the program when a State court orders the employee to provide health insurance coverage for a child of the employee, but the employee fails to provide the coverage, and for other purposes (Rept. No. 106–492).

H.R. 3995: A bill to establish procedures governing the responsibilities of court-appointed receivers who administer departments, offices, and agencies of the District of Columbia government (Rept. No. 106–493).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

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

By Mr. BINGAMAN (for himself, Mr. DOMENICI, and Mr. CONRAD):

S. 3176. A bill to conduct a demonstration program to show that physician shortage, recruitment, and retention problems may be ameliorated in rural states by developing a comprehensive program that will result in statewide physician population growth; to the Committee on Finance.

By Mr. GRASSLEY (for himself, Mr. BREAUX, and Mr. REED):

S. 3177. A bill to require the Secretary of Health and Human Services to establish minimum nursing staff levels for nursing facilities, to provide for grants to improve the quality of care furnished in nursing facilities, and for other purposes; to the Committee on Finance.

By Mr. REID (for Mrs. FEINSTEIN (for herself, Mrs. BOXER, and Mr. AKAKA)):

S. 3178. A bill to amend title 5, United States Code, to provide that the mandatory separation age for Federal firefighters be made the same age that applies with respect to Federal law enforcement officers; to the Committee on Governmental Affairs.

By Mrs. LINCOLN (for herself and Mr. CLELAND):

S. 3179. A bill to promote recreation on Federal lakes, to require Federal agencies responsible for managing Federal lakes to pursue strategies for enhancing recreational experiences of the public, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. EDWARDS:

S. 3180. A bill to provide for the disclosure of the collection of information through computer software, and for other purposes; to the Committee on Commerce, Science, and Transportation.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. MOYNIHAN (for himself, Mr. BYRD, and Mr. SCHUMER):

S. Res. 368. A resolution to recognize the importance of relocating and renovating the Hamilton Grange, New York; to the Committee on Energy and Natural Resources.

By Mr. WARNER (for himself, Mr. INOUYE, Mr. THURMOND, and Mr. STEVENS):

S. Con. Res. 145. A concurrent resolution expressing the sense of Congress on the propriety and need for expeditious construction of the National World War II Memorial at the Rainbow Pool on the National Mall in the Nation's Capital; considered and agreed to.

By Mr. WELLSTONE (for himself and Mr. GRAMS):

S. Con. Res. 146. A concurrent resolution condemning the assassination of Father John Kaiser and others in Kenya, and calling for a thorough investigation to be conducted in those cases, a report on the progress made in such an investigation to be submitted to Congress by December 15, 2000, and a final report on such an investigation to be made public, and for other purposes; to the Committee on Foreign Relations.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

Mr. BINGAMAN (for himself, Mr. DOMENICI and Mr. CONRAD):

S. 3176. A bill to conduct a demonstration program to show that physician shortage, recruitment, and retention problems may be ameliorated in rural states by developing a comprehensive program that will result in statewide physician population growth; to the Committee on Finance.

RURAL STATES PHYSICIAN RECRUITMENT AND RETENTION DEMONSTRATION ACT OF 2000

Mr. BINGAMAN. Mr. President, I rise today with my colleague Senator DOMENICI of New Mexico to introduce legislation that is intended address a significant problem facing some rural states today—a serious shortage of physicians. The bills we are introducing are intended to demonstrate that physician shortages, and recruitment and retention problems can be ameliorated in some rural states by a multifaceted approach, including providing incentives for physicians in training to practice in areas where they are most likely to be needed.

The Council on Graduate Medical Education (COGME) has for some time held the position that the U.S., in the aggregate, has enough, if not too many, physicians. However, COGME's most recent report, published in March 1999, documented that almost half of the counties in our country are designated as Health Professional Shortage Areas—a remarkable finding, given almost three decades of Federal government efforts to address the geographic maldistribution of physicians.

In our State of New Mexico we have physician shortages that are worsening, with certain types of speciality physicians being in the shortest supply. According to 1998 data from the American Medical Association, New Mexico is 20 percent below the U.S. national average of 224 patient care physicians per 100,000 persons. In 15 New Mexico counties, there is no more than 1 physician or less per 1000 population, and 1 New Mexico county has no physician at all to care for its population.

And, Mr. President, New Mexico is not alone. Other rural states are also suffering.

A recent Health Care Finance Administration report showed that there has been a decline over the past 5 years in certain types of specialty physicians either practicing medicine or participating in the Medicare program in many rural states. The worst loss for New Mexico has occurred in thoracic surgery with a 35 percent decline. Several other specialities, such as urology, ophthalmology, and psychiatry, are not that far behind.

The only significant physician growth that can be seen is in primary care and that's still not adequate. With losses occurring in certain physician specialties, problems for all physicians' practices are continuing to worsen—they can't refer patients to specialists without great difficulty. For example, in New Mexico, there have been accounts of patients being referred to ear, nose and throat doctors having to wait up to 9 months for a non-emergency consultation. Without a timely in-state consultation, the patient's primary care physician may have to refer the patient to an out of state speciality physician for care. This is frustrating for the physician, and costly and time consuming for the patient.

As many of you know, New Mexico is one of the nation's poorest states, with a large uninsured population. In 1998, it ranked 48th in the amount of personal income per capita. For many physicians, this means they may never get paid for much of the work they do.

The physician shortage is becoming so severe in our state that last year the New Mexico Medical Society conducted a survey of our physicians to try to find out about how doctors are faring in the state. The response from New Mexico physicians was shocking—42 percent of the physicians surveyed said that they are seriously or somewhat seriously considering leaving their medical practice, and 40 percent said that reimbursement rates are a significant problem. Comments offered by physicians in this survey were very clear—''I make a good income, but to do that I have to work 65–70 hours a week, in, and week out. The reimbursement rates are such that I could move to a lot of nice places and maintain my income and work three-quarters as much. Family life is important.''

Almost weekly, New Mexico newspapers report about problems caused by provider shortages. On September 7th, the Albuquerque Journal carried a story about a women who had fallen, bruised her spinal cord, and rapidly developed paralysis of both hands and arms. She had to wait 18 hours to be seen on an emergency basis because of a critical shortage of neurosurgeons in Albuquerque, New Mexico's largest city. Stories like this one are becoming more and more common. There are many accounts of New Mexicans having to wait up to 9 months for an appointment to be seen by a specialist, and of newborns having to be transported out of state because the neonatal intensive care unit does not have adequate physician coverage.

My offices in Washington, DC, and New Mexico are constantly receiving letters and phone calls, and visits from constituents who want to tell us about physician shortages, physicians leaving the State of New Mexico, and the loss of their individual providers. They can't understand why this happening in a country with the greatest healthcare system in the world.

All of these problems clearly show that New Mexico's health care system

has broken down. However, it is not only New Mexico that is experiencing these problems. Other rural states are experiencing similar problems—they have become states that are being avoided by physicians entering practice. With the population in these states continuing to grow, the problem just gets worse. If this situation is not addressed right now, it will result in a complete breakdown of an already fragile health care delivery system.

This is why we are each introducing this package of legislation today. These two bills, the ''Rural States Physician Recruitment and Retention Demonstration Act of 2000, will together, when enacted, demonstrate that physician shortages and recruitment and retention problems can be ameliorated in rural states by instituting a comprehensive plan that provides for a proper physician speciality mix that will address the needs of a rural state's population.

My legislation will require the Secretary of the Department of Health and Human Services to establish a demonstration program that will:

Target up to a 15 percent increase in physician residency slots identified to be in short supply in demonstration states. These expanded residency slots would carry with them a legally binding commitment to practice in the demonstration state on a year of training for year of service basis.

Establish a loan repayment program to provide incentives for physicians in identified shortage specialities to locate their practices in demonstration states. This program will help physicians repay their educational loans on a year of service for a year of loan repayment basis in return for a commitment to practice in the demonstration state.

Develop a demonstration state health professional data base to capture and track the practice characteristics and distribution of licensed health care providers. This data will be used to develop a baseline and track changes in a demonstration state's health professions workforce, target this demonstration program to identified physician specialities and determine a state's need for other types of supportive health professionals.

Provide for an evaluation of each element of our comprehensive demonstration by the Council on Graduate Medical Education (COGME) for physician workforce issues, and by Medicare Payment Advisory Commission (Medpac) for Medicare reimbursement and Medicare funded graduate medical education positions.

As I mentioned earlier, one of the primary reason physicians report they are leaving New Mexico is because reimbursement is too low, particularly when combined with other factors like long work days, inability to recruit speciality physicians, and provide comprehensive patient care in a reasonable period of time.

That's why the second part of this package, the Physician Recruitment and Retention Act of 2000, consists of legislation that will provide physicians that are practicing in demonstration states with a special 5 percent Medicare part B reimbursement rate increase. This increase will provide a financial incentive to physicians to continue to practice in the underserved states and also to continue to participate in the Medicare program.

Both Senator DOMENICI and I anticipate that by the end of this demonstration program, physician shortages, particularly in specific physician specialities, will be greatly diminished or even have disappeared.

Mr. President, the health care system in New Mexico is near collapse for reasons too numerous and complex to get into here. These bills we are introducing today, in combination with the fixes we are making to the problems resulting from the BBA of 1997, may stave off disaster for a while. I certainly hope they will.

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

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

S. 3176

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Rural States Physician Recruitment and Retention Demonstration Act of 2000''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Definitions.
Sec. 3. Rural States Physician Recruitment and Retention Demonstration Program.
Sec. 4. Establishment of the Health Professions Database.
Sec. 5. Evaluation and reports.
Sec. 6. Contracting flexibility.

SEC. 2. DEFINITIONS.

In this Act:

(1) COGME.—The term ''COGME'' means the Council on Graduate Medical Education established under section 762 of the Public Health Service Act (42 U.S.C. 294o).

(2) DEMONSTRATION PROGRAM.—The term ''demonstration program'' means the Rural States Physician Recruitment and Retention Demonstration Program established by the Secretary under section 3(a).

(3) DEMONSTRATION STATES.—The term ''demonstration States'' means the 2 States selected by the Secretary that, based upon 1998 data, have—

(A) an uninsured population above 20 percent (as determined by the Bureau of the Census);

(B) a population eligible for medical assistance under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) above 17 percent (as determined by the Health Care Financing Administration);

(C) an unemployment rate above 4.8 percent (as determined by the Bureau of Labor Statistics);

(D) an average per capita income below $21,200 (as determined by the Bureau of Economic Analysis); and

(E) a geographic practice cost indices component of the reimbursement rate for physicians under the medicare program that is below the national average (as determined by the Health Care Financing Administration).

(4) ELIGIBLE RESIDENCY OR FELLOWSHIP GRADUATE.—The term ''eligible residency or fellowship graduate'' means a graduate of an approved medical residency training program (as defined in section 1886(h)(5)(A) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(A))) in a shortage physician specialty.

(5) HEALTH PROFESSIONS DATABASE.—The term ''Health Professions Database'' means the database established under section 4(a).

(6) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(7) MEDPAC.—The term ''MedPAC'' means the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

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

(9) SHORTAGE PHYSICIAN SPECIALTIES.—The term ''shortage physician specialty'' means a medical or surgical specialty identified in a demonstration State by the Secretary based on—

(A) an analysis and comparison of National data and demonstration State data; and

(B) recommendations from appropriate Federal, State, and private commissions, centers, councils, medical and surgical physician specialty boards, and medical societies or associations involved in physician workforce, education and training, and payment issues.

SEC. 3. RURAL STATES PHYSICIAN RECRUITMENT AND RETENTION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a Rural States Physician Recruitment and Retention Demonstration Program for the purpose of ameliorating physician shortage, recruitment, and retention problems in rural states in accordance with the requirements of this section.

(2) CONSULTATION.—For purposes of establishing the demonstration program, the Secretary shall consult with—

(A) COGME;

(B) MedPAC;

(C) a representative of each demonstration State medical society or association;

(D) the health workforce planning and physician training authority of each demonstration State; and

(E) any other entity described in section 2(9)(B).

(b) DURATION.—The Secretary shall conduct the demonstration program for a period of 10 years.

(c) CONDUCT OF PROGRAM.—

(1) FUNDING OF ADDITIONAL RESIDENCY AND FELLOWSHIP POSITIONS.—

(A) IN GENERAL.—As part of the demonstration program, the Secretary (acting through the Administrator of the Health Care Financing Administration) shall—

(i) waive any limitation under section 1886 of the Social Security Act (42 U.S.C. 1395ww) with respect to the number of residency and fellowship positions;

(ii) increase by up to 15 percent of the total number residency and fellowship positions approved at each medical residency training program in each demonstration State the number of residency and fellowships in each shortage physician specialty; and

(iii) subject to subparagraph (C), provide funding for such additional positions under subsections (d)(5)(B) and (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(B) ESTABLISHMENT OF ADDITIONAL POSITIONS.—

(i) IDENTIFICATION.—The Secretary shall identify each additional residency and fellowship position created as a result of the application of subparagraph (A).

(ii) NEGOTIATION AND CONSULTATION.—The Secretary shall negotiate and consult with representatives of each approved medical residency training program in a demonstration State at which a position identified under clause (i) is created for purposes of supporting such position.

(C) CONTRACTS WITH RESIDENTS AND FELLOWS.—

(i) IN GENERAL.—The Secretary shall condition the availability of funding for each residency and fellowship position identified under subparagraph (B)(i) on the execution of a contract containing the provisions described in clause (ii) by each individual accepting such a residency or fellowship position.

(ii) PROVISIONS DESCRIBED.—The provisions described in this clause provide that, upon completion of the residency or fellowship, the individual completing such residency or fellowship will practice in the demonstration State in which such residency or fellowship was completed that is designated by the contract for 1 year for each year of training under the residency or fellowship in the demonstration State.

(iii) CONSTRUCTION.—The period that the individual practices in the area designated by the contract shall be in addition to any period that such individual practices in an area designated under a contract executed pursuant to paragraph (2)(C).

(D) LIMITATIONS.—

(i) PERIOD OF PAYMENT.—The Secretary may not fund any residency of fellowship position identified under subparagraph (B)(i) for a period of more than 5 years.

(ii) PHASE-OUT OF PROGRAM.—The Secretary may not enter into any contract under subparagraph (C) after the date that is 5 years after the date on which the Secretary establishes the demonstration program.

(2) LOAN REPAYMENT AND FORGIVENESS PROGRAM.—

(A) IN GENERAL.—As part of the demonstration program, the Secretary (acting through the Administrator of Health Resources and Services Administration) shall establish a loan repayment and forgiveness program, through the holder of the loan, under which the Secretary assumes the obligation to repay a qualified loan amount for an educational loan of an eligible residency or fellowship graduate—

(i) for which the Secretary has approved an application submitted under subparagraph (D); and

(ii) with which the Secretary has entered into a contract under subparagraph (C).

(B) QUALIFIED LOAN AMOUNT.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary shall repay not more than $25,000 per graduate per year of the loan obligation on a loan that is outstanding during the period that the eligible residency or fellowship graduate practices in the area designated by the contract entered into under subparagraph (C).

(ii) LIMITATION.—The aggregate amount under this subparagraph shall not exceed $125,000 for any graduate and the Secretary may not repay or forgive more than 30 loans per year in each demonstration State under this paragraph.

(C) CONTRACTS WITH RESIDENTS AND FELLOWS.—

(i) IN GENERAL.—Each eligible residency or fellowship graduate desiring repayment of a loan under this paragraph shall execute a contract containing the provisions described in clause (ii).

(ii) PROVISIONS.—The provisions described in this clause are provisions that require the eligible residency or fellowship graduate to practice in a demonstration State during the period in which a loan is being repaid or forgiven under this section.

(D) APPLICATION.—

(i) IN GENERAL.—Each eligible residency or fellowship graduate desiring repayment of a loan under this paragraph shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

(ii) PHASE-OUT OF LOAN REPAYMENT AND FORGIVENESS PROGRAM.—The Secretary may not accept an application for repayment of any loan under this paragraph after the date that is 5 years after the date on which the demonstration program is established.

(E) CONSTRUCTION.—Nothing in the section shall be construed to authorize any refunding of any repayment of a loan.

(F) PREVENTION OF DOUBLE BENEFITS.—No borrower may, for the same service, receive a benefit under both this paragraph and any loan repayment or forgiveness program under title VII of the Public Health Service Act (42 U.S.C. 292 et seq.).

(d) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary is authorized to waive any requirement of the medicare program, or approve equivalent or alternative ways of meeting such a requirement, if such waiver is necessary to carry out the demonstration program, including the waiver of any limitation on the amount of payment or number of residents under section 1886 of the Social Security Act (42 U.S.C. 1395ww).

(e) APPROPRIATIONS.—

(1) FUNDING OF ADDITIONAL RESIDENCY AND FELLOWSHIP POSITIONS.—Any expenditures resulting from the establishment of the funding of additional residency and fellowship positions under subsection (c)(1) shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i).

(2) LOAN REPAYMENT AND FORGIVENESS PROGRAM.—There are authorized to be appropriated such sums as may be necessary to carry out the loan repayment and forgiveness program established under subsection (c)(2).

SEC. 4. ESTABLISHMENT OF THE HEALTH PROFESSIONS DATABASE.

(a) ESTABLISHMENT OF THE HEALTH PROFESSIONS DATABASE.—

(1) IN GENERAL.—Not later than 7 months after the date of enactment of this Act, the Secretary (acting through the Administrator of Health Resources and Services Administration) shall establish a State-specific health professions database to track health professionals in each demonstration State with respect to specialty certifications, practice characteristics, professional licensure, practice types, locations, education, training, as well as obligations under the demonstration program as a result of the execution of a contract under paragraph (1)(C) or (2)(C) of section 3(c).

(2) DATA SOURCES.—In establishing the Health Professions Database, the Secretary shall use the latest available data from existing health workforce files, including the AMA Master File, State databases, specialty medical society data sources and information, and such other data points as may be recommended by COGME, MedPAC, the National Center for Workforce Information and Analysis, or the medical society of the respective demonstration State.

(b) AVAILABILITY.—

(1) DURING THE PROGRAM.—During the demonstration program, data from the Health Professions Database shall be made available to the Secretary, each demonstration State, and the public for the purposes of—

(A) developing a baseline and to track changes in a demonstration State's health professions workforce;

(B) tracking direct and indirect graduate medical education payments to hospitals;

(C) tracking the forgiveness and repayment of loans for educating physicians; and

(D) tracking commitments by physicians under the demonstration program.

(2) FOLLOWING THE PROGRAM.—Following the termination of the demonstration program, a demonstration State may elect to maintain the Health Professions Database for such State at its expense.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purpose of carrying out this section.

SEC. 5. EVALUATION AND REPORTS.

(a) EVALUATION.—

(1) IN GENERAL.—COGME and MedPAC shall jointly conduct a comprehensive evaluation of the demonstration program established under section 3.

(2) MATTERS EVALUATED.—The evaluation conducted under paragraph (1) shall include an analysis of the effectiveness of the funding of additional residency and fellowship positions and the loan repayment and forgiveness program on physician recruitment, retention, and specialty mix in each demonstration State.

(b) PROGRESS REPORTS.—

(1) COGME.—COGME shall submit a report on the progress of the demonstration program to the Secretary and Congress 1 year after the date on which the Secretary establishes the demonstration program, 5 years after such date, and 10 years after such date.

(2) MEDPAC.—MedPAC shall submit biennial reports on the progress of the demonstration program to the Secretary and Congress.

(c) FINAL REPORT.—Not later than 1 year after the date on which the demonstration program terminates, COGME and MedPAC shall submit a final report to the President, Congress, and the Secretary which shall contain a detailed statement of the findings and conclusions of COGME and MedPAC, together with such recommendations for such legislation and administrative actions as COGME and MedPAC consider appropriate.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to COGME such sums as may be necessary for the purpose of carrying out this section.

SEC. 6. CONTRACTING FLEXIBILITY.

For purposes of conducting the demonstration program and establishing and administering the Health Professions Database, the Secretary may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

By Mr. GRASSLEY (for himself, Mr. BREAUX, and Mr. REED):

S. 3177. A bill to require the Secretary of Health and Human Services to establish minimum nursing staff levels for nursing facilities, to provide for grants to improve the quality of care furnished in nursing facilities, and for other purposes; to the Committee on Finance.

NURSING HOME STAFF IMPROVEMENT ACT OF 2000

Mr. GRASSLEY. Mr. President, I am pleased to have the support of Senator BREAUX in introducing The Nursing Home Staff Improvement Act of 2000. This is an important piece of legislation for the 1.6 million frail elderly Americans who reside in nursing homes across the nation.

A recently released and long overdue report from the Health Care Financing

Administration was the immediate impetus for our bill. This report was first mandated by Congress in 1990. It took the Department of Health and Human Services 10 years to complete Part I of the report. It will take almost another year to finish it. The first part of the study documented, to just about everyone's satisfaction, severe staffing shortages, severe staffing shortages in our nation's nursing homes. While we are waiting for the agency to complete the second and final part of the report, Senate BREAUX and I want to begin to address the staffing crisis in long-term care. Therefore, we are introducing this legislation today.

We have a long way to go in meeting the staffing needs of elderly nursing home residents. The bill we are introducing today is not the answer to the problem. It is only a first step. Yet, it is an extremely important step that Congress should take.

Before describing the bill Senator BREAUX and I are introducing today, I'd like to take a couple of minutes to go over the history of our committee's work on nursing home quality of care and HCFA oversight of the Nursing Home Reform Act of 1987. It's important for me to emphasize the scope and depth of the problem in order to give my fellow Senators an appreciation of the context out of which this legislation developed.

In the fall of 1997, serious allegations were brought to my attention about the quality of care provided in California nursing homes. These allegations claimed that thousands of California nursing home residents had suffered and met with untimely and unnecessary deaths due to malnutrition, dehydration, decubitus ulcers, and urinary tract infections.

In an effort to respond to these allegations, I asked the General Accounting Office [GAO] to conduct a thorough review of them and, more generally, of the quality of care in California nursing homes.

This review culminated in a 2-day hearing held on July 27–28, 1998, entitled ''Betrayal: The Quality of Care in California Nursing Homes.'' At this hearing, the GAO released its report titled ''California Nursing Homes: Care Problems Persist Despite Federal and State Oversight.'' The findings of this report were explosive and disturbing, illustrating that residents in far too many California nursing homes were threatened by seriously substandard care.

One week prior to this hearing, the Clinton administration announced a broad set of new nursing home initiatives to improve enforcement of the Nursing Home Reform Act and, hence, the quality of care in nursing facilities. The administration was acting in response to the impending release of the GAO's study before the scheduled Aging Committee hearing. It acted also in response to a congressionally mandated report by the Department of Health and Human Services on nursing home oversight that was completed just before the hearing. The Department's report uncovered weaknesses on the part of the federal government in its oversight of nursing home quality of care. As the Federal agency with regulatory oversight responsibility over our Nation's nursing homes, the Health Care Financing Administration [HCFA] is responsible for monitoring the compliance of nursing home facilities in meeting the requirements of the Nursing Home Reform Act. For facilities found to be noncompliant, HCFA is responsible for seeing that remedies or sanctions are imposed until the situation is corrected. The administration's report found shortcomings in HCFA's enforcement of the Nursing Home Reform Act of 1987. The agency's report was really a kind of self-indictment. Up to that point, the agency had failed in its responsibility to protect nursing home residents.

As part of its multistep initiative, the administration called for improvements in nursing home inspections, better and more timely enforcement against nursing homes that repeatedly violate safety rules, and more attention to quality of care for nursing home residents through prevention of bed sores, malnutrition and dehydration. HCFA was given the responsibility for carrying out this initiative. Under my chairmanship, the Senate Special Committee on Aging has taken an active role in overseeing the implementation of the President's nursing home initiative led by the Administrator of HCFA. At regular hearings and forums, 10 to be specific, I have heard from family members, health care professionals and other long-term care experts about the progress and obstacles in achieving improved nursing home quality of care.

Anecdotally, we have heard from the very beginning of our work on nursing home quality of care that understaffing is a root cause of many of the problems facing nursing home residents. Because we desperately needed a more systematic, research-based analysis of this understaffing problem, I had persistently urged HCFA to finish the long delayed staffing report I mentioned earlier.

On July 27, 2000, Part I of the report, entitled ''Appropriateness of Minimum Staffing Ratios in Nursing Homes'' was done, and our committee held a hearing to take testimony on it. The report and the hearing presented groundbreaking new information on nursing facility staffing. It was the first time that understaffing, and the consequences of understaffing, were described by a scientifically sound government report. Although a Part II of the report will be required to completely validate the findings of Part I and to analyze a number of other questions raised by Part I, the report showed for the first time what family members and resident advocates had been saying for years: that the majority of nursing homes in our country are dramatically understaffed. Specifically, the report concluded that more than half of nursing facilities around the country employ too few nurses and nurse aides to provide adequate care to residents.

As a result of these report findings, I began working on legislation to address the serious problems of understaffing. I started by seeking input from interested parties, including the Administration, nursing home providers, health care professionals, and resident advocates. I finalized my proposal right around the same time the President announced the administration's initiative in this area. The two proposals are similar in their goal to start addressing the problems of understaffing in nursing facilities.

As I said earlier, the impetus for my bill was the Report to Congress on the ''Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes''. The major conclusions of the report are outlined in the Findings section of our bill. The report found that 2.0 nurse aide hours per resident day is a threshold below which residents' lives are at risk, not a standard for the provision of appropriate care. The findings also showed that 2.9 nurse aide hours per resident day are necessary for a nurse aide to complete core resident care tasks, although, because of the very conservative estimates used in this part of the study, 2.9 hours probably significantly understates the staffing levels necessary for a nurse aide to complete these core tasks. Part I of the report also indicated that Part II will analyze and report on minimum staffing levels according to a facility's resident acuity level. I urge Congress and the Administration to be careful in accepting either the 2.0 or 2.9 nurse aide hours per resident day as a minimum goal for nursing facilities until these results are validated and case-mix is included in the equation. It is reasonable to expect that staffing requirements will be substantially higher for facilities that have residents with higher acuity.

Our bill calls for the completion of phase two of the study. It requires the Secretary to complete the report not later than July 1, 2001. It adds to the original authority a requirement that the study undertake several tasks that Part I of the report stated would be done in the second phase. Among other things, these tasks include a requirement that the case mix analysis of Part I of the report be further refined and related to appropriate minimum staffing levels. It also adds to the original authority a requirement that the report analyze ''optimal minimum'' caregiver to resident levels and ''optimal minimum'' supervisor to caregiver levels of skilled nursing facilities participating in the Medicare program and nursing facilities participating in the Medicaid program. We modified the original authority in this manner because we believed the public should know not just appropriate minimum

staffing levels, but also what more optimal staffing levels should be in nursing facilities.

My bill requires that minimum staffing levels be developed and enforced within one year of the completion of the Report. It requires the Secretary to make recommendations regarding appropriate minimum caregiver to resident levels and minimum supervisor to caregiver levels for skilled nursing facilities participating in the Medicare program and nursing facilities participating in the Medicaid program. The Secretary further shall require through the administrative rulemaking process compliance with appropriate minimum staffing levels as a condition for such facilities to receive payment under those programs. The Secretary would be required to promulgate a final rule not later than one year after completion of the report.

The bill requires that the Secretary establish appropriate minimum staffing levels because we believed that a regulatory requirement should establish those staffing levels that will assure that residents receive the quality of care they have a right to receive under the terms of the Nursing Home Reform Act of 1987. We assume that the resident case mix of a facility will have an effect on the appropriate minimum staffing levels of the facility.

In order to help States prepare for the minimum staffing levels that the Secretary will promulgate by July 1, 2002, my bill establishes a competitive state grant program. The purpose of the grant program will be to improve staffing levels in nursing facilities in order to improve the quality of care to residents of such facilities. A state that secures such a grant may provide technical or financial support to nursing facilities, labor organizations, nonprofit organizations, community colleges, or other organizations approved by the Secretary. Such support from the state shall be used for projects which will help to increase or improve recruitment and retention of direct care nursing staff. Projects supported by a state must be consistent with the requirements of sections 1818 and 1919 of the Social Security Act. No funds may be made available to county or state-owned nursing facilities. Funds used under a grant to a state may only be used to supplement, not supplant, other funds that the state extends to carry out the activities that may be supported by this grant program. The Secretary shall evaluate this grant program and report to the Congress on her findings not later than six months after completion of the grant program. Authorized to be appropriated are $500,000,000 for each of fiscal years 2001 and 2002.

My bill includes a requirement for reporting of accurate information on staffing. Skilled nursing facilities participating in the Medicare program and nursing facilities participating in the Medicaid program would be required to submit staffing information to the Secretary in a form and manner determined by the Secretary. Such information must be attested to as accurate by the reporting facility. The Secretary shall periodically post and update such information on the Nursing Home Compare web site. Skilled nursing facilities participating in the Medicare program and nursing facilities participating in the Medicaid program shall submit to the Secretary a classification of all residents of the facility according to the resident classification system required under current law. My understanding is that nursing facilities should have data on hand and in a form that would be required by the Secretary for reporting to the Department, and, thus, the administrative burden of this requirement should be minimal.

My bill includes a requirement for posting of facility staffing information. Facilities participating in the Medicare and Medicaid program would be required to post daily for each nursing unit and each work shift the current number of licensed and unlicensed nursing staff directly responsible for resident care together with the number of residents per unit and shift.

Throughout my work and oversight activity of nursing facility quality of care, I have made it a point to stress that there are many good nursing facilities. When a family is in need of a facility for a loved one, it is critically important that individuals shop around and gather information in order to find the best nursing home to meet the needs of their loved ones. The provision in my bill calling for additional reporting of staffing and facility posting of staffing data will help families which need to find a good facility for a loved one's placement. It should also eventually have an effect on the overall quality of care in nursing facilities as families search out and choose better facilities.

The information collected by HCFA will help it improve and maintain its Nursing Home Compare web site. This is a database which contains information on every Medicare and Medicaid certified nursing home in the country. You can locate nursing homes in your area and find information about compliance with Medicare and Medicaid regulations based on the facility's most recent survey by state inspectors. Additionally, the web site contains useful phone numbers for survey agencies and long term care ombudsmen on the web site's ''Phone Directory'' page.

In closing, I plan to continue my work to improve quality of care and quality of life for nursing home residents. In my position as Chairman of the Special Committee on Aging, I will continue to monitor the quality of care provided to our nation's nursing home residents. With the assistance of the GAO, I will continually assess and monitor the Health Care Financing Administration's progress and commitment to improving the quality of care in nursing homes.

Mr. BREAUX. Mr. President, I rise today as ranking member of the Special Committee on Aging and am proud to inform you that after the culmination of years of investigation and attention to the relationship between nursing home staff levels and quality of care, today Senator GRASSLEY—my colleague on the Committee—and I are introducing legislation on this important issue. Our ''Nursing Facility Staff Improvement Act of 2000'' would encourage increased quantities of staff but also would improve the quality of those caring for our loved ones in nursing homes.

Chairman GRASSLEY and I have been committed to ensuring that our seniors are getting the best quality care possible in our nation's nursing homes, and the Aging Committee has held numerous hearings regarding the best way to reach this goal. We have been working with HCFA to determine the best way to ensure state surveyors are appropriately monitoring the quality of care their residents receive. Additionally, we held a hearing to learn from industry representatives about the links between nursing home bankruptcies and quality care. And we have continually and consistently sent the message that we will remain involved and committed to improvement for as long as it takes.

The bill we introduce today—the Nursing Facility Staff Improvement Act of 2000—is the result of bipartisan efforts to put something on the books that will not only provide real incentives for nursing home staff to strive to do their jobs well but will also be a huge step toward defining what optional nursing home care should entail. I commend President Clinton for building on the Aging Committee's findings and making this very important issue one of his priorities.

More specifically, this bill will:

Call for the Secretary of HHS to establish a competitive grant program to the states to increase or improve the recruitment and retention of direct care nursing staff. Provide for $1 billion over two years. Require that HCFA complete Phase II of their Nursing Home Staffing study and report back not later than July 1, 2001. Appropriate use of grant monies would include: establishing career ladders for nurse aides; improving nursing management; providing additional training programs for staff.

In conclusion, it is exciting for me to put forth a piece of legislation that offers tangible incentives to current and future staff and also directly encourages appropriate nursing home care for our loved ones. This effort has truly been one of joint cooperation between my Republican colleague on the Aging Committee and myself and I am proud to introduce it to you today.

Mr. REED. Mr. President, I rise today to join my colleague from Iowa, the Chairman of the Special Senate Committee on Aging, to introduce legislation that we hope will begin to address an immediate and critical labor

shortage facing nursing home facilities across the nation as well as the long term objective of establishing nursing home staffing thresholds.

In late July, the Health Care Financing Administration, HCFA, released the first phase of its long awaited report on the feasibility and appropriateness of minimum nursing home staffing ratios. The initial phase of this report explored the relationship between staffing levels and quality of care. The HCFA study found a strong correlation between certain staffing thresholds and the quality of care provided to nursing home residents. The report also found that nursing homes are having great difficulty in recruiting and retaining qualified staff to work in their facilities. Clearly, we can and should be doing more to ensure that the care of our elderly and disabled is not being placed at risk.

In my home state of Rhode Island, we have been dealing with a critical shortage in the number of Certified Nursing Assistants, CNAs, in particular. CNAs provide direct care in a skilled nursing setting to residents who need help with essential daily living tasks, such as dressing, feeding and bathing. A state task force comprised of long term care providers and nursing home consumer advocates found that over 26,000 individuals were licensed as CNAs, but only 14,000 are currently working in the field. The task force also found that the turnover rate for CNAs rose to an unprecedented 82.6 percent in 1999.

The two most important issues identified in the state report were wages and adequate staffing levels. In terms of wages, a person in my state can make more in starting salary as a hotel maid in Providence ($9.50/hour) than they would as a licensed CNA ($7.69/hour). Those individuals who have dedicated their careers to caring for our most vulnerable citizens certainly deserve better and the legislation we are introducing today will help to restore respect and dignity to the caregiver profession.

The Nursing Home Staff Improvement Act will address these problems in essentially two ways. First, the legislation requires the Secretary of Health and Human Services to complete the second phase of the nursing home staffing report by July 2001. The Secretary will then be called upon to use the findings and recommendations of the final report to develop appropriate caregiver to resident and supervisor to caregiver ratios for nursing facilities that participate in the Medicare and Medicaid programs. The second major component of the bill is the establishment of a grant program to States for the purpose of augmenting staffing levels. This provision, which is based on a initiative announced by President Clinton in mid-September, will support projects aimed at improving the recruitment and retention of direct nursing staff. The bill also requires nursing homes to post, on a daily basis, the number of staff and residents at the facility as well as submit staffing information to the Secretary.

As a member of the Special Senate Committee on Aging, I am pleased to be an original cosponsor of the Nursing Home Staff Improvement Act, a balanced piece of legislation that I believe will go a long way in stabilizing nursing home staffing levels nationwide. I look forward to working with Senator GRASSLEY and my other colleagues to enact this important legislation.

By Mrs. LINCOLN (for herself and Mr. CLELAND):

S. 3179. A bill to promote recreation on Federal lakes, to require Federal agencies responsible for managing Federal lakes to pursue strategies for enhancing recreational experiences of the public, and for other purposes; to the Committee on Energy and Natural Resources.

RECREATION LAKES ACT OF 2000

Mrs. LINCOLN. Mr. President, I rise today to introduce the Recreation Lakes Act of 2000—a bill that will recognize the benefits and value of recreation at federal lakes and give recreation a seat at the table in the management decisions of all our federal lakes. I am proud to be joined in this effort today by Senator CLELAND.

Recreation on our federal lakes has become a powerful tourist magnet, attracting some 900 million visitors annually and generating an estimated $44 billion in economic activity—mostly spent on privately-provided goods and services. And by the middle of this century, our federal lakes are expected to host nearly two billion visitors per year.

Yet, even with the millions of visitors each year to our lakes and reservoirs, recreation has suffered from a lack of unifying policy direction and leadership, as well as insufficient interagency and intergovernmental planning and coordination. Most federal agencies are focused on the traditional functions of man-made lakes and reservoirs; flood control, hydroelectric power, water supply, irrigation, and navigation. And often recreation is left out of the decision process.

Mr. President, this legislation will reaffirm that recreation is also an authorized purpose at almost all federal lakes and direct the agencies managing these projects to take action to reemphasize recreation programs in their management plans. This legislation will emphasis partnerships between the federal government, local governments, and private groups to promote responsible recreation on all our federal lakes.

It will establish a National Recreational Lakes Demonstration Program, comprised of up to 20 lakes across the nation. At each of these federal lakes, the managing agency will be empowered to develop creative agreements with private sector recreation providers as well as state land agencies to enhance recreation opportunities. Rather than just building new federal campgrounds with tax dollars, we need to create new partnerships to provide support for building recreation infrastructure that is in line with visitor and tourist desires for recreation. The National Recreation Lakes Demonstration Program will be a pilot project to test these creative agreements and management techniques on a small scale to demonstrate their effectiveness at promoting recreation on federal lakes.

Second, this legislation will establish a Federal Recreation Lakes Leadership Council to coordinate the National Recreation Lakes Demonstration Program and coordinate efforts among federal agencies to promote recreation on federal lakes.

It also will include the Bureau of Reclamation and the U.S. Army Corps of Engineers in the Recreation Fee Demonstration Program. The Fee Demo Program has had wide successes in Arkansas and across the country in allowing individual parks and recreation areas to keep more of their fee revenues on-site to reduce the often overwhelming maintenance backlog.

The legislation will also provide for periodic review of the management of recreation at federal water projects—something long overdue. A great deal has changed since many of the water projects were authorized, yet the initial legislative direction from over 70 years ago continues to be the basis for the management practices now in the year 2000—and that is not right.

Finally, the legislation will provide new opportunities to link the national recreation lakes initiative with other federal recreation assistance efforts, including the Wallop-Breaux program for boating and fishing.

Mr. President, let me give you a little background on how this legislation was developed. In 1996, the U.S. Senate recognized that recreation was becoming more important on federal lakes and conceived the National Recreation Lakes Study Commission to review the current and anticipated demand for recreational opportunities on federally managed lakes and reservoirs. The National Recreation Lakes Study Commission was charged to ''review the current and anticipated demand for recreational opportunities at federally-managed man-made lakes and reservoirs'' and ''to develop alternatives for enhanced recreational use of such facilities.''

The Commission released its long-awaited report confirming the impact of recreation on federally-managed, man-made lakes in June of last year. The Commission also recognized that we are far from realizing their full potential. The study documented that these lakes are powerful tourist magnets, attracting some 900 million visitors annually and generating an estimated $44 billion in economic activity—mostly spent on privately-provided goods and services.

During the Energy and Natural Resources Committee's hearing last year

on the Recreation Lakes Study, the Chairman and I spent some time discussing how children today do not take full advantage of the outdoor opportunities that are available to them. It is so important that we encourage our children to enjoy the great outdoors that often times is less than an hour's drive away.

As the mother of twin 4-year-old boys, I feel we need to encourage our children to be children, not to become adults too quickly, to learn how to enjoy the outdoors. The only way we can do that is by exposing them to it early and often.

In this nation we have nearly 1,800 federally-managed lakes and reservoirs. There are 38 in my home state of Arkansas. With so many federal lakes spread throughout the country, there's no reason why we shouldn't do all we can to promote recreation on our federal lakes. I know that in Arkansas, we don't think twice about getting away to the lake for the weekend to go boating or fishing, or to just get away from the day-to-day grind. And that doesn't even begin to get into the tremendous economic impact from recreation on our federal lakes.

Mr. President, this bill is not an attempt to completely rewrite how federal lakes in this country are managed or to put recreation in front of all other authorized purposes at federal lakes.

The Recreation Lakes Act of 2000 will work with all current laws and regulations to ensure that recreation is merely given a seat at the table when the management decisions are made for our federal lakes.

Mr. President, this is a good bill. In everything from the creation of jobs to the money that tourists like myself spend at the marinas and local stores surrounding the lake—our Federal lakes and reservoirs have an immense recreational value that can and does bring revenues into our local economies. The best way to encourage and expand this aspect is to ensure that recreation is given a higher priority in the management of our federal lakes.

I encourage my colleagues to support this legislation and look forward to the debate on how we can promote recreation on our federal lakes.

By Mr. EDWARDS:

S. 3180. A bill to provide for the disclosure of the collection of information through computer software, and for other purposes; to the Committee on Commerce, Science, and Transportation.

THE SPYWARE CONTROL AND PRIVACY PROTECTION ACT

Mr. EDWARDS. Mr. President, how would you feel if someone was eavesdropping on your private phone conversations without your knowledge? Well, if it happened to me, I would be very disturbed. And I think that most Americans would be very disturbed to know that something similar may be happening every time they use their computers.

The shocking fact is that many software programs contain something called spyware. Spyware is computer code that surreptitiously uses our Internet connection to transmit information about things like our purchasing patterns and our health and financial status. This information is collected without our knowledge or explicit permission and the spyware programs run undetected while you surf the Internet.

Spyware has been found in Quicken software, which is manufactured by Intuit, Inc. So let me use this as an example. Imagine you purchase Quicken software or download it from the Internet. You install it on your computer to help you with your finances. However, unbeknownst to you, Quicken does more than install financial planning tools on your computer. It also installs a little piece of spyware. The spyware lies dormant until one day when you get on the Internet.

As you start surfing the Internet, the spyware sends back information to Intuit about what you buy and what you are interested in. And all of this happens without your knowledge. You could be on Amazon.com or researching health issues and at the very same time Intuit spyware is using your Internet connection, transmitting some of your most private data to someone you never heard of.

In the months since it was reported that Quicken contained spyware, the folks at Intuit may have decided to remove the spyware from Quicken. However, Quicken is not the only software program that may contain spyware. One computer expert recently found spyware programs in popular children's software that is designed to help them learn, such as Mattel Interactive's Reader Rabbit and Arthur's Thinking Games. And, according to another expert's assessment, spyware is present in four hundred software programs, including commonly used software such as RealNetworks RealDownload, Netscape/AOL Smart Download, and NetZip Download Demon. Spyware in these software programs can transmit information about every file you download from the Internet.

I rise today to introduce the Spyware Control and Privacy Protection Act of 2000. I believe that this legislation will help Americans regain some control over their personal information and will help stop the loss of their privacy and the privacy of their families.

My proposal is common-sense and simple. It incorporates all four fair information practices of notice, choice, access and security—practices that I believe are essential to effective computer privacy legislation.

First, the Act requires that any software that contains spyware must provide consumers with clear and conspicuous notice—at the time the software is installed—that the software contains spyware. The notice must also describe the information that the spyware will collect and indicate to whom it will be transmitted.

Another critical provision of my bill requires that software users must first give their affirmative consent before the spyware is enabled and allowed to start obtaining and sharing users' personal information with third parties. In other words, software users must ''opt-in'' to the collection and transmission of their information. My bill gives software users a choice whether they will allow the spyware to collect and share their information.

The Spyware Control and Privacy Protection Act allows for some common-sense exceptions to the notice and opt-in requirements. Under my proposal, software users would not have to receive notice and give their permission to enable the spyware if the software user's information is gathered in order to provide technical support for use of the software. In addition, users' information may be collected if it is necessary to determine if they are licensed users of the software. And finally, the legislation would not apply to situations where employers are using spyware to monitor Internet usage by their employees. I believe that this last issue is a serious one and deserves to be addressed in separate legislation.

Another important aspect of the Spyware Control and Privacy Protection Act is that it would incorporate the fair information practice known as ''access.'' What this means is that an individual software user would have the ability to find out what information has been collected about them, and would be given a reasonable chance to correct any errors.

And finally, the fourth fair information practice guaranteed by my bill is ''security.'' Anyone that uses spyware to collect information about software users must establish procedures to keep that information confidential and safe from hackers.

Spyware is a modern day Trojan horse. You install software on your computer thinking it's designed to help you, and it turns out that something else is hidden inside that may be quite harmful.

I have been closely following the privacy debate for some time now. And I am struck by how often I discover new ways in which our privacy is being eroded. Spyware is among the more startling examples of how this erosion is occurring.

Most people would agree that modern technology has been extraordinarily beneficial. It has enabled us to obtain information more quickly and easily than ever before. And companies have streamlined their processes for providing goods and services.

But these remarkable developments can have a startling downside. They have made it easier to track personal information such as medical and financial records, and buying habits. In