equipment (including paying the costs of amortizing the principal of, and paying the interest on, loans for such facilities and equipment) to support or further the operation of the subgrantee; and

''(C) the construction and structural modification (including equipment acquisition) of facilities to permit the integrated delivery of behavioral health and primary care of specialty medical services to individuals with co-occurring mental illnesses and chronic medical or surgical diseases at a single service site.

''(e) REQUEST TO TRANSFER OBLIGATION.—An eligible entity that receives a grant under this section may submit a request to the Secretary for permission to transfer the 10-year obligation of facility use, as described in subsection (c)(1)(F), to another facility.

''(f) AGREEMENT TO FEDERAL SHARE.—As a condition of receipt of a grant under this section, an eligible entity shall agree, with respect to the costs to be incurred by the entity in carrying out the activities for which such grant is awarded, that the entity will make available non-Federal contributions (which may include State or local funds, or funds from the qualified community program) in an amount equal to not less than $1 for every $1 of Federal funds provided under the grant.

''(g) REPORTING.—

''(1) REPORTING BY STATES.—During the 10-year period referred to in subsection (c)(1)(F), the Secretary shall require that a State that receives a grant under this section submit, as part of the report of the State required under the Community Mental Health Services Block Grant under subpart I of part B of title XIX and the Substance Abuse Prevention and Treatment Block Grant under subpart II of such part, a description of the progress on—

''(A) the projects carried out pursuant to the grant under this section; and

''(B) the assurances that the facilities involved continue to be used for the purpose for which they were funded under such grant during such 10-year period.

''(2) REPORTING BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—The Secretary shall establish reporting requirements for Indian tribes and tribal organizations that receive a grant under this section. Such reporting requirements shall include that such Indian tribe or tribal organization provide a description of the progress on—

''(A) the projects carried out pursuant to the grant under this section; and

''(B) the assurances that the facilities involved continue to be used for the purpose for which they were funded under such grant during the 10-year period referred to in subsection (c)(1)(F).

''(h) FAILURE TO MEET OBLIGATIONS.—

''(1) IN GENERAL.—If an eligible entity that receives a grant under this section fails to meet any of the obligations of the entity required under this section, the Secretary shall take appropriate steps, which may include—

''(A) requiring that the entity return the unused portion of the funds awarded under this section for the projects that are incomplete; and

''(B) extending the length of time that the entity must ensure that the facility involved is used for the purposes for which it is intended, as described in subsection (c)(1)(F).

''(2) HEARING.—Prior to requesting the return of the funds under paragraph (1)(B), the Secretary shall provide the entity notice and opportunity for a hearing.

''(i) COLLABORATION.—The Secretary may establish intergovernmental and interdepartmental memorandums of agreement as necessary to carry out this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $20,000,000 for fiscal year 2008 and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

By Mr. SMITH (for himself, Mr. BINGAMAN, Mr. SALAZAR, and Mr. SANDERS):

S. 2186. A bill to permit individuals who are employees of a grantee that is receiving funds under section 330 of the Public Health Service Act to enroll in health insurance coverage provided under the Federal Employees Health Benefits Program; to the Committee on Homeland Security and Governmental Affairs.

Mr. SMITH. Mr. President, today I am introducing the Community Health Center Employee Health Coverage Act of 2007, a bill that will help provide community health centers, or CHCs, better access to more affordable health insurance for their employees. I am pleased to have my colleagues Senators BINGAMAN, SALAZAR and SANDERS join me as original cosponsors on this important proposal.

CHCs form the backbone of the Nation's health care safety net. They provide essential medical services to some of our most vulnerable citizens, including the uninsured and Medicaid and Medicare beneficiaries. In my home State of Oregon, health centers provide over 130 points of access, where upwards of 180,000 individuals receive care each year. Approximately 41 percent of those served are uninsured and 36 percent are on Medicaid, and most all reside in either a rural or economically depressed area. Clearly, CHCs have an important role in ensuring that those who otherwise might be unable to afford health coverage have access to the care they need.

CHCs also serve their patients in a very efficient manner. Studies have shown that care provided Medicaid patients at CHCs costs 30 percent less than care provided in other settings. This is mainly due to a lower number of specialty referrals and fewer overall hospital admissions. CHCs effectively demonstrate how focusing on primary and preventive care can help keep individuals healthier, which ultimately enhances their lives and saves the broader health care system money. Above and beyond the efficiencies CHCs have achieved in service delivery, patients report overwhelming satisfaction for the treatment they are provided. Health care providers across the spectrum would be well-served by emulating CHCs' example of delivering affordable, high-quality health care in an efficient manner.

Given the enormous value CHCs have to the U.S. health care system, I believe Congress should do all it can to support their mission. I commend President Bush's commitment to increasing funding for health center expansion in recent years. I am pleased the administration's request for $180

million in new funding in fiscal year 2007 was included in the Senate's version of the budget resolution. As the appropriations process continues to move forward, I hope that those much-needed funds are ultimately approved by Congress.

The bill I am filing today will compliment the increased funding CHCs have received in recent years. Just like businesses across the nation, health centers are coping with the rising cost of providing health benefit to their employees. Premiums for private health insurance grew by 9.5 percent in 2005, the fifth consecutive year of increases over 9 percent. Because CHCs operate on very limited budgets, it has become more and more difficult for them to absorb these increased costs while continuing to provide affordable health care to their patients.

It is important to note that CHCs rely upon the Federal Government for more than half of their operating revenues. Each year, health centers receive 26 percent of their funding from direct Federal grants and another 36 percent from the Medicaid Program. Because CHCs are predominantly a Federal enterprise, I believe it makes sense for them to be able to reap many of the same benefits of other Federal entities. That is why the bill I am filing today would allow CHCs to purchase more affordable health insurance coverage for their employees through the Federal Employee Health Benefits Program, FEHBP.

Allowing federally funded entities to purchase health coverage through FEHBP is not unprecedented. Employees of Gallaudet University and certain U.S. Department of Agriculture grantees already are able to participate in FEHBP as if they were directly employed by the Federal Government. Considering that CHC providers are already deemed ''Federal employees'' for the purpose of receiving medical liability protection through the Federal Government, it is a logical next step to allow them to purchase health coverage through FEHBP. In doing so, we will be able to provide CHCs much needed security in knowing that their employees will have steady access to affordable health insurance.

I believe that in the long run, CHCs will be able to achieve a great deal of savings by purchasing health coverage for their employees through FEHBP. Premiums for policies purchased through FEHBP consistently grow at a much slower rate than other commercial policies. Every dollar CHCs save in employee benefit costs can be redirected into medical care for the vulnerable populations they serve. Access to FEHBP coverage also may help some CHCs provide health benefits to their employees for the first time. This could help recruit much needed medical personnel in underserved and rural communities. I am hopeful health centers in rural parts of my State will be able to attract the physicians they so desperately need by offering them FEHBP coverage.

There is wide support for CHCs in the Senate, as evidenced by the development of a number of CHC-related measures. Earlier this year, I joined a group of bipartisan Senators in filing the Community Health Center Reauthorization Act, to ensure that vulnerable populations have access to basic health care for the next several years. I hope the Senate's leadership will move these bills quickly through the process, as a sign of appreciation for the important role CHCs play in the U.S. health care system.

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

S. 2186

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 ''Community Health Center Employee Health Coverage Act of 2007''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Federally Qualified Health Centers (referred to in this section as ''FQHCs'') are required under section 330 of the Public Health Service Act (42 U.S.C. 254b) to be located in, and serve, a community that is designated as ''medically underserved''.

(2) FQHCs are required under such section 330 to make its services available to all residents of the community, without regard to ability to pay, and to make those services affordable by discounting charges for otherwise uncovered care to low-income families in accordance with family income.

(3) FQHCs are required under such section 330 to provide comprehensive primary health care services, including preventive care, care for illness or injury, services which improve the accessibility of care, and the effectiveness of care.

(4) FQHCs are required under such section 330 to be governed by a board of directors, a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the health care needs of the community it serves.

(5) FQHCs delivered comprehensive primary and preventive care to more than 16,000,000 people in 2006, more than 6,000,000 of whom had no health insurance coverage.

(6) FQHCs employ nearly 100,000 people across the United States.

(7) FQHCs are being challenged by increasing financial pressures that jeopardize their ability to provide health services to medically underserved populations, including the elderly, the uninsured, and lower-income individuals.

(8) Health insurance costs in the small employer market have risen more than 30 percent in the past 2 years, forcing many FQHCs to use additional Federal funding to continue to provide health insurance coverage for their employees.

(9) The Federal Government negotiates premiums with health insurance companies for millions of Federal employees, thereby ensuring the best possible rates under the Federal Employee Health Benefit Program (referred to in this section as ''FEHBP'').

(10) Last year FEHBP premiums increased 6.6 percent, far less than that of even large employers.

(11) FQHCs receive Federal grants from the Health Resource and Services Administration that help cover the cost of providing high quality, affordable health care for everyone in their communities, including the uninsured.

(12) FQHCs use a portion of their Federal grant to cover the cost of health insurance for their employees.

(13) As health insurance premiums rise, FQHCs may be forced to reduce health insurance coverage for their own employees, or reduce the availability of care in their communities.

(14) Last year, almost 1,400,000 Americans joined the ranks of the uninsured—bringing our Nation's total to more than 47,000,000 people without health insurance, while another 30,000,000 or more are underinsured.

(15) The uninsured are in significantly worse health than those with health insurance, receive fewer preventive services, are less likely to receive regular care for chronic diseases, and are more likely to be hospitalized for a condition that could have been treated more effectively with timely access to ambulatory care.

(16) Adding FQHC employees to the list of those covered under the FEHBP would help control rising health insurance costs, reduce the cost of providing health insurance to their employees, and enable centers to use scarce funds to continue providing care in their communities.

SEC. 3. ADDITION OF HEALTH CENTER EMPLOYEES TO FEHBP.

(a) DEFINITIONS.—Section 8901(l) of title 5, United States Code, is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

(2) in subparagraph (I), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(J) an individual who is an employee of a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))) that has elected to offer coverage under this chapter or who is an employee of a grantee that is receiving funds under section 330(l) of the Public Health Service Act (42 U.S.C. 254b(l)) that has elected to offer coverage under this chapter.''.

(b) EMPLOYEES HEALTH BENEFITS FUND.—Section 8909 of title 5, United States Code, is amended by adding at the end the following:

''(h) An individual who is an employee of a federally qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B))) who has elected coverage under this chapter or who is an employee of a grantee that is receiving funds under section 330(l) of the Public Health Service Act (42 U.S.C. 254b(l)) who has elected coverage under this chapter shall be required to pay currently into the Employees Health Benefits Fund, under arrangements satisfactory to the Office, an amount equal to the sum of—

''(1) the employee and agency contributions which would be required in the case of an employee enrolled in the same health benefits plan and level of benefits; and

''(2) an amount, determined under regulations prescribed by the Office, necessary for administrative expenses, but not to exceed 2 percent of the total amount under clause (i).''.

By Mr. BINGAMAN (for himself, Ms. SNOWE, Mr. SALAZAR, Mr. SMITH, Mr. AKAKA, and Mr. SANDERS):

S. 2188. A bill to amend title XVIII of the Social Security Act to establish a prospective payment system instead of the reasonable cost-based reimbursement method for Medicare-covered services provided by Federally qualified health centers and to expand the scope of such covered services to account for expansions in the scope of

services provided by Federally qualified health centers since the inclusion of such services for coverage under the Medicare Program; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, I rise today with Senators Snowe, Salazar, Smith, Akaka, and Sanders to introduce the Medicare Access to Community Health Center, MATCH, Act, which would address a long standing problem for a key component of our Nation's health care safety net, community health centers. These facilities serve as medical homes to nearly 16 million underserved patients. Over 1 million of those patients are Medicare beneficiaries. Health centers are known for providing high quality, comprehensive care to some of our Nation's most vulnerable populations.

Over 15 years ago, Congress created the Federally Qualified Health Center, FQHC, Medicare benefit to ensure that health centers were not forced to subsidize Medicare payments with Federal grant dollars. Congress required centers to be paid their reasonable costs for providing care to their patients. The Centers for Medicare and Medicaid Services later established a per visit payment cap in regulations based on a statute applicable to Rural Health Clinics. CMS applied the cap to FQHCs without meaningful data to support the payment limit but with the promise of future reviews to guarantee that health centers were adequately reimbursed. However, these reviews have not taken place. Now, 15 years later, over ¾ of health centers are losing money serving Medicare beneficiaries, with losses totaling over $50 million annually according to an analysis done by the National Association of Community Health Centers. In my home State of New Mexico, NACHC estimates that health centers have lost more than a million dollars annually.

I have repeatedly asked CMS to review this antiquated cap but I have had little success. So I rise today to introduce legislation to improve the Medicare payment mechanism for FQHCs. MATCH will establish a Prospective Payment System for FQHCs, based on actual cost of providing care to health center patients. This new mechanism mirrors the successful Medicaid FQHC Prospective Payment System. By reforming the payment structure at FQHCs, we will ensure health centers are able to dedicate their Federal grant dollars for their original intent, providing care to the uninsured. This new mechanism will also increase efficiency and stability in the Medicare program for health centers.

This legislation is long overdue. I ask my colleagues to join me in strengthening the Medicare FQHC program to ensure that health centers can continue to provide high quality, affordable primary and preventive care to our Nation's seniors and people with disabilities.

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 placed in the RECORD, as follows:

S. 2188

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 ''Medicare Access to Community Health Centers (MATCH) Act of 2007''.

SEC. 2. FINDINGS.

Congress finds that:

(1) NATIONAL IMPORTANCE.—Community health centers serve as the medical home and family physician to over 16,000,000 people nationally. Patients of community health centers represent 1 in 7 low-income persons, 1 in 8 uninsured Americans, 1 in 9 Medicaid beneficiaries, 1 in 10 minorities, and 1 in 10 rural residents.

(2) HEALTH CARE SAFETY NET.—Because Federally qualified health centers (FQHCs) are generally located in medically underserved areas, the patients of Federally qualified health centers are disproportionately low income, uninsured or publicly insured, and minorities, and they frequently have poorer health and more complicated, costly medical needs than patients nationally. As a chief component of the health care safety net, Federally qualified health centers are required by regulation to serve all patients, regardless of insurance status or ability to pay.

(3) MEDICARE BENEFICIARIES.—Medicare beneficiaries are typically less healthy and, therefore, costlier to treat than other patients of Federally qualified health centers. Medicare beneficiaries tend to have more complex health care needs as—

(A) more than half of Medicare patients have at least 2 chronic conditions;

(B) 45 percent take 5 or more medications; and

(C) over half of Medicare beneficiaries have more than 1 prescribing physician.

(4) NEED TO IMPROVE FQHC PAYMENT.—While the Centers for Medicare & Medicaid Services have nearly 15 years' worth of cost report data from Federally qualified health centers, which would equip the agency to develop a new Medicare reimbursement system, the agency has failed to update and improve the Medicare FQHC payment system.

SEC. 3. EXPANSION OF MEDICARE-COVERED PRIMARY AND PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1861(aa)(3) of the Social Security Act (42 U.S.C. 1395x(aa)(3)) is amended to read as follows:

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

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

''(B) preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act,

when furnished to an individual as a patient of a Federally qualified health center and such services when provided by a health care provider or health care professional employed by or under contract with a Federally qualified health center and for this purpose, any reference to a rural health clinic or a physician described in paragraph (2)(B) is deemed a reference to a Federally qualified health center or a physician at the center, respectively. Services described in the previous sentence shall be treated as billable visits for purposes of payment to the Federally qualified health center.''.

(b) CONFORMING AMENDMENT TO PERMIT PAYMENT FOR HOSPITAL-BASED SERVICES.—Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by inserting ''Federally qualified health center services,'' after ''qualified psychologist services,''.

(c) EFFECTIVE DATES.—The amendments made by subsections (a) and (b) shall apply to services furnished on or after January 1, 2008.

SEC. 4. ESTABLISHMENT OF A MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.

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

''(3)(A) in the case of services described in section 1832(a)(2)(D)(i) the costs which are reasonable and related to the furnishing of such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A) but in no case may the payment for such services (other than for items and services described in 1861(s)(10)(A)) exceed 80 percent of such costs; and

''(B) in the case of services described in section 1832(a)(2)(D)(ii) furnished by a Federally qualified health center—

''(i) subject to clauses (iii) and (iv), for services furnished on and after January 1, 2008, during the center's fiscal year that ends in 2008, an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center of furnishing such services during such center's fiscal years ending during 2006 and 2007 which are reasonable and related to the cost of furnishing such services, or which are based on such other tests of reasonableness as the Secretary prescribes in regulations including those authorized under section 1861(v)(1)(A) (except that in calculating such cost in a center's fiscal years ending during 2006 and 2007 and applying the average of such cost for a center's fiscal year ending during fiscal year 2008, the Secretary shall not apply a per visit payment limit or productivity screen), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items or services described in section 1861(s)(10)(A)) exceed 80 percent of such average of such costs;

''(ii) subject to clauses (iii) and (iv), for services furnished during the center's fiscal year ending during 2009 or a succeeding fiscal year, an amount (calculated on a per visit basis and without the application of a per visit limit or productivity screen) that is equal to the amount determined under this subparagraph for the center's preceding fiscal year (without regard to any copayment)—

''(I) increased for a center's fiscal year ending during 2009 by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for 2009 and increased for a center's fiscal year ending during 2010 or any succeeding fiscal year by the percentage increase for such year of a market basket of Federally qualified health center costs as developed and promulgated through regulations by the Secretary; and

''(II) adjusted to take into account any increase or decrease in the scope of services, including a change in the type, intensity, duration, or amount of services, furnished by the center during the center's fiscal year,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items or services described in section 1861(s)(10)(A)) exceed 80 percent of the amount determined under this clause (without regard to any copayment);

''(iii) subject to clause (iv), in the case of an entity that first qualifies as a Federally qualified health center in a center's fiscal year ending after 2007—

''(I) for the first such center fiscal year, an amount (calculated on a per visit basis and without the application of a per visit payment limit or productivity screen) that is equal to 100 percent of the costs of furnishing such services during such center fiscal year based on the per visit payment rates established under clause (i) or (ii) for a comparable period for other such centers located in the same or adjacent areas with a similar caseload or, in the absence of such a center, in accordance with the regulations and methodology referred to in clause (i) or based on such other tests of reasonableness (without the application of a per visit payment limit or productivity screen) as the Secretary may specify, less the amount a provider may charge as described in clause (ii) of section 1866 (a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; and

''(II) for each succeeding center fiscal year, the amount calculated in accordance with clause (ii); and

''(iv) with respect to Federally qualified health center services that are furnished to an individual enrolled with a MA plan under part C pursuant to a written agreement described in section 1853(a)(4) (or, in the case of MA private fee for service plan, without such written agreement) the amount (if any) by which—

''(I) the amount of payment that would have otherwise been provided under clauses (i), (ii), or (iii) (calculated as if '100 percent' were substituted for '80 percent' in such clauses) for such services if the individual had not been enrolled; exceeds

''(II) the amount of the payments received under such written agreement (or, in the case of MA private fee for service plans, without such written agreement) for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds) less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(B);''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2008.

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

S. 2189. A bill to provide for educational opportunities for all students in State public school systems, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. DODD. Mr. President, I rise today to introduce the Student Bill of Rights. This bill would ensure that every child in America has an equal opportunity to receive a high quality education.

The Student Bill of Rights would achieve this goal by providing America's children with components needed for a solid education. These components include highly qualified teachers, challenging curricula, small classes, current textbooks, quality libraries, and up-to-date technology.

Currently, federal law requires that schools within the same district provide comparable educational services. The Student Bill of Rights would extend that basic guarantee of equal opportunity to the state level by requiring comparability of resources across school districts within a state.

More than 50 years ago, Brown v. Board of Education struck down segregation in law. Over 50 years later, we know that just because there is no segregation in law does not mean that it does not persist. Today, our education system remains largely separate and unequal, and in light of a recent Supreme Court decision, we need to find more creative ways to promote equity in our schools.

All too often, where a child's family can afford to live determines whether that child is taught by a high quality teacher, has access to the best courses and instructional materials, goes to school in a new, modern building, and otherwise benefits from educational resources that have been shown to be essential to a quality education. In fact, the U.S. ranks at the bottom among developed countries in the disparity in the quality of schools available to wealthy and low-income children. This gap is simply unacceptable, and it is why the Student Bill of Rights is so important to our children's ability to gain the skills they need to be responsible, participating citizens in our diverse democracy, and to compete and succeed in the global economy.

While other factors such as supportive parents, motivated peers, and positive role models in the community are also beneficial to academic achievement, we know that adequate resources are crucial to providing students with the opportunity to receive a solid education.

The quality of a child's education should not be determined by his or her ZIP code. The Student Bill of Rights will help ensure that each and every child gets a decent education, and in turn, an equal opportunity for a successful future. I hope that my colleagues will join me in supporting the Student Bill of Rights.

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

S. 2189

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 ''Student Bill of Rights''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

Sec. 1. Short title.
Sec. 2. Table of contents.
Sec. 3. Findings and purposes.

TITLE I—ACCESS TO EDUCATIONAL OPPORTUNITY

Sec. 101. State public school systems.
Sec. 102. Fundamentals of educational opportunity.

TITLE II—STATE ACCOUNTABILITY

Sec. 201. State accountability plan.
Sec. 202. Consequences of failure to meet requirements.

TITLE III—REPORT TO CONGRESS AND THE PUBLIC

Sec. 301. Annual report on State public school systems.

TITLE IV—REMEDY

Sec. 401. Civil action for enforcement.

TITLE V—GENERAL PROVISIONS

Sec. 501. Definitions.
Sec. 502. Rulemaking.
Sec. 503. Construction.

SEC. 3. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds the following:

(1) A high-quality, highly competitive education for all students is imperative for the economic growth and productivity of the United States, for its effective national defense, and to achieve the historical aspiration to be one Nation of equal citizens. It is therefore necessary and proper to overcome the nationwide phenomenon of State public school systems that do not meet the requirements of section 101(a), in which high-quality public schools typically serve high-income communities and poor-quality schools typically serve low-income, urban, rural, and minority communities.

(2) In 2005, the National Academies found in their report ''Rising Above the Gathering Storm: Energizing and Employing America for a Brighter Economic Future'' that the inadequate preparation of kindergarten through grade 12 students in science and mathematics, including the significant lack of teachers qualified to teach these subjects, threatens the economic prosperity of the United States. When students do not receive quality mathematics and science preparation in kindergarten through grade 12, they are not prepared to take advanced courses in these subjects at the postsecondary level, leaving the United States with a critical shortage of scientists and engineers—a shortfall being filled by professionals from other countries.

(3) There exists in the States a significant educational opportunity gap for low-income, urban, rural, and minority students characterized by the following:

(A) Continuing disparities within States in students' access to the fundamentals of educational opportunity described in section 102.

(B) Highly differential educational expenditures (adjusted for cost and need) among school districts within States.

(C) Radically differential educational achievement among students in school districts within States as measured by the following:

(i) Achievement in mathematics, reading or language arts, and science on State academic assessments required under section 1111(b)(3) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)) and on the National Assessment of Educational Progress.

(ii) Advanced placement courses taken.

(iii) SAT and ACT test scores.

(iv) Dropout rates and graduation rates.

(v) College-going and college-completion rates.

(4) As a consequence of this educational opportunity gap, the quality of a child's education depends largely upon where the child's family can afford to live, and the detriments of lower quality education are imposed particularly on—

(A) children from low-income families;

(B) children living in urban and rural areas; and

(C) minority children.

(5) Since 1785, Congress, exercising the power to admit new States under section 3 of

article IV of the Constitution (and previously, the Congress of the Confederation of States under the Articles of Confederation), has imposed upon every State, as a fundamental condition of the State's admission, that the State provide for the establishment and maintenance of systems of public schools open to all children in such State.

(6) Over the years since the landmark ruling in Brown v. Board of Education, 347 U.S. 483, 493 (1954), when a unanimous Supreme Court held that ''the opportunity of an education . . . , where the State has undertaken to provide it, is a right which must be made available to all on equal terms'', courts in 44 States have heard challenges to the establishment, maintenance, and operation of State public school systems that are separate and not educationally adequate.

(7) In 1970, the Presidential Commission on School Finance found that significant disparities in the distribution of educational resources existed among school districts within States because the States relied too significantly on local district financing for educational revenues, and that reforms in systems of school financing would increase the Nation's ability to serve the educational needs of all children.

(8) In 1999, the National Research Council of the National Academy of Sciences published a report entitled ''Making Money Matter, Financing America's Schools'', which found that the concept of funding adequacy, which moves beyond the more traditional concepts of finance equity to focus attention on the sufficiency of funding for desired educational outcomes, is an important step in developing a fair and productive educational system.

(9) In 2001, the Executive Order establishing the President's Commission on Educational Resource Equity declared, ''A quality education is essential to the success of every child in the 21st century and to the continued strength and prosperity of our Nation. . . . [L]ong-standing gaps in access to educational resources exist, including disparities based on race and ethnicity.'' (Exec. Order No. 13190, 66 Fed. Reg. 5424 (2001)).

(10) According to the Secretary of Education, as stated in a letter (with enclosures) from the Secretary to States dated January 19, 2001—

(A) racial and ethnic minorities continue to suffer from lack of access to educational resources, including ''experienced and qualified teachers, adequate facilities, and instructional programs and support, including technology, as well as . . . the funding necessary to secure these resources''; and

(B) these inadequacies are ''particularly acute in high-poverty schools, including urban schools, where many students of color are isolated and where the effect of the resource gaps may be cumulative. In other words, students who need the most may often receive the least, and these students often are students of color.''.

(11) In the amendments made by the No Child Left Behind Act of 2001, Congress—

(A)(i) required each State to establish standards and assessments in mathematics, reading or language arts, and science; and

(ii) required schools to ensure that all students are proficient in mathematics, reading or language arts, and science not later than 12 years after the end of the 2001–2002 school year, and held schools accountable for the students' progress; and

(B) required each State to describe how the State will help local educational agencies and schools to develop the capacity to improve student academic achievement.

(12) The standards and accountability movement will succeed only if, in addition to standards and accountability, all schools have access to the educational resources necessary to enable students to achieve.

(13) Raising standards without ensuring access to educational resources may in fact exacerbate achievement gaps and set children up for failure.

(14) According to the World Economic Forum's Global Competitiveness Report 2001–2002, the United States ranks last among developed countries in the difference in the quality of schools available to rich and poor children.

(15) The persistence of pervasive inadequacies in the quality of education provided by State public school systems effectively deprives millions of children throughout the United States of the opportunity for an education adequate to enable the children to—

(A) acquire the knowledge and skills necessary for responsible citizenship in a diverse democracy, including the ability to participate fully in the political process through informed electoral choice;

(B) meet challenging student academic achievement standards; and

(C) be able to compete and succeed in a global economy.

(16) Each State government has ultimate authority to determine every important aspect and priority of the public school system that provides elementary and secondary education to children in the State, including whether students throughout the State have access to the fundamentals of educational opportunity described in section 102.

(17) Because a well educated populace is critical to the Nation's political and economic well-being and national security, the Federal Government has a substantial interest in ensuring that States provide a high-quality education by ensuring that all students have access to the fundamentals of educational opportunity described in section 102 to enable the students to succeed academically and in life.

(b) PURPOSES.—The purposes of this Act are the following:

(1) To further the goals of the Elementary and Secondary Education Act of 1965 (as amended by the No Child Left Behind Act of 2001), by holding States accountable for providing all students with access to the fundamentals of educational opportunity described in section 102.

(2) To ensure that all students in public elementary schools and secondary schools receive educational opportunities that enable such students to—

(A) acquire the knowledge and skills necessary for responsible citizenship in a diverse democracy, including the ability to participate fully in the political process through informed electoral choice;

(B) meet challenging student academic achievement standards; and

(C) be able to compete and succeed in a global economy.

(3) To end the pervasive pattern of States maintaining public school systems that do not meet the requirements of section 101(a).

TITLE I—ACCESS TO EDUCATIONAL OPPORTUNITY

SEC. 101. STATE PUBLIC SCHOOL SYSTEMS.

(a) REQUIREMENTS.—Each State receiving Federal financial assistance for elementary or secondary education shall ensure that the State's public school system provides all students within the State with an education that enables the students to acquire the knowledge and skills necessary for responsible citizenship in a diverse democracy, including the ability to participate fully in the political process through informed electoral choice, to meet challenging student academic achievement standards, and to be able to compete and succeed in a global economy, through—

(1) the provision of fundamentals of educational opportunity described in section 102, at adequate or ideal levels as defined by the State under section 201(a)(1)(A) to students at each public elementary school and secondary school in the State;

(2) the provision of educational services in school districts that receive funds under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.) that are, taken as a whole, at least comparable to educational services provided in school districts not receiving such funds; and

(3) compliance with any final Federal or State court order in any matter concerning the adequacy or equitableness of the State's public school system.

(b) DETERMINATIONS CONCERNING STATE PUBLIC SCHOOL SYSTEMS.—Not later than October 1 of each year, the Secretary shall determine whether each State maintains a public school system that meets the requirements of subsection (a). The Secretary may make a determination that a State public school system does not meet such requirements only after providing notice and an opportunity for a hearing.

(c) PUBLICATION.—The Secretary shall publish and make available to the general public (including by means of the Internet) the determinations made under subsection (b).

SEC. 102. FUNDAMENTALS OF EDUCATIONAL OPPORTUNITY.

The fundamentals of educational opportunity are the following:

(1) HIGHLY QUALIFIED TEACHERS, PRINCIPALS, AND ACADEMIC SUPPORT PERSONNEL.—

(A) HIGHLY QUALIFIED TEACHERS.—Instruction from highly qualified teachers in core academic subjects.

(B) HIGHLY QUALIFIED PRINCIPALS.—Leadership, management, and guidance from principals who meet State certification standards.

(C) HIGHLY QUALIFIED ACADEMIC SUPPORT PERSONNEL.—Necessary additional academic support in reading or language arts, mathematics, and other core academic subjects from personnel who meet applicable State standards.

(2) RIGOROUS ACADEMIC STANDARDS, CURRICULA, AND METHODS OF INSTRUCTION.—Rigorous academic standards, curricula, and methods of instruction, as measured by the extent to which each school district succeeds in providing high-quality academic standards, curricula, and methods of instruction to students in each public elementary school and secondary school within the district.

(3) SMALL CLASS SIZES.—Small class sizes, as measured by—

(A) the average class size and the range of class sizes; and

(B) the percentage of elementary school classes with 17 or fewer students.

(4) TEXTBOOKS, INSTRUCTIONAL MATERIALS, AND SUPPLIES.—Textbooks, instructional materials, and supplies, as measured by—

(A) the average age and quality of textbooks, instructional materials, and supplies used in core academic subjects; and

(B) the percentage of students who begin the school year with school-issued textbooks, instructional materials, and supplies.

(5) LIBRARY RESOURCES.—Library resources, as measured by—

(A) the size and qualifications of the library's staff, including whether the library is staffed by a full-time librarian certified under applicable State standards;

(B) the size (relative to the number of students) and quality (including age) of the library's collection of books and periodicals; and

(C) the library's hours of operation.

(6) SCHOOL FACILITIES AND COMPUTER TECHNOLOGY.—

(A) QUALITY SCHOOL FACILITIES.—Quality school facilities, as measured by—

(i) the physical condition of school buildings and major school building features;

(ii) environmental conditions in school buildings; and

(iii) the quality of instructional space.

(B) COMPUTER TECHNOLOGY.—Computer technology, as measured by—

(i) the ratio of computers to students;

(ii) the quality of computers and software available to students;

(iii) Internet access;

(iv) the quality of system maintenance and technical assistance for the computers; and

(v) the number of computer laboratory courses taught by qualified computer instructors.

(7) QUALITY GUIDANCE COUNSELING.—Qualified guidance counselors, as measured by the ratio of students to qualified guidance counselors who have been certified under an applicable State or national program.

TITLE II—STATE ACCOUNTABILITY

SEC. 201. STATE ACCOUNTABILITY PLAN.

(a) GENERAL PLAN.—

(1) CONTENTS.—Each State receiving Federal financial assistance for elementary and secondary education shall annually submit to the Secretary a plan, developed by the State educational agency, in consultation with local educational agencies, teachers, principals, pupil services personnel, administrators, other staff, and parents, that contains the following:

(A) A description of 2 levels of high access (adequate and ideal) to each of the fundamentals of educational opportunity described in section 102 that measure how well the State, through school districts, public elementary schools, and public secondary schools, is achieving the purposes of this Act by providing children with the resources they need to succeed academically and in life.

(B) A description of a third level of access (basic) to each of the fundamentals of educational opportunity described in section 102 that measures how well the State, through school districts, public elementary schools, and public secondary schools, is achieving the purposes of this Act by providing children with the resources they need to succeed academically and in life.

(C) A description of the level of access of each school district, public elementary school, and public secondary school in the State to each of the fundamentals of educational opportunity described in section 102, including identification of any such schools that lack high access (as described in subparagraph (A)) to any of the fundamentals.

(D) An estimate of the additional cost, if any, of ensuring that the system meets the requirements of section 101(a).

(E) Information stating the percentage of students in each school district, public elementary school, and public secondary school in the State that are proficient in mathematics, reading or language arts, and science, as measured through assessments administered as described in section 1111(b)(3)(C)(v) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)(C)(v)).

(F) Information stating whether each school district, public elementary school, and public secondary school in the State is making adequate yearly progress, as defined under section 1111(b)(2) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(2)).

(G)(i) For each school district, public elementary school, and public secondary school in the State, information stating—

(I) the number and percentage of children counted under section 1124(c) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6333(c)); and

(II) the number and percentage of students described in section 1111(b)(3)(C)(xiii) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)(C)(xiii)).

(ii) For each such school district, information stating whether the district is an urban, mixed, or rural district (as defined by the National Center for Education Statistics).

(2) LEVELS OF ACCESS.—For purposes of the plan submitted under paragraph (1)—

(A) in defining basic, adequate, and ideal levels of access to each of the fundamentals of educational opportunity, each State shall consider, in addition to the factors described in section 102, the access available to students in the highest-achieving decile of public elementary schools and secondary schools, the unique needs of low-income, urban and rural, and minority students, and other educationally appropriate factors; and

(B) the levels of access described in subparagraphs (A) and (B) of paragraph (1) shall be aligned with the challenging academic content standards, challenging student academic achievement standards, and high-quality academic assessments required under the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.).

(3) INFORMATION.—The State shall annually disseminate to parents, in an understandable and uniform format, the descriptions, estimate, and information described in paragraph (1).

(b) ACCOUNTABILITY AND REMEDIATION.—

(1) ACCOUNTABILITY.—If the Secretary determines under section 101(b) that a State maintains a public school system that fails to meet the requirements of section 101(a)(1), the plan submitted under subsection (a)(1) shall—

(A) demonstrate that the State has developed and is implementing a single, statewide State accountability system that will be effective in ensuring that the State makes adequate yearly progress under this Act (as defined by the State in a manner that annually reduces the number of public elementary schools and secondary schools in the State without high access (as described in subsection (a)(1)(A)) to each of fundamentals of educational opportunity described in section 102);

(B) demonstrate, based on the levels of access described in paragraph (1) what constitutes adequate yearly progress of the State under this Act toward providing all students with high access to the fundamentals of educational opportunity described in section 102; and

(C) ensure—

(i) the establishment of a timeline for that adequate yearly progress that includes interim yearly goals for the reduction of the number of public elementary schools and secondary schools in the State without high access to each of the fundamentals of educational opportunity described in section 102; and

(ii) that not later than 12 years after the end of the 2005–2006 school year, each public elementary school in the State shall have access to each of the fundamentals of educational opportunity described in section 102.

(2) REMEDIATION.—If the Secretary determines under section 101(b) that a State maintains a public school system that fails to meet the requirements of section 101(a)(2), not later than 1 year after the Secretary makes the determination, the State shall include in the plan submitted under subsection (a)(1) a strategy to remediate the conditions that caused the Secretary to make such determination, not later than the end of the second school year beginning after submission of the plan.

(c) AMENDMENTS.—A State may amend the plan submitted under subsection (a)(1) to improve the plan or to take into account significantly changed circumstances.

(d) DISAPPROVAL.—The Secretary may disapprove the plan submitted under subsection (a)(1) (or an amendment to such a plan) if the Secretary determines, after notice and opportunity for hearing, that the plan (or amendment) is inadequate to meet the requirements described in subsections (a) and (b).

(e) WAIVER.—

(1) IN GENERAL.—A State may request, and the Secretary may grant, a waiver of the requirements of subsections (a) and (b) for 1 year for exceptional circumstances, such as a precipitous decrease in State revenues, or another circumstance that the Secretary determines to be exceptional, that prevents a State from complying with the requirements of subsections (a) and (b).

(2) CONTENTS OF WAIVER REQUEST.—A State that requests a waiver under paragraph (1) shall include in the request—

(A) a description of the exceptional circumstance that prevents the State from complying with the requirements of subsections (a) and (b); and

(B) a plan that details the manner in which the State will comply with such requirements by the end of the waiver period.

SEC. 202. CONSEQUENCES OF FAILURE TO MEET REQUIREMENTS.

(a) INTERIM YEARLY GOALS.—

(1) IN GENERAL.—For a fiscal year and a State described in section 201(b)(1), the Secretary shall withhold from the State 2.75 percent of funds otherwise available to the State for the administration of Federal elementary and secondary education programs, for each covered goal that the Secretary determines the State is not meeting during that year.

(2) DEFINITION.—In this subsection, the term ''covered goal'', used with respect to a fiscal year, means an interim yearly goal described in section 201(b)(1)(C)(i) that is applicable to that year or a prior fiscal year.

(b) CONSEQUENCES OF NONREMEDIATION.—Notwithstanding any other provision of law, if the Secretary determines that a State required to include a strategy under section 201(b)(2) continues to maintain a public school system that does not meet the requirements of section 101(a)(2) at the end of the second school year described in section 201(b)(2), the Secretary shall withhold from the State not more than 33⅓ percent of funds otherwise available to the State for the administration of programs authorized under the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.) until the Secretary determines that the State maintains a public school system that meets the requirements of section 101(a)(2).

(c) CONSEQUENCES OF NONCOMPLIANCE WITH COURT ORDERS.—If the Secretary determines under section 101(b) that a State maintains a public school system that fails to meet the requirements of section 101(a)(3), the Secretary shall withhold from the State not more than 33⅓ percent of funds otherwise available to the State for the administration of programs authorized under the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.).

(d) DISPOSITION OF FUNDS WITHHELD.—

(1) DETERMINATION.—Not later than 1 year after the Secretary withholds funds from a State under this section, the Secretary shall determine whether the State has corrected the condition that led to the withholding.

(2) DISPOSITION.—

(A) CORRECTION.—If the Secretary determines under paragraph (1), that the State has corrected the condition that led to the withholding, the Secretary shall make the

withheld funds available to the State to use for the original purpose of the funds during 1 or more fiscal years specified by the Secretary.

(B) NONCORRECTION.—If the Secretary determines under paragraph (1), that the State has not corrected the condition that led to the withholding, the Secretary shall allocate the withheld funds to public school districts, public elementary schools, or public secondary schools in the State that are most adversely affected by the condition that led to the withholding, to enable the districts or schools to correct the condition during 1 or more fiscal years specified by the Secretary.

(3) AVAILABILITY.—Amounts made available or allocated under subparagraph (A) or (B) of paragraph (2) shall remain available during the fiscal years specified by the Secretary under that subparagraph.

TITLE III—REPORT TO CONGRESS AND THE PUBLIC

SEC. 301. ANNUAL REPORT ON STATE PUBLIC SCHOOL SYSTEMS.

(a) ANNUAL REPORT TO CONGRESS.—Not later than October 1 of each year, beginning the year after completion of the first full school year after the date of enactment of this Act, the Secretary shall submit to Congress a report that includes a full and complete analysis of the public school system of each State.

(b) CONTENTS OF REPORT.—The analysis conducted under subsection (a) shall include the following:

(1) PUBLIC SCHOOL SYSTEM INFORMATION.—The following information related to the public school system of each State:

(A) The number of school districts, public elementary schools, public secondary schools, and students in the system.

(B)(i) For each such school district and school—

(I) information stating the number and percentage of children counted under section 1124(c) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6333(c)); and

(II) the number and percentage of students, disaggregated by groups described in section 1111(b)(3)(C)(xiii) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)(C)(xiii)).

(ii) For each such district, information stating whether the district is an urban, mixed, or rural district (as defined by the National Center for Education Statistics).

(C) The average per-pupil expenditure (both in actual dollars and adjusted for cost and need) for the State and for each school district in the State.

(D) Each school district's decile ranking as measured by achievement in mathematics, reading or language arts, and science on State academic assessments required under section 1111(b)(3) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)) and on the National Assessment of Educational Progress.

(E) For each school district, public elementary school, and public secondary school—

(i) the level of access (as described in section 201(a)(1)) to each of the fundamentals of educational opportunity described in section 102;

(ii) the percentage of students that are proficient in mathematics, reading or language arts, and science, as measured through assessments administered as described in section 1111(b)(3)(C)(v) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)(C)(v)); and

(iii) whether the school district or school is making adequate yearly progress—

(I) as defined under section 1111(b)(2) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(2)); and

(II) as defined by the State under section 201(b)(1)(A).

(F) For each State, the number of public elementary schools and secondary schools that lack, and names of each such school that lacks, high access (as described in section 201(a)(1)(A)) to any of the fundamentals of educational opportunity described in section 102.

(G) For the year covered by the report, a summary of any changes in the data required in subparagraphs (A) through (F) for each of the preceding 3 years (which may be based on such data as are available, for the first 3 reports submitted under subsection (a)).

(H) Such other information as the Secretary considers useful and appropriate.

(2) STATE ACTIONS.—For each State that the Secretary determines under section 101(b) maintains a public school system that fails to meet the requirements of section 101(a), a detailed description and evaluation of the success of any actions taken by the State, and measures proposed to be taken by the State, to meet the requirements.

(3) STATE PLANS.—A copy of each State's most recent plan submitted under section 201(a)(1).

(4) RELATIONSHIP BETWEEN COMPLIANCE AND ACHIEVEMENT.—An analysis of the relationship between meeting the requirements of section 101(a) and improving student academic achievement, as measured on State academic assessments required under section 1111(b)(3) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(3)).

(c) SCOPE OF REPORT.—The report required under subsection (a) shall cover the school year ending in the calendar year in which the report is required to be submitted.

(d) SUBMISSION OF DATA TO SECRETARY.—Each State receiving Federal financial assistance for elementary and secondary education shall submit to the Secretary, at such time and in such manner as the Secretary may reasonably require, such data as the Secretary determines to be necessary to make a determination under section 101(b) and to submit the report under this section. Such data shall include the information used to measure the State's success in providing the fundamentals of educational opportunity described in section 102.

(e) FAILURE TO SUBMIT DATA.—If a State fails to submit the data that the Secretary determines to be necessary to make a determination under section 101(b) regarding whether the State maintains a public school system that meets the requirements of section 101(a)—

(1) such State's public school system shall be deemed not to have met the applicable requirements until the State submits such data and the Secretary is able to make such determination under section 101(b); and

(2) the Secretary shall provide, to the extent practicable, the analysis required in subsection (a) for the State based on the best data available to the Secretary.

(f) PUBLICATION.—The Secretary shall publish and make available to the general public (including by means of the Internet) the report required under subsection (a).

TITLE IV—REMEDY

SEC. 401. CIVIL ACTION FOR ENFORCEMENT.

A student or parent of a student aggrieved by a violation of this Act may bring a civil action against the appropriate official in an appropriate Federal district court seeking declaratory or injunctive relief to enforce the requirements of this Act, together with reasonable attorney's fees and the costs of the action.

TITLE V—GENERAL PROVISIONS

SEC. 501. DEFINITIONS.

In this Act:

(1) REFERENCED TERMS.—The terms ''elementary school'', ''secondary school'', ''local educational agency'', ''highly qualified'', ''core academic subjects'', ''parent'', and ''average per-pupil expenditure'' have the meanings given those terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(2) FEDERAL ELEMENTARY AND SECONDARY EDUCATION PROGRAMS.—The term ''Federal elementary and secondary education programs'' means programs providing Federal financial assistance for elementary or secondary education, other than programs under the following provisions of law:

(A) The Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.).

(B) Title III of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6801 et seq.).

(C) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

(D) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

(3) PUBLIC SCHOOL SYSTEM.—The term ''public school system'' means a State's system of public elementary and secondary education.

(4) STATE.—The term ''State'' means each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 502. RULEMAKING.

The Secretary may prescribe regulations to carry out this Act.

SEC. 503. CONSTRUCTION.

Nothing in this Act shall be construed to require a jurisdiction to increase its property tax or other tax rates or to redistribute revenues from such taxes.

Mr. ROCKEFELLER:

S. 2190. A bill to amend title XVIII of the Social Security Act to provide for the inclusion of barbiturates and bezodiazepines as covered part D drugs beginning in 2008; to the Committee on Finance.

Mr. ROCKEFELLER. Mr. President, today I rise to introduce the Medicare Mental Health Prescription Drug Access Act of 2007—legislation to provide our Nation's seniors and individuals with disabilities access to the mental health drugs that best meet their needs.

As many of my colleagues are aware, nearly one out of four Americans, 58 million people, will experience a mental illness during any given year, and a large number of them will be senior citizens and individuals with disabilities.

For far too long, mental illness has been shrouded in fear, misunderstanding and stigma. I believe it is long past time for us to address the inequitable treatment of mental illness in our broader health care system. Mental health parity is a critical part of the solution. We must fulfill the intent of the 1996 mental health parity law and expand the definition of parity to include deductibles, co-payments, coinsurance, out-of-pocket expenses, as well as scope and duration of treatment.

However, parity alone is not a panacea to the problem of treating mental illness in this country. We must improve the range of mental health illnesses and treatment options covered by health plans, particularly for children and seniors.

This year in the Senate, we have taken a major step toward improving

access to mental health services for children by passing the Children's Health Insurance Program, CHIP, Reauthorization Act, H.R. 976, not once, but twice. Among the many important provisions included in this legislation, which I co-authored, is a provision that requires the private health insurance plans that administer CHIP to provide mental health services for children that are equivalent to the coverage provided for physical illnesses. In other words, we require full mental health parity for children enrolled in CHIP.

I still believe that we must do more to ensure that all children have the broadest health care coverage possible for mental health screening and treatment, along the lines of what is provided to children enrolled in Medicaid through the Early Periodic Screening Diagnosis and Treatment, EPSDT, program. However, we have taken a significant step in the right direction toward addressing the mental health needs of our nation's children by passing the CHIP reauthorization bill.

Unfortunately, the same is not true for our nation's seniors and individuals with disabilities. We haven't done nearly enough to address their mental health needs. In fact, we have taken a step backwards in the mental health coverage provided to Medicare participants, particularly those that are dually eligible for Medicare and Medicaid.

Many of my colleagues will recall that the Medicare Prescription Drug, Improvement and Modernization Act of 2003 excluded certain classes of medications from the newly-created Medicare prescription drug program. Among the prescription drugs excluded were two important classes of mental health drugs, benzodiepines and barbiturates, central nervous system depressants which have multiple clinical benefits.

Benzodiazepines and barbiturates are used to help seniors and individuals with disabilities who are dealing with a variety of conditions including anxiety, depression, insomnia, panic disorders, muscle spasms and seizures. Despite being some of the oldest and most effective medications for the treatment of mental illness, benzodiazepines and barbiturates are currently unavailable to most seniors and individuals with disabilities enrolled in Medicare. That is just wrong.

Patients who have found success with benzodiazepines and barbiturates are reluctant to change prescriptions because of the potential side effects or the understandable fear that their conditions might return. Often, there is also an increased cost associated with alternative medications, but the efficacy of these ''replacement'' drugs may actually be less than benzodiazepines and barbiturates. So, why should we require MediCare participants to use prescription drugs that could cost more without offering any greater clinical benefit? I don't believe we should. Medicare participants deserve affordable access to the prescription medications that are best suited to treat their conditions.

Many of my colleagues may be wondering why these two classes of prescription drugs were excluded from the Medicare prescription drug program in the first place. They were excluded because of an inappropriate application of existing Medicaid law to the Medicare prescription drug program. The 1990 law that established the Medicaid prescription drug rebate program gave state Medicaid agencies the OPTION to exclude barbiturates and benzodiazepines from their drug formularies. Even though no states have excluded these medications from their Medicaid formularies, the Medicare law makes this exclusion MANDATORY for seniors and individuals with disabilities.

It is unfair to restrict access to prescribed medications that have been proven to be safe and effective in the treatment of mental illnesses and other conditions that commonly affect seniors and the disabled. That is why I am introducing this important piece of legislation today, and I urge my colleagues to support it.

We know that mental illness is treatable, and treatment can help people to live healthy, productive lives. Yet, our Nation's focus on mental health has continued to take a backseat to our focus on physical health even though the two are interrelated. We must act now to bring an end to the silent epidemic of mental illness in our country.

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. 2190

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 ''Medicare Mental Health Prescription Drug Access Act of 2007''.

SEC. 2. INCLUSION OF BARBITURATES AND BENZODIAZEPINES AS COVERED PART D DRUGS BEGINNING IN 2008.

Section 1860D–2(e)(2)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(2)(A)) is amended by inserting ''and, beginning in 2008, other than subparagraphs (I) (relating to barbiturates) and (J) (relating to benzodiazepines) of such section'' after ''agents)''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 349—HONORING VICE PRESIDENT ALBERT GORE, JR., AND THE INTERGOVERNMENTAL PANEL ON CLIMATE CHANGE FOR RECEIVING THE 2007 NOBEL PEACE PRIZE, IN RECOGNITION OF THEIR EFFORTS TO PROMOTE UNDERSTANDING OF THE THREATS POSED BY GLOBAL WARMING

Mr. REID (for himself, Mrs. BOXER, Mr. DURBIN, Mr. CARDIN, Mr. OBAMA, Mr. LEAHY, Mr. BIDEN, Mr. KENNEDY, Mr. WHITEHOUSE, Mr. HARKIN, Mr. SCHUMER, Mr. REED, Mr. DODD, Mrs. FEINSTEIN, Mr. KOHL, Mr. NELSON of Florida, Ms. MIKULSKI, Mr. LAUTENBERG, and Mr. CASEY) submitted the following resolution; which was considered and agreed to:

S. RES. 349

Whereas the Norwegian Nobel Committee selected Vice President Albert Arnold (Al) Gore, Jr., and the Intergovernmental Panel on Climate Change (IPCC) as Nobel Peace Prize Laureates for 2007, acknowledging them ''for their efforts to build up and disseminate greater knowledge about man-made climate change, and to lay the foundations for the measures that are needed to counteract such change'';

Whereas the Nobel Committee found that Vice President Gore ''became aware at an early stage of the climatic challenges the world is facing'', and that his ''strong commitment . . . has strengthened the struggle against climate change'';

Whereas the IPCC, according to the Nobel Committee, is composed of thousands of scientists and officials from more than 100 countries, has sponsored research and scientific collaboration over the last 2 decades and ''has created an ever-broader informed consensus about the connection between human activities and global warming: and

Whereas the Nobel Committee stated that Vice President Gore ''is probably the single individual who has done most to create greater worldwide understanding of the measures that need to be adopted'' to combat global warming, Now, therefore, be it

Resolved, That the Senate honors Vice President Albert Arnold Gore, Jr., and the Intergovernmental Panel on Climate Change for receiving the 2007 Nobel Peace Prize, in recognition of their longstanding efforts to promote understanding of the threats posed by global warming.

SENATE RESOLUTION 350—HONORING THE ACHIEVEMENTS OF MARIO R. CAPECCHI, SIR MARTIN J. EVANS, AND OLIVER SMITHIES, WINNERS OF THE 2007 NOBEL PRIZE IN PHYSIOLOGY OR MEDICINE

Mr. HATCH (for himself, Mr. BENNETT, Mrs. DOLE, and Mr. BURR) submitted the following resolution; which was considered and agreed to:

S. RES. 350

Whereas Mario R. Capecchi was born in Italy in 1937 and earned a PhD in biophysics from Harvard University in 1967;

Whereas Sir Martin J. Evans was born in Great Britain in 1941 and earned a PhD in anatomy and embryology from University College in London in 1969;

Whereas Oliver Smithies was born in Great Britain in 1925 and earned a PhD in biochemistry from Oxford University in 1951;

Whereas Mario Capecchi currently serves as Distinguished Professor of Human Genetics and Biology at the University of Utah School of Medicine;

Whereas Sir Martin J. Evans currently serves as the Professor of Mammalian Genetics and Director of the School of Biosciences at Cardiff University in Wales;

Whereas Oliver Smithies currently serves as an Excellence Professor of Pathology and Laboratory Medicine at the University of North Carolina at Chapel Hill;

Whereas Mario R. Capecchi, Sir Martin J. Evans, and Oliver Smithies have made a series of discoveries concerning embryonic