

depredate and ill-conceived policies by the United States Government regarding Indian tribes and offer an apology to all Native Peoples on behalf of the United States.

S. RES. 124

At the request of Mr. HAGEL, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. Res. 124, a resolution recognizing the importance of increasing awareness of autism spectrum disorders, supporting programs for increased research and improved treatment of autism, and improving training and support for individuals with autism and those who care for individuals with autism.

AMENDMENT NO. 595

At the request of Mr. OBAMA, the names of the Senator from Indiana (Mr. LUGAR), the Senator from Colorado (Mr. SALAZAR), the Senator from Iowa (Mr. HARKIN), the Senator from Indiana (Mr. BAYH), the Senator from Illinois (Mr. DURBIN), the Senator from Minnesota (Mr. COLEMAN), the Senator from Missouri (Mr. TALENT) and the Senator from Minnesota (Mr. DAYTON) were added as cosponsors of amendment No. 595 intended to be proposed to H.R. 3, a bill to authorize funds for Federal-aid highways, highway safety programs, and transit programs, and for other purposes.

AMENDMENT NO. 609

At the request of Mr. BINGAMAN, his name was added as a cosponsor of amendment No. 609 intended to be proposed to H.R. 3, a bill to authorize funds for Federal-aid highways, highway safety programs, and transit programs, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. FEINSTEIN (for herself, Mrs. HUTCHISON, Mr. DURBIN, Ms. SNOWE, Mr. LEAHY, Mr. FEINGOLD, and Mrs. LINCOLN):

S. 994. A bill to authorize the Attorney General to make grants to improve the ability of State and local governments to prevent the abduction of children by family members, and for other purposes; to the Committee on the Judiciary.

Mrs. FEINSTEIN. Mr. President, I rise today along with Senators HUTCHISON, DURBIN, SNOWE, LEAHY and FEINGOLD to reintroduce the "Family Abduction Prevention Act of 2005," a bill to help the thousands of children who are abducted by a family member each year. We introduced this legislation last Congress, but it is just as needed today as it was then.

Family abductions are the most common form of abduction, yet they receive little attention, and law enforcement often doesn't treat them as the serious crimes that they are.

The Family Abduction Prevention Act of 2005 would provide grants to States for costs associated with family abduction prevention. Specifically, it

would assist States with: costs associated with the extradition of individuals suspected of committing the crime of family abduction; costs borne by State and local law enforcement agencies to investigate cases of missing children; training for local and State law enforcement agencies in responding to family abductions; outreach and media campaigns to educate parents on the dangers of family abductions; and assistance to public schools to help with costs associated with "flagging" school records.

Each year, over 200,000 children—78 percent of all abductions in the United States—are kidnapped by a family member, usually a non-custodial parent.

More than half of abducting parents have a history of domestic violence, substance abuse, or a criminal record.

Most State and local law enforcement agencies do not treat these abductions as serious crimes. Approximately 70 percent of law enforcement agencies do not have written guidelines on responding to family abduction and many are not informed about the Federal laws available to help in the search and recovery of an abducted child.

Many people believe that a child is not in grave danger if the abductor is a family member. Unfortunately, this is not true, and this assumption can endanger a child's life. Research shows that the most common motive in family abduction cases is revenge against the other parent—not love for the child.

The effects of family abduction on children are very traumatic. Abducted children suffer from severe separation anxiety. To break emotional ties with the left-behind parent, some family abductors will coach a child into falsely disclosing abuse by the other parent to perpetuate their control during or after abduction. The child is often told that the other parent is dead or did not really love them.

As the child adapts to a fugitive's lifestyle, deception becomes a part of life. The child is taught to fear those that one would normally trust, such as police, doctors, teachers and counselors. Even after recovery, the child often has a difficult time growing into adulthood.

Let me give an illustrative example about a girl named Rebekah. On Takeroot.org, a website devoted to victims of family abductions, Rebekah told the story of when her mother kidnapped her.

Her mother was diagnosed as manic and was verbally abusive to her children and husband. Rebekah's father was awarded full custody of her and her brothers. However, one weekend, when Rebekah was 4-years-old, her mother took her to Texas.

Her mother had all Rebekah's moles and distinguishing marks removed from her body and she had fake birth certificates made for Rebekah and herself. As Rebekah grew up, she was told

that her father didn't love her and that her siblings didn't want to see her. When the FBI finally found Rebekah, she didn't remember her father and felt very alone.

In addition, in many family abduction cases, children are given new identities at an age when they are still developing a sense of who they are. In extreme cases, the child's sexual identity is covered up to avoid detection.

Abducting parents often deprive their children of education and much-needed medical attention to avoid the risk of being tracked via school or medical records.

In some cases, the abducting parent leaves the child with strangers at an underground "safe house" where health, safety, and other basic needs are extremely compromised.

For example, in Lafayette, CA, two girls were abducted by their mother and moved from house to house under the control of a convicted child molester. Kelli Nunez absconded with her daughters, 6-year-old Anna and 4-year-old Emily in violation of court custody orders. Nunez drove her daughters cross-country, and then returned by plane to San Francisco, where she handed the children to someone holding a coded sign at the airport.

The person holding the sign belonged to an underground vigilante group called the California Family Law Center led by Florencio Maning, a convicted child molester. For six months, Maning orchestrated the concealment of the Nunez girls with help from other people. Luckily, police were able to track down the girls, and they were successfully reunited with their father.

California has been the Nation's leader in fighting family abduction. In my State, we have a system that places the responsibility for the investigation and resolution of family abduction cases with the County District Attorney's Office. Each California County District Attorney's Office has an investigative unit that is focused on family abduction cases. These investigators only handle family abduction cases and become experts in the process.

However, most States lack the training and resources to effectively recover children who are kidnapped by a family member. According to a study conducted by Plass, Finkelhor and Hotaling, 62 percent of parents surveyed said they were "somewhat" or "very" dissatisfied with police handling of their family abduction cases.

The "Family Abduction Prevention Act of 2005" would be an important first step in addressing this serious issue.

I urge my colleagues to quickly act on this important legislation.

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. 994

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 “Family Abduction Prevention Act of 2005”.

SEC. 2. FINDINGS.

Congress findings that—

(1) each year more than 203,000 children in the United States (approximately 78 percent of all abducted children) are abducted by a family member, usually a parent;

(2) more than half of the parents who abduct their children have a history of alcohol or substance abuse, a criminal record, or a history of violence;

(3) the most common motive for family abduction is revenge against the other parent, not protecting the child’s safety;

(4) children who are abducted by family members suffer emotional, psychological, and often physical abuse at the hands of their abductors;

(5) children who are victims of family abductions are forced to leave behind family, friends, their homes, their neighborhoods, their schools, and all that is familiar to them;

(6) children who are victims of family abductions are often told that the parent who did not abduct the child has died, does not love them, or will harm them;

(7) children who are abducted by their parents or other family members are sometimes forced to live in fear of discovery and may be compelled to conceal their true identity, including their real names, family histories, and even their gender;

(8) children who are victims of family abductions are often denied the opportunity to attend school or to receive health and dental care;

(9) child psychologists and law enforcement authorities now classify family abduction as a form of child abuse;

(10) approximately 70 percent of local law enforcement agencies do not have written guidelines for what to do in the event of a family abduction or how to facilitate the recovery of an abducted child;

(11) the first few hours of a family abduction are crucial to recovering an abducted child, and valuable hours are lost when law enforcement is not prepared to employ the most effective techniques to locate and recover abducted children;

(12) when parents who may be inclined to abduct their own children receive counseling and education on the harm suffered by children under these circumstances, the incidence of family abductions is greatly reduced; and

(13) where practiced, the flagging of school records has proven to be an effective tool in assisting law enforcement authorities find abducted children.

SEC. 3. DEFINITIONS.

In this Act:

(1) **FAMILY ABDUCTION.**—The term “family abduction” means the taking, keeping, or concealing of a child or children by a parent, other family member, or person acting on behalf of the parent or family member, that prevents another individual from exercising lawful custody or visitation rights.

(2) **FLAGGING.**—The term “flagging” means the process of notifying law enforcement authorities of the name and address of any person requesting the school records of an abducted child.

(3) **INDIAN TRIBE.**—The term “Indian tribe” means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(4) **STATE.**—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Virgin Islands, any territory or possession of the United States, and any Indian tribe.

SEC. 4. GRANTS TO STATES.

(a) **MATCHING GRANTS.**—The Attorney General shall make grants to States for projects involving—

(1) the extradition of individuals suspected of committing a family abduction;

(2) the investigation by State and local law enforcement agencies of family abduction cases;

(3) the training of State and local law enforcement agencies in responding to family abductions and recovering abducted children, including the development of written guidelines and technical assistance;

(4) outreach and media campaigns to educate parents on the dangers of family abductions; and

(5) the flagging of school records.

(b) **MATCHING REQUIREMENT.**—Not less than 50 percent of the cost of a project for which a grant is made under this section shall be provided by non-Federal sources.

SEC. 5. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out this Act, there are authorized to be appropriated to the Attorney General \$500,000 for fiscal year 2006 and such sums as may be necessary for each of fiscal years 2007 and 2008.

Mr. BURNS (for himself, Mr. ENZI, and Mr. THUNE):

S. 996. A bill to improve the Veterans Beneficiary Travel Program of the Department of Veterans Affairs; to the Committee on Veterans’ Affairs.

Mr. BURNS. Mr. President, today, I join my colleagues, Senator ENZI and Senator THUNE in introducing “The Veterans Road to Health Care Act of 2005.”

Montana veterans are often forced to travel hundreds of miles throughout our great State to receive the healthcare they need. Whether traveling to the only Veterans’ Administration (VA) hospital located just outside of Helena at Fort Harrison, or to one of the eight Community Based Outpatient Clinics, CBOCs, the distances traveled by our veterans is great. We have a lot of dirt between light bulbs in Montana. This distance, combined with the increase in gas prices and the cost of lodging for veterans and their families adds up quickly. Many of these folks do not have any other option for their health care, and I think that anything which can be done to help those who are travel eligible would be appreciated.

The Veterans Road to Health Care Act of 2005 would help ease this burden by raising the travel reimbursement rate for veterans who must travel to VA facilities for treatment. The current reimbursement rate of 11 cents per mile would be increased to the Federal rate of 40.5 cents per mile. It seems only fair that veterans who have sacrificed so much for this country receive the same compensation as Federal employees.

My bill would also allow payment under the Travel Beneficiary Program to veterans who cannot receive ade-

quate care at their VA facility and are thereby forced to travel to another care center for specialized treatment. This referral to another facility for additional treatment often increases the costs for veterans from rural States like Montana, who must make another trip and sometimes travel even longer distances, for medical assistance.

It is important that veterans in rural areas receive fair compensation, as they travel to obtain healthcare. I want to acknowledge Senators ENZI and THUNE for joining me in support of this bill. Their work on this and all other veterans’ issues is to be commended, and I look forward to working with them and my other Senate colleagues to pass this important piece of legislation. We need to do this for veterans in Montana and other rural areas across the country.

Mr. ENZI. Mr. President, I rise today in strong support of the Veterans Road to Health Care Act of 2005 that I introduced with my colleagues Senator BURNS and Senator THUNE. This legislation would raise the travel reimbursement rate for veterans who must travel to Department of Veterans Affairs’ hospitals for treatment. The current reimbursement rate is 11 cents per mile. This bill would raise that figure to match the Federal employees travel reimbursement rate which is 40.5 cents per mile.

The average price for gas in Wyoming right now is \$2.20 per gallon. The current rate of 11 cents per mile barely makes a dent in the expenses incurred by veterans who have no choice but to travel by automobile for health care. I have received numerous letters from veterans in Wyoming describing how difficult it is to work into their budget the money necessary to travel between their hometown and the VA hospital. Being able to access health care is vital; veterans should not have to choose between driving to receive needed treatment and being able to afford other necessities.

In Wyoming, we have two VA Medical Centers, one in Cheyenne and one in Sheridan. Veterans have to travel to one of these facilities to be treated for health conditions and be covered by the health care plan that the government provides for them. This poses a serious problem in terms of travel expense, especially with the rise in gasoline prices. Some towns in Wyoming are over 300 miles away from the nearest VA facility. A veteran living in Riverton must drive 215 miles to the Sheridan facility or nearly 300 to the Cheyenne facility. This problem is then compounded when these facilities, which provide great service for our veterans, must refer the veterans to a larger hospital in Salt Lake City or Denver for additional treatment or procedures.

This bill addresses the health care of veterans who have special needs. It would allow veterans who have been referred to a special care center by their VA physician to be reimbursed under

the Travel Beneficiary Program for their travel to the specialized facility. This applies only to those veterans who cannot receive adequate care at their VA facility.

This legislation is important to all veterans, but it is especially significant to those veterans who live in rural states, like my home State of Wyoming. Rural States are less populated; there is greater distance between towns and far fewer options for transportation. Wyoming has miles and miles of miles and miles. Cars are the main mode of transportation and many times the only option.

It is our duty to compensate our servicemen and women for the sacrifices that they made defending the freedoms of this country. With our current recruitment and retention problems in the military, it is our Nation's responsibility to give veterans the kind of access to healthcare they have earned through their service to our country. The rising cost of gasoline should not be a factor for veterans to ignore their health concerns because they cannot afford to travel to the nearest veterans' clinic. I strongly urge my colleagues to support this important bill.

By Mr. BURNS:

S. 997. A bill to direct the Secretary of Agriculture to convey land in the Beaverhead-Deerlodge Forest, Montana, to Jefferson County, Montana, for use as a cemetery; to the Committee on Energy and Natural Resources.

Mr. BURNS. Mr. President, this bill conveys 3.4 acres on the Beaverhead-Deerlodge National Forest to Jefferson County, MT for continued use as a cemetery.

The Elkhorn Cemetery in Jefferson County has been used as a cemetery since the 1860's. Due to surveying errors and limited information when the National Forest boundaries were surveyed in the early 1900's, the cemetery was included as National Forest lands. The cemetery is still in use by local families who homesteaded and worked the mines in the area. However, Forest Service manual direction strongly discourages burials on National Forest lands, placing both the families and Forest Service in an awkward position.

It is clear the cemetery should not have been included as part of the National Forest. The County Commissioners and the local public strongly support the conveyance.

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. 997

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 "Montana Cemetery Act of 2005".

SEC. 2. CONVEYANCE TO JEFFERSON COUNTY, MONTANA.

(a) CONVEYANCE.—Not later than 180 days after the date of enactment of this Act and subject to valid existing rights, the Secretary of Agriculture (referred to in this Act as the "Secretary"), acting through the Chief of the Forest Service, shall convey to Jefferson County, Montana, for no consideration, all right, title, and interest of the United States in and to the parcel of land described in subsection (b).

(b) DESCRIPTION OF LAND.—The parcel of land referred to in subsection (a) is the parcel of National Forest System land (including any improvements on the land) known as the Elkhorn Cemetery, which consists of 10 acres in Jefferson County located in SW1/4 Sec. 14, T. 6 N., R. 3 W.

(c) ADDITIONAL TERMS AND CONDITIONS.—The Secretary may require such additional terms and conditions for the conveyance under subsection (a) as the Secretary considers appropriate to protect the interests of the United States.

By Mr. CRAPO (for himself and Mr. CRAIG):

S. 998. A bill to include the State of Idaho as an affected area under the Radiation Exposure Compensation Act (42 U.S.C. 2210 note); to the committee on the Judiciary.

Mr. CRAPO. Mr. President, in the 1950s and 1960s, this country was in the midst of a cold war and arms race, a race to perfect the hydrogen bomb. To win the race, nuclear weapons technology was developed using above ground testing in Idaho's neighbor to the south, Nevada. During these tests, Idahoans recount going outside in the evenings to look at the beautiful sunsets caused by the testing. Unfortunately and unbeknown to them, these skies were filled with dangerous radiation that very much elevated their exposure and subsequent risk of developing cancer.

I will not debate whether government authorities adequately knew the extent of the long-term dangers to radiation exposure. However, after a long and protracted discussion in this very chamber, Congress did recognize that what had occurred during this time of nuclear testing and rightly came forward providing for compensation through the Radiation Exposure Compensation Act of 1990 (RECA). This bill said that if you lived in certain counties in certain States during a certain period of time and had specified diseases, you were eligible for compensation. It is now time to review that program and make it work for everyone who may have become ill because of radiation fall-out exposure.

The criteria established in the Act were driven by limited scientific knowledge and political expediency. This was recognized in 1999, when a group of Senators, led by Senator HATCH, amended RECA to include additional counties in Arizona. During the floor debate at the time, Senator HATCH said, "Through advances in science, we now know so much more about the effects of radiation than we did in the late 1950s and 1960s. Our current state of scientific knowledge al-

lows us to pinpoint with more accuracy which diseases are reasonably believed to be related to radiation exposure, and that is what necessitated the legislation we are considering today."

But the truth is even more encompassing than a few more counties. According to a report from the National Academies of Sciences, a report commissioned by Congress, radiation fall-out didn't know any arbitrary geographic boundaries. It didn't stop because it crossed a State or county line. The NAS report, released last month, clearly demonstrated that we continue to be wide of the mark in who is eligible for compensation and that is why I am introducing legislation today to bring RECA back on course. Information used to establish who would be eligible for compensation failed to recognize that four counties in Idaho ranked in the top five in having the highest per capita thyroid dosage of radiation in the nation, more than any county currently recognized by RECA for eligibility. This clear inequity must be rectified; Idaho has a documented history of high cancer rates in people who lived in these areas during testing.

At this time I would like to thank people like Sheri Garmon, Kathy Skippen, Tona Henderson, and so many others who have spent time and energy on this issue. Some like Sheri are fighting multiple cancers and yet have taken the time to pursue their belief that they deserved to be eligible for the RECA program. The NAS report recognizes that the RECA program needs revamping, but Idahoans deserve equal treatment with those in Utah, Arizona, and Nevada now. They should not have to wait while Congress comes up with a better way to administer this program. That is why I am introducing legislation today that will extend the present program to cover the full State of Idaho. And I am encouraging my colleagues to work with me on making the entire RECA program more comprehensive for the future.

It is the right thing to do.

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

S. 999. A bill to provide for a public response to the public health crisis of pain, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. WYDEN:

S. 1000. A bill to amend the Public Health Service Act to increase the number of permanent faculty in palliative care medicine at accredited allopathic and osteopathic medical schools and to promote the development of faculty careers as academic palliative specialists who emphasize teaching; to the Committee on Health, Education, Labor, and Pensions.

By Mr. WYDEN

S. 1001. A bill to establish hospice demonstration projects and a hospice grant program for beneficiaries under the medicare program under title XVII

of the Social Security Act, and for other purposes; to the Committee on Finance.

Mr. WYDEN. Mr. President, several weeks ago, I outlined what I believed this country needs to do in order to address the true issues related to how we care for those who are dying. Today, I am introducing 3 bills to improve access to pain management, increase the number of providers trained to care for those with life-threatening illness, and improve the Medicare hospice benefit.

Our medical system is geared towards curing patients, and gives short shrift to those we cannot cure. Modern advances in technology allow us to live longer, but that also means that many of us will live longer with chronic diseases including pain.

The Conquering Pain Act will help those patients living and dying in pain, support their families and assist providers in getting information and guidance. This legislation will provide an opportunity for the country to develop and test different ways of providing pain management to patients 24 hours a day, seven days a week. It would create and fund regional networks to assist patients so they would not have to wait until normal business hours to get relief and help providers receive timely information and guidance as they treat difficult cases. This bill would create a website and require access to it in health care settings so families, patients and providers can have instant information. In addition, the bill requires several studies so we can better understand the other roadblocks for patients seeking pain management. These roadblocks include the lack of health insurance coverage for pain management and the interaction of the enforcement of laws concerning controlled substances and the delivery of appropriate pain management. I am pleased that my colleague from Oregon is cosponsoring the Conquering Pain Act.

Another aspect of our health care system that needs strengthening, is in assuring that we have providers who know how to provide support and comfort care to the dying. The Palliative Care Training Act will increase the number of providers trained in palliative care. Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness. It does so through the prevention and relief of suffering by early identification, assessment and treatment of pain and other problems. Palliative care affirms life and regards dying as a normal process. It neither hastens nor postpones death and is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and offers a support system to help patients live as actively as possible until death.

My legislation provides grants to individuals with appointments as junior

faculty at accredited medical schools so they will teach other providers palliative care. This is modeled after existing awards for the training of other specialties. When it comes down to it, assuring there is faculty in schools to teach this area of medicine, is an inexpensive way of strengthening the health care system in providing this needed care. I am pleased to note that when the National Hospice and Palliative Care Association recently testified before the Senate Health, Education and Labor Committee, they identified this legislation as addressing an important need.

As we look at how to better care for those at the end of life, Medicare's hospice benefit bears examination. When the benefit was added to Medicare, it was hailed as a cost effective benefit that would assist many. In truth, few Americans know what hospice really is and the benefits it can provide. Too often seniors are advised of the benefits too late to get the full effect of the medical, social and spiritual support this benefit can provide. Part of the reason for this is Medicare requires the patient to choose between continuing to seek "curative" care or hospice and palliative care. This means that literally the patient must choose between the hope of a cure and accepting that they are dying. Not many of us would want to give up seeking a cure or want to give up hope. However, that is what the Medicare program requires now. The Medicare Hospice Demonstration Act tests the idea that patients would not have to give up seeking "curative" care, to get hospice. It is my belief that as people experience what hospice can do for them and for their families, they will find they can accept living the end of their lives with hospice and palliative care instead of seeking less effective care that will not cure them or enhance the quality of their life.

It the U.S. Senate is going to examine end of life issues, we should not just look at legal issues. I believe these proposals are essential elements of the health care system that need to be supported and strengthened.

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

There being no objection, the bills were ordered to be printed in the RECORD, as follows:

S. 999

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 "Conquering Pain Act of 2005".

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

Sec. 1. Short title.

Sec. 2. Findings.

Sec. 3. Definitions.

TITLE I—EMERGENCY RESPONSE TO THE PUBLIC HEALTH CRISIS OF PAIN

Sec. 101. Guidelines for the treatment of pain.

Sec. 102. Patient expectations to have pain and symptom management.

Sec. 103. Quality improvement projects.

Sec. 104. Pain coverage quality evaluation and information.

Sec. 105. Surgeon General's report.

TITLE II—DEVELOPING COMMUNITY RESOURCES

Sec. 201. Family support networks in pain and symptom management.

TITLE III—REIMBURSEMENT BARRIERS

Sec. 301. Reimbursement barriers report.

Sec. 302. Insurance coverage of pain and symptom management.

TITLE IV—IMPROVING FEDERAL COORDINATION OF POLICY, RESEARCH, AND INFORMATION

Sec. 401. Advisory Committee on Pain and Symptom Management.

Sec. 402. Institutes of Medicine report on controlled substance regulation and the use of pain medications.

Sec. 403. Conference on pain research and care.

TITLE V—DEMONSTRATION PROJECTS

Sec. 501. Provider performance standards for improvement in pain and symptom management.

Sec. 502. End of life care demonstration projects.

SEC. 2. FINDINGS.

Congress finds that—

(1) pain is often left untreated or undertreated especially among older patients, African Americans, Hispanics and other minorities, and children;

(2) chronic pain is a public health problem affecting at least 50,000,000 Americans through some form of persisting or recurring symptom;

(3) 40 to 50 percent of patients experience moderate to severe pain at least half the time in their last days of life;

(4) 70 to 80 percent of cancer patients experience significant pain during their illness;

(5) one in 7 nursing home residents experience persistent pain that may diminish their quality of life;

(6) despite the best intentions of physicians, nurses, pharmacists, and other health care professionals, pain is often undertreated because of the inadequate training of clinicians in pain management;

(7) despite the best intentions of physicians, nurses, pharmacists, mental health professionals, and other health care professionals, pain and symptom management is often suboptimal because the health care system has focused on cure of disease rather than the management of a patient's pain and other symptoms;

(8) the technology and scientific basis to adequately manage most pain is known;

(9) pain should be considered the fifth vital sign; and

(10) coordination of Federal efforts is needed to improve access to high quality effective pain and symptom management in order to assure the needs of chronic pain patients and those who are terminally ill are met.

SEC. 3. DEFINITIONS.

In this Act:

(1) **CHRONIC PAIN.**—The term "chronic pain" means a pain state that is persistent and in which the cause of the pain cannot be removed or otherwise alleviated. Such term includes pain that may be associated with long-term incurable or intractable medical conditions or disease.

(2) **END OF LIFE CARE.**—The term "end of life care" means a range of services, including hospice care, provided to a patient, in the final stages of his or her life, who is suffering from 1 or more conditions for which treatment toward a cure or reasonable improvement is not possible, and whose focus of care is palliative rather than curative.

(3) **FAMILY SUPPORT NETWORK.**—The term “family support network” means an association of 2 or more individuals or entities in a collaborative effort to develop multi-disciplinary integrated patient care approaches that involve medical staff and ancillary services to provide support to chronic pain patients and patients at the end of life and their caregivers across a broad range of settings in which pain management might be delivered.

(4) **HOSPICE.**—The term “hospice care” has the meaning given such term in section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)).

(5) **MEDICATION THERAPY MANAGEMENT SERVICES.**—The term “medication therapy management services” means consultations with a physician or other health care professional (including a pharmacist) who is practicing within the scope of the professional’s license, concerning a patient which results in—

(A) a change in the drug regimen of the patient to avoid an adverse drug interaction with another drug or disease state;

(B) a change in inappropriate drug dosage or dosage form with respect to the patient;

(C) discontinuing an unnecessary or harmful medication with respect to the patient;

(D) an initiation of medication therapy for a medical condition of the patient;

(E) consultation with the patient or a caregiver in a manner that results in a significant improvement in drug regimen compliance; or

(F) patient and caregiver understanding of the appropriate use and adherence to medication therapy.

(6) **PAIN AND SYMPTOM MANAGEMENT.**—The term “pain and symptom management” means services provided to relieve physical or psychological pain or suffering, including any 1 or more of the following physical complaints—

(A) weakness and fatigue;

(B) shortness of breath;

(C) nausea and vomiting;

(D) diminished appetite;

(E) wasting of muscle mass;

(F) difficulty in swallowing;

(G) bowel problems;

(H) dry mouth;

(I) failure of lymph drainage resulting in tissue swelling;

(J) confusion;

(K) dementia;

(L) delirium;

(M) anxiety;

(N) depression; and

(O) other related symptoms

(7) **PALLIATIVE CARE.**—The term “palliative care” means the total care of patients whose disease is not responsive to curative treatment, the goal of which is to provide the best quality of life for such patients and their families. Such care—

(A) may include the control of pain and of other symptoms, including psychological, social and spiritual problems;

(B) affirms life and regards dying as a normal process;

(C) provides relief from pain and other distressing symptoms;

(D) integrates the psychological and spiritual aspects of patient care;

(E) offers a support system to help patients live as actively as possible until death; and

(F) offers a support system to help the family cope during the patient’s illness and in their own bereavement.

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

TITLE I—EMERGENCY RESPONSE TO THE PUBLIC HEALTH CRISIS OF PAIN

SEC. 101. GUIDELINES FOR THE TREATMENT OF PAIN.

(a) **DEVELOPMENT OF WEBSITE.**—Not later than 2 months after the date of enactment of this Act, the Secretary, acting through the Agency for Healthcare Research and Quality, shall develop and maintain an Internet website to provide information to individuals, health care practitioners, and health facilities concerning evidence-based practice guidelines developed for the treatment of physical and psychological pain. Websites in existence on such date may be used if such websites meet the requirements of this section.

(b) **REQUIREMENTS.**—The website established under subsection (a) shall—

(1) be designed to be quickly referenced by health care practitioners; and

(2) provide for the updating of guidelines as scientific data warrants.

(c) **PROVIDER ACCESS TO GUIDELINES.**—

(1) **IN GENERAL.**—In establishing the website under subsection (a), the Secretary shall ensure that health care facilities have made the website known to health care practitioners and that the website is easily available to all health care personnel providing care or services at a health care facility.

(2) **USE OF CERTAIN EQUIPMENT.**—In making the information described in paragraph (1) available to health care personnel, the facility involved shall—

(A) ensure that such personnel have access to the website through the computer equipment of the facility;

(B) carry out efforts to inform personnel at the facility of the location of such equipment; and

(C) ensure that patients, caregivers, and support groups are provided with access to the website.

(3) **RURAL AREAS.**—

(A) **IN GENERAL.**—A health care facility, particularly a facility located in a rural or underserved area, without access to the Internet shall provide an alternative means of providing practice guideline information to all health care personnel.

(B) **ALTERNATIVE MEANS.**—The Secretary shall determine appropriate alternative means by which a health care facility may make available practice guideline information on a 24-hour basis, 7 days a week if the facility does not have Internet access. The criteria for adopting such alternative means should be clear in permitting facilities to develop alternative means without placing a significant financial burden on the facility and in permitting flexibility for facilities to develop alternative means of making guidelines available. Such criteria shall be published in the Federal Register.

SEC. 102. PATIENT EXPECTATIONS TO HAVE PAIN AND SYMPTOM MANAGEMENT.

(a) **IN GENERAL.**—The administrator of each of the programs described in subsection (b) shall ensure that, as part of any informational materials provided to individuals under such programs, such materials shall include information, where relevant, to inform such individuals that they should expect to have their pain assessed and should expect to be provided with effective pain and symptom relief, when receiving benefits under such program.

(b) **PROGRAMS.**—The programs described in this subsection shall include—

(1) the medicare and medicaid programs under titles XIX and XXI of the Social Security Act (42 U.S.C. 1935 et seq., 1936 et seq.);

(2) programs carried out through the Public Health Service;

(3) programs carried out through the Indian Health Service;

(4) programs carried out through health centers under section 330 of the Public Health Service Act (42 U.S.C. 254b);

(5) the Federal Employee Health Benefits Program under title 5, United States Code;

(6) the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined in section 1073(4) of title 10, United States Code; and

(7) other programs administered by the Secretary.

SEC. 103. QUALITY IMPROVEMENT EDUCATION PROJECTS.

The Secretary shall provide funds for the implementation of special education projects, in as many States as is practicable, to be carried out by peer review organizations of the type described in section 1152 of the Social Security Act (42 U.S.C. 1320c-1) to improve the quality of pain and symptom management. Such projects shall place an emphasis on improving pain and symptom management at the end of life, and may also include efforts to increase the quality of services delivered to chronic pain patients and the chronically ill for whom pain may be a significant symptom.

SEC. 104. PAIN COVERAGE QUALITY EVALUATION AND INFORMATION.

(a) **IN GENERAL.**—Section 1851(d)(4) of the Social Security Act (42 U.S.C. 42 U.S.C. 1395w-21(d)(4)) is amended—

(1) in subparagraph (A), by adding at the end the following:

“(ix) The organization’s coverage of pain and symptom management.”; and

(2) in subparagraph (D)—

(A) in clause (iii), by striking “and” at the end;

(B) in clause (iv), by striking the period and inserting “, and”; and

(C) by adding at the end the following:

“(v) not later than 2 years after the date of enactment of this clause, an evaluation (which may be made part of any other relevant report of quality evaluation that the plan is required to prepare) for the plan (updated annually) that indicates the performance of the plan with respect to access to, and quality of, pain and symptom management, including such management as part of end of life care. Data shall be posted in a comparable manner for consumer use on www.medicare.gov.”.

(b) **EFFECTIVE DATE.**—The amendments made by paragraph (1) apply to information provided with respect to annual, coordinated election periods (as defined in section 1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395-21(e)(3)(B))) beginning after the date of enactment of this Act.

SEC. 105. SURGEON GENERAL’S REPORT.

Not later than October 1, 2006, the Surgeon General shall prepare and submit to the appropriate committees of Congress and the public, a report concerning the state of pain and symptom management in the United States. The report shall include—

(1) a description of the legal and regulatory barriers that may exist at the Federal and State levels to providing adequate pain and symptom management;

(2) an evaluation of provider competency in providing pain and symptom management;

(3) an identification of vulnerable populations, including children, advanced elderly, non-English speakers, and minorities, who may be likely to be underserved or may face barriers to access to pain management and recommendations to improve access to pain management for these populations;

(4) an identification of barriers that may exist in providing pain and symptom management in health care settings, including assisted living facilities;

(5) an identification of patient and family attitudes that may exist which pose barriers

in accessing pain and symptom management or in the proper use of pain medications;

(6) an evaluation of medical, nursing, and pharmacy school training and residency training for pain and symptom management;

(7) a review of continuing medical education programs in pain and symptom management; and

(8) a description of the use of and access to mental health services for patients in pain and patients at the end of life.

TITLE II—DEVELOPING COMMUNITY RESOURCES

SEC. 201. FAMILY SUPPORT NETWORKS IN PAIN AND SYMPTOM MANAGEMENT.

(a) ESTABLISHMENT.—The Secretary, acting through the Public Health Service, shall award grants for the establishment of 6 National Family Support Networks in Pain and Symptom Management (in this section referred to as the “Networks”) to serve as national models for improving the access and quality of pain and symptom management to chronic pain patients (including chronically ill patients for whom pain is a significant symptom) and those individuals in need of pain and symptom management at the end of life and to provide assistance to family members and caregivers.

(b) ELIGIBILITY AND DISTRIBUTION.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(A) be an academic facility or other entity that has demonstrated an effective approach to training health care providers including mental health professionals concerning pain and symptom management and palliative care services; and

(B) prepare and submit to the Secretary an application (to be peer reviewed by a committee established by the Secretary), at such time, in such manner, and containing such information as the Secretary may require.

(2) DISTRIBUTION.—In providing for the establishment of Networks under subsection (a), the Secretary shall ensure that—

(A) the geographic distribution of such Networks reflects a balance between rural and urban needs; and

(B) at least 3 Networks are established at academic facilities.

(c) ACTIVITIES OF NETWORKS.—A Network that is established under this section—

(1) shall provide for an integrated interdisciplinary approach, that includes psychological and counseling services, to the delivery of pain and symptom management;

(2) shall provide community leadership in establishing and expanding public access to appropriate pain care, including pain care at the end of life;

(3) shall provide assistance, through caregiver supportive services, that include counseling and education services;

(4) shall develop a research agenda to promote effective pain and symptom management for the broad spectrum of patients in need of access to such care that can be implemented by the Network;

(5) shall provide for coordination and linkages between clinical services in academic centers and surrounding communities to assist in the widespread dissemination of provider and patient information concerning how to access options for pain management;

(6) shall establish telemedicine links to provide education and for the delivery of services in pain and symptom management;

(7) shall develop effective means of providing assistance to providers and families for the management of a patient's pain 24 hours a day, 7 days a week; and

(8) may include complimentary medicine provided in conjunction with traditional medical services.

(d) PROVIDER PAIN AND SYMPTOM MANAGEMENT COMMUNICATIONS PROJECTS.—

(1) IN GENERAL.—Each Network shall establish a process to provide health care personnel with information 24 hours a day, 7 days a week, concerning pain and symptom management. Such process shall be designed to test the effectiveness of specific forms of communications with health care personnel so that such personnel may obtain information to ensure that all appropriate patients are provided with pain and symptom management.

(2) TERMINATION.—The requirement of paragraph (1) shall terminate with respect to a Network on the day that is 2 years after the date on which the Network has established the communications method.

(3) EVALUATION.—Not later than 60 days after the expiration of the 2-year period referred to in paragraph (2), a Network shall conduct an evaluation and prepare and submit to the Secretary a report concerning the costs of operation and whether the form of communication can be shown to have had a positive impact on the care of patients in chronic pain or on patients with pain at the end of life.

(4) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as limiting a Network from developing other ways in which to provide support to families and providers, 24 hours a day, 7 days a week.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$18,000,000 for fiscal years 2005 through 2007.

TITLE III—REIMBURSEMENT BARRIERS

SEC. 301. REIMBURSEMENT BARRIERS REPORT.

The Medicare Payment Advisory Commission (MedPac) established under section 1805 of the Social Security Act (42 U.S.C. 1396b-6) shall conduct a study, and prepare and submit to the appropriate committees of Congress a report, concerning—

(1) the manner in which medicare policies may pose barriers in providing pain and symptom management and palliative care services in different settings, including a focus on payment for nursing home and home health services;

(2) the identification of any financial barriers that may exist within the medicare and medicaid programs under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq., 1396 et seq.) that interfere with continuity of care and interdisciplinary care or supportive care for the broad range of chronic pain patients (including patients who are chronically ill for whom pain is a significant symptom), and for those who are terminally ill, and include the recommendations of the Commission on ways to eliminate those barriers that the Commission may identify;

(3) the reimbursement barriers that exist, if any, in providing pain and symptom management through hospice care, particularly in rural areas, and if barriers exist, recommendations concerning adjustments that would assist in assuring patient access to pain and symptom management through hospice care in rural areas;

(4) whether the medicare reimbursement system provides incentives to providers to delay informing terminally ill patients of the availability of hospice and palliative care; and

(5) the impact of providing payments for medication therapy management services in pain and symptom management and palliative care services.

SEC. 302. INSURANCE COVERAGE OF PAIN AND SYMPTOM MANAGEMENT.

(a) IN GENERAL.—The General Accounting Office shall conduct a survey of public and private health insurance providers, including managed care entities, to determine whether the reimbursement policies of such insurers inhibit the access of chronic pain patients to

pain and symptom management and pain and symptom management for those in need of end-of-life care (including patients who are chronically ill for whom pain is a significant symptom). The survey shall include a review of formularies for pain medication and the effect of such formularies on pain and symptom management.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the General Accounting Office shall prepare and submit to the appropriate committees of Congress a report concerning the survey conducted under subsection (a).

TITLE IV—IMPROVING FEDERAL COORDINATION OF POLICY, RESEARCH, AND INFORMATION

SEC. 401. ADVISORY COMMITTEE ON PAIN AND SYMPTOM MANAGEMENT.

(a) ESTABLISHMENT.—The Secretary shall establish an advisory committee, to be known as the Advisory Committee on Pain and Symptom Management, to make recommendations to the Secretary concerning a coordinated Federal agenda on pain and symptom management.

(b) MEMBERSHIP.—The Advisory Committee established under subsection (a) shall be comprised of 11 individuals to be appointed by the Secretary, of which at least 1 member shall be a representative of—

(1) physicians (medical doctors or doctors of osteopathy) who treat chronic pain patients or the terminally ill;

(2) nurses who treat chronic pain patients or the terminally ill;

(3) pharmacists;

(4) hospice;

(5) pain researchers;

(6) patient advocates;

(7) caregivers; and

(8) mental health providers.

The members of the Committee shall designate 1 member to serve as the chairperson of the Committee.

(c) MEETINGS.—The Advisory Committee shall meet at the call of the chairperson of the Committee.

(d) AGENDA.—The agenda of the Advisory Committee established under subsection (a) shall include—

(1) the development of recommendations to create a coordinated Federal agenda on pain and symptom management;

(2) the development of proposals to ensure that pain is considered as the fifth vital sign for all patients;

(3) the identification of research needs in pain and symptom management, including gaps in pain and symptom management guidelines;

(4) the identification and dissemination of pain and symptom management practice guidelines, research information, and best practices;

(5) proposals for patient education concerning how to access pain and symptom management across health care settings;

(6) the manner in which to measure improvement in access to pain and symptom management and improvement in the delivery of care;

(7) the development of ongoing strategies to assure the aggressive use of pain medications, including opioids, regardless of health care setting; and

(8) the development of an ongoing mechanism to identify barriers or potential barriers to pain and symptom management created by Federal policies.

(e) RECOMMENDATION.—Not later than 2 years after the date of enactment of this Act, the Advisory Committee established under subsection (a) shall prepare and submit to the Secretary recommendations concerning a prioritization of the need for a

Federal agenda on pain and symptom management, and ways in which to better coordinate the activities of entities within the Department of Health and Human Services, and other Federal entities charged with the responsibility for the delivery of health care services or research on pain and symptom management with respect to pain management.

(f) **CONSULTATION.**—In carrying out this section, the Advisory Committee shall consult with all Federal agencies that are responsible for providing health care services or access to health services to determine the best means to ensure that all Federal activities are coordinated with respect to research and access to pain and symptom management.

(g) **ADMINISTRATIVE SUPPORT; TERMS OF SERVICE; OTHER PROVISIONS.**—The following shall apply with respect to the Advisory Committee:

(1) The Committee shall receive necessary and appropriate administrative support, including appropriate funding, from the Department of Health and Human Services.

(2) The Committee shall hold open meetings and meet not less than 4 times per year.

(3) Members of the Committee shall not receive additional compensation for their service. Such members may receive reimbursement for appropriate and additional expenses that are incurred through service on the Committee which would not have incurred had they not been a member of the Committee.

(4) The requirements of Appendix 2 of title 5, United States Code.

SEC. 402. INSTITUTES OF MEDICINE REPORT ON CONTROLLED SUBSTANCE REGULATION AND THE USE OF PAIN MEDICATIONS.

(a) **IN GENERAL.**—The Secretary, acting through a contract entered into with the Institute of Medicine, shall review findings that have been developed through research conducted concerning—

(1) the effects of controlled substance regulation on patient access to effective care;

(2) factors, if any, that may contribute to the underuse of pain medications, including opioids;

(3) the identification of State legal and regulatory barriers, if any, that may impact patient access to medications used for pain and symptom management; and

(4) strategies to assure the aggressive use of pain medications, including opioids, regardless of health care setting.

(b) **REPORT.**—Not later than 18 months after the date of enactment of this Act, the Secretary shall prepare and submit to the appropriate committees of Congress a report concerning the findings described in subsection (a).

SEC. 403. CONFERENCE ON PAIN RESEARCH AND CARE.

Not later than December 31, 2007, the Secretary, acting through the National Institutes of Health, shall convene a national conference to discuss the translation of pain research into the delivery of health services including mental health services to chronic pain patients and those needing end-of-life care. The Secretary shall use unobligated amounts appropriated for the Department of Health and Human Services to carry out this section.

TITLE V—DEMONSTRATION PROJECTS

SEC. 501. PROVIDER PERFORMANCE STANDARDS FOR IMPROVEMENT IN PAIN AND SYMPTOM MANAGEMENT.

(a) **IN GENERAL.**—The Secretary, acting through the Health Resources Services Administration, shall award grants for the establishment of not less than 5 demonstration projects to determine effective methods to

measure improvement in the skills, knowledge, and attitudes and beliefs of health care personnel in pain and symptom management as such skill, knowledge, and attitudes and beliefs apply to providing services to chronic pain patients and those patients requiring pain and symptom management at the end of life.

(b) **EVALUATION.**—Projects established under subsection (a) shall be evaluated to determine patient and caregiver knowledge and attitudes toward pain and symptom management.

(c) **APPLICATION.**—To be eligible to receive a grant under subsection (a), an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require.

(d) **TERMINATION.**—A project established under subsection (a) shall terminate after the expiration of the 2-year period beginning on the date on which such project was established.

(e) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 502. END OF LIFE CARE DEMONSTRATION PROJECTS.

The Secretary, acting through the Health Resources and Services Administration, shall—

(1) not later than January 1, 2007, carry out not less than 5 demonstration and evaluation projects that implement care models for individuals at the end of life, at least one of which shall be developed to assist those individuals who are terminally ill and have no family or extended support, and each of which may be carried out in collaboration with domestic and international entities to gain and share knowledge and experience on end of life care;

(2) conduct 3 demonstration and evaluation activities concerning the education and training of clinicians in end of life care, and assist in the development and distribution of accurate educational materials on both pain and symptom management and end of life care;

(3) in awarding grants for the training of health professionals, give priority to awarding grants to entities that will provide training for health professionals in pain and symptom management and in end-of-life care at the undergraduate level;

(4) shall evaluate demonstration projects carried out under this section within the 5-year period beginning on the commencement of each such project; and

(5) develop a strategy and make recommendations to Congress to ensure that the United States health care system—

(A) has a meaningful, comprehensive, and effective approach to meet the needs of individuals and their caregivers as the patient approaches death; and

(B) integrates broader supportive services.

S. 1000

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 “Palliative Care Training Act”.

SEC. 2. PALLIATIVE CARE TRAINING PROGRAM.

(a) **IN GENERAL.**—Section 753 of the Public Health Service Act (42 U.S.C. 294c) is amended by adding at the end the following:

“(d) **HOSPICE AND PALLIATIVE CARE ACADEMIC CAREER AWARDS.**—

“(1) **IN GENERAL.**—The Secretary shall establish a program to provide Hospice and Palliative Care Academic Career Awards to eligible individuals under this subsection.

“(2) **ELIGIBILITY.**—To be eligible to receive an Award under this subsection, an individual shall—

“(A) be board certified or board eligible in internal medicine, family practice, or pediatrics and their subspecialties including geriatrics, palliative medicine, or other specialties as determined by the Secretary;

“(B) have completed an approved fellowship program or demonstrated specialized experience in palliative medicine as determined by the Secretary; and

“(C) have a junior faculty appointment at an accredited (as determined by the Secretary) school of medicine (allopathic or osteopathic) and within an internship or residency program that is approved by the Accreditation Council on Graduate Medical Education or the American Osteopathic Association.

“(3) **AMOUNT AND TERM.**—

“(A) **AMOUNT.**—The amount of an Award to an individual under this subsection shall be equal to \$75,000 for fiscal year 2006, adjusted for subsequent fiscal years to reflect the increase in the Consumer Price Index.

“(B) **TERM.**—The term of any Award made under this subsection shall not exceed 5 years.

“(4) **SERVICE REQUIREMENT.**—An individual who receives an Award under this subsection shall provide training in hospice care and palliative medicine, including the training of interdisciplinary teams of health care professionals. The provision of such training shall constitute at least 75 percent of the obligations of such individual under the terms of the Award.

“(5) **EFFECTIVE DATE.**—This subsection shall take effect 90 days after the date of enactment of the Palliative Care Training Act.”

(b) **AUTHORIZATION OF APPROPRIATIONS.**—Section 757 of the Public Health Service Act (42 U.S.C. 294g) is amended—

(1) in subsection (a), by striking “through 2002” and inserting “through 2010”;

(2) in subsection (b)(1)(C), by striking “\$22,631,000” and inserting “\$55,779,000”; and

(3) in subsection (c), by adding at the end the following:

“(3) **GERIATRIC EDUCATION AND TRAINING.**—Of the amount made available under subsection (b)(1)(C) for fiscal year 2006, the Secretary may obligate for awards under subsections (a), (b), and (c) of section 753 an amount not less than \$31,805,000.”

S. 1001

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 Hospice Demonstration Act of 2005”.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) Each year more than 1/3 of the people who die suffer from a chronic illness.

(2) Approximately 1/3 of Americans are unsure about whom to contact to get the best care during life’s last stages.

(3) Americans want a team of professionals to care for the patient at the end of life.

(4) Americans want emotional and spiritual support for the patient and family.

(5) Ninety percent of Americans do not realize that hospice care is a benefit provided under the Medicare program under title XVIII of the Social Security Act.

(6) Data of the Centers for Medicare & Medicaid Services show that beneficiaries were enrolled in hospice for an average of less than 7 weeks in 1998, far less than the full 6-month benefit under the Medicare program.

(7) According to the most recent data available, although more Medicare beneficiaries are enrolled in hospice, the Medicare length of stay has declined.

(8) Use of hospice among medicare beneficiaries has been decreasing, from a high of 59 days in 1995 to less than 48 days in 1998.

SEC. 3. HOSPICE DEMONSTRATION PROJECTS AND HOSPICE EDUCATION GRANTS.

(a) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term “demonstration project” means a demonstration project established by the Secretary under subsection (b)(1).

(2) HOSPICE CARE.—The term “hospice care” means the items and services described in subparagraphs (A) through (I) of section 1861(dd)(1) of the Social Security Act (42 U.S.C. 1395x(dd)(1)) that are provided to a seriously ill medicare beneficiary under a demonstration project by a hospice program (or by others under an arrangement with such a program) under a written plan for providing such care to such beneficiary established and periodically reviewed by the beneficiary’s attending physician, by the medical director of the program, and by the interdisciplinary group described in section 1861(dd)(2)(B) of such Act (42 U.S.C. 1395x(dd)(2)(B)).

(3) HOSPICE PROGRAM.—The term “hospice program” has the meaning given that term in section 1861(dd)(2) of the Social Security Act (42 U.S.C. 1395x(dd)(2)).

(4) MEDICARE BENEFICIARY.—The term “medicare beneficiary” means any individual who is entitled to benefits under part A or enrolled under part B of the medicare program.

(5) 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.).

(6) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(7) SERIOUSLY ILL.—The term “seriously ill” has the meaning given such term by the Secretary (in consultation with hospice programs and academic experts in end-of-life care), except that the Secretary may not limit such term to individuals who are terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act (42 U.S.C. 1395x(dd)(3)(A))).

(b) HOSPICE DEMONSTRATION PROJECTS.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this subsection to increase the utility of the hospice care for seriously ill medicare beneficiaries.

(2) PARTICIPATION.—

(A) HOSPICE PROGRAMS.—Except as provided in paragraph (4)(A), only a hospice program with an agreement under section 1866 of the Social Security Act (42 U.S.C. 1395cc), a consortium of such hospice programs, or a State hospice association may participate in the demonstration program.

(B) SERIOUSLY ILL MEDICARE BENEFICIARIES.—The Secretary shall permit any seriously ill medicare beneficiary residing in the service area of a hospice program participating in a demonstration project to participate in such project on a voluntary basis.

(3) SERVICES UNDER DEMONSTRATION PROJECTS.—The provisions of section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) shall apply to the payment for hospice care provided under the demonstration projects, except that—

(A) notwithstanding section 1862(a)(1)(C) of such Act (42 U.S.C. 1395y(a)(1)(C)), the Secretary shall provide for reimbursement for items and services provided under the supportive and comfort care benefit established under paragraph (3);

(B) any licensed nurse practitioner or physician assistant may admit a seriously ill medicare beneficiary as the primary care provider when necessary and within the scope of practice of such practitioner or assistant under State law;

(C) if an underserved community included in a demonstration project does not have a qualified social worker, any professional (other than a social worker) who has the necessary knowledge, skills, and ability to provide medical social services may provide such services;

(D) the Secretary shall waive any requirement that nursing facilities used for respite care have skilled nurses on the premises 24 hours per day;

(E) the Secretary shall permit respite care to be provided to the seriously ill medicare beneficiary at home; and

(F) the Secretary shall waive reimbursement regulations to provide—

(i) reimbursement for consultations and preadmission informational visits, even if the seriously ill medicare beneficiary does not elect hospice care at that time;

(ii) except with respect to the supportive and comfort care benefit under paragraph (3), a minimum payment for hospice care provided under the demonstration projects based on the provision of hospice care to a seriously ill medicare beneficiary for a period of 14 days, that—

(I) the Secretary shall pay to any hospice program participating in a demonstration project and providing such care (regardless of the length of stay of the seriously ill medicare beneficiary); and

(II) may not be less than the amount of payment that would have been made for hospice care if payment had been made at the daily rate of payment for such care under section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i));

(iii) an increase in the reimbursement rates for hospice care to offset—

(I) changes in hospice care and oversight under the demonstration projects;

(II) the higher costs of providing hospice care in rural areas due to lack of economies of scale or large geographic areas; and

(III) the higher costs of providing hospice care in urban underserved areas due to unique costs specifically associated with people living in those areas, including providing security;

(iv) direct payment of any nurse practitioner or physician assistant practicing within the scope of State law in relation to hospice care provided by such practitioner or assistant; and

(v) a per diem rate of payment for in-home care under subparagraph (E) that reflects the range of care needs of the seriously ill medicare beneficiary and that—

(I) in the case of a seriously ill medicare beneficiary that needs routine care, is not less than 150 percent, and not more than 200 percent, of the routine home care rate for hospice care; and

(II) in the case of a seriously ill medicare beneficiary that needs acute care, is equal to the continuous home care day rate for hospice care.

(4) SUPPORTIVE AND COMFORT CARE BENEFIT.—

(A) IN GENERAL.—For purposes of the demonstration projects, the Secretary shall establish a supportive and comfort care benefit for any eligible seriously ill medicare beneficiary (as defined in subparagraph (C)).

(B) PARTICIPATION.—Any individual or entity with an agreement under section 1866 of the Social Security Act (42 U.S.C. 1395cc) may furnish items or services covered under the supportive and comfort care benefit.

(C) BENEFIT.—Under the supportive and comfort care benefit, any eligible seriously ill medicare beneficiary may—

(i) continue to receive benefits for disease and symptom modifying treatment under the medicare program (and the Secretary may not require or prohibit any specific treatment or decision);

(ii) receive case management and hospice care through a hospice program participating in a demonstration project (for which payment shall be made under paragraph (2)(F)(ii)); and

(iii) receive information and education in order to better understand the utility of hospice care.

(D) PAYMENT.—The Secretary shall establish procedures under which the Secretary pays for items and services furnished to seriously ill medicare beneficiaries under the supportive and comfort care benefit on a fee-for-service basis.

(E) ELIGIBLE SERIOUSLY ILL MEDICARE BENEFICIARY DEFINED.—

(i) IN GENERAL.—In this paragraph, the term “eligible seriously ill medicare beneficiary” means any seriously ill medicare beneficiary that meets the criteria approved by the Secretary under clause (ii).

(ii) APPROVAL OF CRITERIA.—

(I) IN GENERAL.—With respect to each demonstration project, the Secretary shall approve criteria for determining whether a seriously ill medicare beneficiary is eligible for hospice care under a demonstration project that has been developed by hospice programs in consultation with researchers in end-of-life care and the broader medical community.

(II) DATA COMPARABILITY.—The Secretary may only approve criteria that ensures that each demonstration project yields comparable data with respect to eligible seriously ill medicare beneficiaries on—

(a) the utilization of services by such beneficiaries;

(b) the cost of providing services to such beneficiaries, including any costs associated with providing services before an individual is terminally ill (as defined in section 1861(dd)(3)(A) of the Social Security Act (42 U.S.C. 1395x(dd)(3)(A))); and

(c) the effect of the demonstration project on the quality of care of such beneficiaries.

(III) LIMITATION.—The Secretary may not approve criteria if the purpose of such criteria is to segment services or to provide a benefit for the chronically ill.

(5) CONDUCT OF DEMONSTRATION PROJECTS.—

(A) SITES.—The Secretary shall conduct demonstration projects in at least 3, but not more than 6, sites (which may be statewide).

(B) SELECTION OF SITES.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall select demonstration sites on the basis of proposals submitted under subparagraph (C) that are located in geographic areas that—

(I) include both urban and rural hospice programs; and

(II) are geographically diverse and readily accessible to a significant number of seriously ill medicare beneficiaries.

(ii) EXCEPTIONS.—

(I) UNDERSERVED URBAN AREAS.—If a geographic area does not have any rural hospice program available to participate in a demonstration project, such area may substitute an underserved urban area, but the Secretary shall give priority to those proposals that include a rural hospice program.

(II) SPECIFIC SITE.—The Secretary shall select as a demonstration site the State in which (according to the Hospital Referral Region of Residence, 1994–1995, as listed in the Dartmouth Atlas of Health Care 1998) the largest metropolitan area of the State had the lowest percentage of medicare beneficiary deaths in a hospital when compared to the largest metropolitan area of each other State, and the percentage of enrollees who experienced intensive care during the last 6 months of life was 21.5 percent.

(C) PROPOSALS.—

(i) IN GENERAL.—The Secretary shall accept proposals by any State hospice association, hospice program, or consortium of hospice programs at such time, in such manner, and in such form as the Secretary may reasonably require.

(ii) RESEARCH DESIGNS.—The Secretary shall permit research designs that use time series, sequential implementation of the intervention, randomization by wait list, and other designs that allow the strongest possible implementation of the demonstration projects, while still allowing strong evaluation about the merits of the demonstration projects.

(D) FACILITATION OF EVALUATION.—The Secretary shall design the program to facilitate the evaluation conducted under paragraph (7).

(6) DURATION.—The Secretary shall complete the demonstration projects within a period of 6½ years that includes a period of 18 months during which the Secretary shall complete the evaluation under paragraph (7).

(7) EVALUATION.—During the 18-month period following the first 5 years of the demonstration projects, the Secretary shall complete an evaluation of the demonstration projects in order to determine—

(A) the short-term and long-term costs and benefits of changing hospice care provided under the medicare program to include the items, services, and reimbursement options provided under the demonstration projects;

(B) whether any increase in payments for the hospice care provided under the medicare program are offset by savings in other parts of the medicare program;

(C) the projected cost of implementing the demonstration projects on a national basis; and

(D) in consultation with hospice organizations and hospice programs (including organizations and providers that represent rural areas), whether a payment system based on diagnosis-related groups is useful for administering the hospice care provided under the medicare program.

(8) REPORTS TO CONGRESS.—

(A) PRELIMINARY REPORT.—Not later than 3 years after the date of enactment of this Act, the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate a preliminary report on the progress made in the demonstration projects.

(B) INTERIM REPORT.—Not later than 30 months after the implementation of the demonstration projects, the Secretary, in consultation with participants in the projects, shall submit to the committees described in subparagraph (A) an interim report on the demonstration projects.

(C) FINAL REPORT.—Not later than the date on which the demonstration projects end, the Secretary shall submit a final report to the committees described in subparagraph (A) on the demonstration projects that includes the results of the evaluation conducted under paragraph (7) and recommendations for appropriate legislative changes.

(9) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(10) SPECIAL RULES FOR PAYMENT OF MEDICARE ADVANTAGE ORGANIZATIONS.—The Secretary shall establish procedures under which the Secretary provides for an appropriate adjustment in the monthly payments made under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) to any Medicare Advantage organization offering a Medicare Advantage plan to reflect the participation of each seriously ill medicare beneficiary en-

rolled in such plan in a demonstration project.

(c) HOSPICE EDUCATION GRANT PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish a Hospice Education Grant program under which the Secretary awards education grants to entities participating in the demonstration projects for the purpose of providing information about—

(A) the hospice care under the medicare program; and

(B) the benefits available to medicare beneficiaries under the demonstration projects.

(2) USE OF FUNDS.—Grants awarded under paragraph (1) shall be used—

(A) to provide—

(i) individual or group education to medicare beneficiaries and the families of such beneficiaries; and

(ii) individual or group education of the medical and mental health community caring for medicare beneficiaries; and

(B) to test strategies to improve the general public knowledge about hospice care under the medicare program and the benefits available to medicare beneficiaries under the demonstration projects.

(d) FUNDING.—

(1) HOSPICE DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) such sums as may be necessary to carry out this section.

(B) SUPPORTIVE AND COMFORT CARE BENEFIT.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines is appropriate, such sums as may be necessary to provide for payment of the costs attributable to the supportive and comfort care benefit.

(2) HOSPICE EDUCATION GRANTS.—The Secretary shall expend such sums as may be necessary for the purposes of carrying out the Hospice Education Grant program established under subsection (c)(1) from the Research and Demonstration Budget of the Centers for Medicare & Medicaid Services.

By Mr. GRASSLEY (for himself and Mr. BAUCUS):

S. 1002. A bill to amend title XVIII of the Social Security Act to make improvements in payments to hospitals under the medicare program, and for other purposes; to the Committee on Finance.

MR. GRASSLEY. Mr. President, physician-owned specialty hospitals continue to raise a number of troubling issues, and I feel strongly that additional action to address these issues is needed from Congress. Today, I am pleased to join Senator MAX BAUCUS, the ranking Democrat on the Senate Finance Committee, in introducing the Hospital Fair Competition Act of 2005. This bill has an effective date of June 8, 2005, regardless of when it may be enacted as this is the date the current moratorium on specialty hospitals expires.

Now, specialty hospitals have existed for quite some time. There are other types of hospitals with a special focus, such as children's hospitals and psy-

chiatric facilities. But these are not really what we are talking about. We are talking about the emergence of a new type of hospital. These new facilities are mostly for-profit. They are mainly owned by the physicians who refer their patients to these hospitals. And, they provide treatment in very specific areas such as cardiac, orthopedic or surgical care.

The number of these specialty hospitals has more than tripled in the past 10 years. While they are still relatively small in number—about 100—they are increasing quickly. They are mainly located in certain pockets of the country, concentrated in those States without a “certificate of need” requirement. That means they are mainly located in States where hospitals are permitted to add beds or build new facilities without first obtaining approval by the State. This approval process helps ensure that there is an actual public health need for additional health resources in the community.

Congress, in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), placed a moratorium on the development of new physician-owned specialty hospital hospitals until June 8, 2005. First, there were concerns about the conflict of interest inherent in physician self-referral. Second, it was thought that specialty hospitals might be an unfair form of competition. And third, in all of this, was a concern about the impact these hospitals may be having on the health care system as a whole.

The Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare and Medicaid Services (CMS) were directed by the MMA to study and report on a number of issues related to specialty hospitals. Today's Hospital Fair Competition Act draws heavily from MedPAC's non-partisan recommendations in its March 8, 2005, report to Congress.

Three separate government studies have found that physician-owned specialty hospitals treat the most profitable patients and services, leaving community hospitals to treat a disproportionate share of less profitable cases, Medicaid cases and the uninsured.

An April 2003 report by the Government Accountability Office (GAO) found that patients at specialty hospitals tended to be less sick than patients with the same diagnoses at general hospitals. The Centers for Medicare and Medicaid Services (CMS) reported in March its preliminary findings that specialty hospitals generally treat less severe cases than community hospitals. And, MedPAC reported that physician-owned specialty hospitals treat patients who are less sick, and thus more profitable, and concentrate on certain diagnosis-related groups (DRGs) that are more profitable.

In addition, approximately 93 percent of community hospitals operate emergency rooms, compared to less than half of specialty hospitals, thus treating any and all patients who walk

through their doors. They also serve a much greater share of poor patients, averaging 15 percent versus four percent for specialty heart hospitals and one percent for specialty orthopedic hospitals. When community hospitals lose their profitable services, they must shift costs to private patients to make up the difference. This then means private employers may pay higher premiums—all so physician-owned specialty hospitals can profit.

Specialty hospitals are able to take advantage of an outdated payment system. The current inpatient payment rates have not been recalibrated in over 20 years. This has resulted in certain patients and certain case types being significantly more profitable to treat than others. In fact, specialty heart hospitals have been found by MedPAC to treat Medicare patients who are 13 percent more profitable than the average mix of patients. And at specialty surgical hospitals this number is 14 percent.

This bill would make corrections to the payment system so that certain cases and patients are not significantly more profitable or less profitable to treat than others. While we believe the secretary has the authority to make these payment changes, this bill will direct CMS to do so beginning in 2007. This will improve payment accuracy for all hospitals, and will better reflect the actual cost of delivering care.

But Medicare payment changes are not enough.

I also have great concerns about the inherent conflict of interest in physician ownership. This interest in gaming the system may not be in the best interest of the patient, and this is troubling. Physicians are paid by Medicare to treat the patient. In addition, because they are owners of the hospital, physician owners get a payment from Medicare for use of the facility. And, because they are also investors in the hospital, these physician owners also get dividends on their investment. MedPAC found these annual dividends for older facilities are frequently in excess of 20 percent.

I am concerned that this focus on profit may unduly influence physician decision-making on the part of some physicians. This is not good for unsuspecting patients, the Medicare program or taxpayers. Some physicians may choose where to send a patient based on whether or not they think that patient will profit their hospital. In addition, changes to the payment system don't prevent some physician-owners from selecting patients based on their insurance. Specialty hospitals would likely continue to treat few—if any—poor or uninsured patients.

MedPAC has found that specialty hospital hospitals treat far fewer Medicaid recipients than community hospitals in the same market—75 percent fewer for specialty heart hospitals, and 94 percent fewer for specialty orthopedic hospitals. In addition, CMS found that specialty hospitals provided only

about 40 percent of the share of uncompensated care that the local community hospitals provided. We now have 45 million uninsured Americans in our country, and I continue to be very concerned about their health care.

Congress has passed laws that, with very few exceptions, prevent physician physicians from referring Medicare and Medicaid patients to facilities in which they are owners. This was adopted in response to a number of studies that found that physician-owners tended to make more referrals to their facilities and order substantially more services at higher cost.

One exception, however, is the “whole hospital” exception. The law allows physicians to invest in a “whole hospital” because it is believed that no particular referral would economically advantage a specific physician owner. Because the referrals would be diluted across multiple services, there would not be a direct link to any one physician's income. But specialty hospitals are not really whole hospitals. In fact, they are more like a hospital department such as a cardiac unit or an orthopedic unit. Under current law, we believe that the secretary has the authority to define what constitutes a whole hospital, and we encourage CMS to determine whether specialty hospitals meet this definition. The law clearly states that it is illegal for physicians to invest in hospital departments.

This loophole in the law, the “whole hospital” exception, is being exploited. The Hospital Fair Competition Act will close this loophole. New specialty hospitals will not qualify for the “whole hospital” exception as of June 8, 2005—the date the moratorium expires.

Existing specialty hospitals, those in operation or under development before November 18, 2003, will be able to continue operating under certain restrictions. These “grandfathered” specialty hospitals will be prohibited from increasing their total number of physician owners. Also, the bill caps each individual physician's investment and the aggregate physician investment in the facility as of June 8, 2005. Grandfathered specialty hospitals will not be allowed to expand their scope of services. And finally, they will be prohibited from increasing their number of beds or operating rooms. I believe that halting the growth in physician ownership at existing specialty hospitals is the only way to prevent the inherent conflict of interest associated with self-referral, and ensure that patients' interests are not compromised.

Now, I have heard from a number of physician-owners on this issue and they have said to me that they invest in these hospitals because it allows them to have greater control over their workplace. It gives them a say in operations, and more control over the quality and cost of patient care. I believe that certain coordinated care incentive arrangements have the potential to assist physicians in doing just that.

So this bill would provide an opportunity to better align physician and hospital financial incentives. It would allow physicians to share in hospital savings achieved by re-engineering clinical care in the hospitals. These well-designed and approved arrangements might include agreed-upon use of certain medical devices or implants for certain type of surgeries. Or perhaps they would include improving operating room efficiency and scheduling. Or they might include the adoption of clinical protocols or evidence-based medicine to standardize certain aspects of the practice of medicine.

While these arrangements have the potential to improve patient care while reducing hospital costs, I want to make sure the patient—the Medicare beneficiary—is protected. So, this bill would require the secretary to develop safeguards and monitor these coordinated care arrangements to make sure that physicians are not profiting for increased referrals or for reducing quality care.

In summary, The Hospital Fair Competition Act would:

Improve the accuracy of Medicare inpatient payments by directing the secretary to level the playing field by using estimated costs rather than charges in setting the DRG weights; calculating DRG weights at the hospital level before aggregating them to a national level; adjusting the DRG weights to account for high cost outlier payments, and ensuring that the DRGs appropriately capture differences in the severity of illness of patients.

Allow existing specialty hospitals to continue operation under certain restrictions, especially regarding physician investment.

Close the “whole hospital” loophole by prohibiting new specialty hospitals from having ownership or investment interest from physicians who refer Medicare or Medicaid patients to the hospital, effective June 8, 2005.

Allow physicians and hospitals to enter into certain coordinated care arrangements where physicians could share in savings experienced by a hospital by implementing certain cost-reduction efforts.

Establish safeguards to ensure that coordinated care arrangements protect quality of care and minimize any impact on physician referrals.

I urge all my colleagues to join Senator BAUCUS and me in support of this very important bill.

Mr. BAUCUS. Mr. President, I rise today to join Chairman GRASSLEY in introducing the Hospital Fair Competition Act of 2005.

This bill, based primarily on recommendations of the Medicare Payment Advisory Commission (MedPAC), will improve the accuracy of Medicare's inpatient hospital prospective payment system (PPS); prevent the establishment of new specialty hospitals to which physician-owners can self-

refer, while allowing existing physician-owned specialty hospitals to continue with restrictions; and allow "gainsharing" arrangements to foster improved physician-hospital efficiency. This legislation is important for patients, taxpayers, and the Medicare program, and I urge my colleagues to support it.

About 17 months ago, Congress passed the Medicare Modernization Act—the MMA. This 400-page bill included many important provisions, including long-awaited outpatient drug benefits under Medicare.

The MMA also included a small provision—Section 507—related to the construction of physician-owned specialty hospitals. These facilities specialize in cardiac, orthopedic or general surgical care, and are partly- or wholly-owned by physicians. The provision was a response to growing concerns over physician self-referral, and placed a moratorium on the construction of new, physician-owned specialty hospitals, while "grandfathering" existing facilities and those in development.

Having reviewed several independent analyses on this issue, I believe Congress was right to place a moratorium on specialty hospital construction. And I also believe that moratorium should effectively be extended permanently, while allowing existing facilities to continue operating in their current capacity.

Some view specialty hospitals as innovative, focused factories for high-quality, specialized care. Advocates for these facilities say that by focusing on a limited number of services, specialty hospitals provide excellent care at a good price, while adding competition to the health care marketplace.

Others say specialty hospitals flourish because they exploit a Medicare loophole allowing physician-owners to select patients who are healthier and, therefore, more profitable.

For my part, I don't want to stand in the way of innovation or competition. For example, I'm glad that Congress brought innovation to Medicare in the form of outpatient drug benefits. That was long overdue.

And hospitals and physicians should work together in innovative ways to improve efficiency in health care. The U.S. spends twice as much—or more—per-person on health care compared to any other developed country. And yet, our health outcomes are worse than theirs. We should get a better bang for our health-care buck, and we can take steps to that end by encouraging quality and accountability in health care.

That's why I am pushing to advance incentives for quality improvement in Medicare, so patients—and taxpayers—get the most for their money. I introduced legislation last year to require that Medicare pay dialysis providers and Medicare managed care plans based on the quality of care they provide. And I am working on legislation to extend these principles of paying for quality to other parts of Medicare.

As for competition, I'm all for it—as long as it's carried out on a level playing field. But when it comes to physician ownership of specialty hospitals, I'm not convinced the playing field is level. That's because physicians alone choose where patients go on the playing field—either to community hospitals or specialty hospitals. Some liken physician-owners of specialty hospitals to coaches who choose the starting lineup for both teams—in this case, the specialty hospital team and the community hospital team.

And for the third time, a Federal agency has told us that the healthiest teams, that is, the most profitable patients, end up at physician-owned specialty hospitals.

In 2003, the non-partisan Government Accountability Office (GAO) reported that, by and large, specialty hospitals care for relatively healthier patients than their community hospital counterparts. GAO surveyed 25 specialty hospitals, and found that 21 of the 25 had a less acute mix patients than community hospitals. GAO determined that of the hospitals studied, 17 percent cardiac patients seen by specialty hospitals could be classified as severe cases, compared with 22 percent in general hospitals. And about 5 percent of orthopedic cases in specialty hospitals were severe, compared with 8 percent in community hospitals.

Earlier this year, on March 8, MedPAC issued its MMA-mandated report on specialty hospitals, and arrived at findings similar to those of the GAO. MedPAC found that despite shorter lengths of stay, physician-owned specialty hospitals are not more cost efficient than community hospitals. MedPAC found that specialty hospitals tend to treat lower shares of Medicaid patients than community hospitals. And, just as GAO did, MedPAC found that specialty hospitals treat patients who are generally less sick—and therefore, more profitable—compared to community hospitals.

And while the Department of Health and Human Services has not officially issued its MMA-mandated report on the topic—but is expected to shortly—HHS reported on March 8 that, based on the small number of facilities it studied, specialty hospitals tend to care for a healthier patient population than their community hospital counterparts.

I believe the phenomenon of specialty hospitals treating healthier patients is the result of a loophole in the Stark self-referral law. This loophole—related to the "whole hospital exception"—is one that should be closed. If it is not closed, Congress will effectively sanction the practice of physician self-referral that has been prohibited for years.

In 1989, the HHS Inspector General reported that patients of referring physicians who owned or invested in independent clinical labs received 45% more lab services than Medicare patients in general.

In 1992, a study found that physical therapy visits per patient were 39% to 45% higher in facilities with physician ownership compared to those without. In short, the authors of the study found that utilization and charges per-patient were higher when facilities were owned by physicians with an ownership interest.

In response to these studies and others like them, Congress passed the Stark laws, to prevent physician self-referral, first in the area of clinical labs, and subsequently in 10 other areas, including physical therapy and certain imaging procedures.

But the Stark laws did not address the issue of physician self-referral to specialty hospitals. In part, that's because there weren't many specialty hospitals at the time. As the GAO pointed out in its 2003 report, the vast majority of specialty hospitals were built in 1992 or later.

Instead, the Stark law included a provision that has come to be known as the "whole hospital exception." While the Stark law prohibits physicians with ownership interest in only a hospital department from referring patients to that department, the law does allow physicians to refer to a facility they partially own, under two conditions. First, the physician must have admitting privileges in that hospital. Second, the physician must have a financial interest in the "whole hospital," not just a department of the hospital.

As the GAO explained in 2003:

"The premise [of the whole hospital exception] is that any referral or decision made by a physician who has a stake in an entire hospital would produce little personal economic gain because hospitals tend to provide a diverse and large group of services. However, the Stark law does prohibit physicians who have ownership interest only in a hospital subdivision from referring patients to that subdivision. With respect to specialty hospitals, the concern exists that, as these hospitals are usually much smaller in size and scope than general hospitals and closer in size to hospital departments, the exception to Stark could allow physician owners to influence their hospitals—and therefore their own financial gain through practice patterns and referrals."

The problem with the "whole hospital" loophole is that it treats a 10-bed surgical facility the same as a 500-bed community hospital, even though that 10-bed facility more resembles a department of the 500-bed hospital than it does the hospital itself. This loophole is unfair, and our bill closes it, by preventing the establishment of new specialty hospitals to which physician-owners can self-refer.

Let me note that our bill does nothing to prevent the construction of new specialty hospitals—as long as self-referral is not part of the business model. Hospitals specializing in one type of care or another have existed in this country for years, and should be encouraged—as long as their owners and referrers are not one and the same.

Opponents of this bill will likely make at least three claims. First, they

will state that preventing the construction of new, physician-owned specialty hospitals is anticompetitive. Second, they will suggest that since the average physician-owner's share in a specialty hospital is small, economic incentives to self-refer are minimal. Third, they will claim the bill thwarts health care quality. Let me take these claims in turn.

As I stated previously, I am all for competition—as long as it's fair. But I don't think it's fair to further a system in which physician-owners can send healthier and more profitable patients to facilities they own, while sending sicker, less-profitable ones to hospitals they don't own. There's a reason Congress acted to mitigate the effects of physician self-referral over 15 years ago, and I see no reason why that principle should not be extended to the specialty hospital setting.

On the issue of economic incentives, some argue that physician self-referral to specialty hospitals is a non-issue, since physicians typically own a very small share of a particular facility. In fact, MedPAC found that in about one-third of specialty hospitals they surveyed, the largest share owned by a single physician was just two percent. And as a group, physicians own just over a third of the typical heart hospital. But MedPAC also pointed out that about one-third of orthopedic and surgical hospitals were owned almost entirely by their physicians. Perhaps more important, MedPAC showed that even a relatively small ownership interest can reap large profits for an individual physician investor. Page 21 of MedPAC's March report on specialty hospitals says:

What is the order of magnitude of physicians financial incentives to increase utilization when they own a hospital? What follows is a hypothetical example of the marginal profit associated with a group of cardiologists each referring just one additional patient (above the current patient load) for coronary artery bypass graft (CABG) surgery. In fiscal year 2002, the base payment for CABG surgery with cardiac catheterization (DRG 107) was roughly \$24,000. Our examination of Medicare cost reports and hospital financial statements suggests that variable costs equal approximately 60 percent of the DRG payment, roughly \$14,400. Hence the marginal profit—payments minus variable cost—would be \$9,600 per patient (\$24,000-\$14,400). If 10 cardiologists owned a 3 percent interest each and they all induced one additional surgery per year, each cardiologist's income would increase by \$2,880 (\$9,600 3% 10)."

In other words, even a small ownership share—just three percent—can provide a strong profit motive—and a strong incentive toward self-referral.

Finally, let me address the third claim that will likely be made against this bill—that it thwarts the provision of quality care. Specialty hospital advocates claim that due to the focused nature of their mission, physician-owned specialty hospitals provide better quality and outcomes than their community hospital counterparts. But recently the *New England Journal of Medicine* published a study showing

that patients undergoing certain heart procedures in specialty hospitals were less likely to have coexisting conditions than those being treated at general hospitals. The authors of the study stated, ". . . given that we found no significant differences in outcomes between specialty and general hospitals with similar volumes or between specialty cardiac hospitals and specialized general hospitals, it could be argued that the specialty-hospital model itself does not yield better outcomes." They also said, ". . . our study provides no definitive evidence that cardiac specialty hospitals provide better or more efficient care than general hospitals with similar procedural volumes."

In short, there is solid evidence that despite being less efficient, physician-owned specialty hospitals care for healthier, more-profitable patients, leaving community hospitals to care for sicker, less-profitable ones. Economic incentives toward physician self-referral in specialty hospitals are significant. And there is slim evidence that specialty hospitals provide better care than community hospitals.

Given this evidence, it's clear that Congress should not facilitate the construction of more physician-owned specialty hospitals. And while we support "grandfathering" existing facilities, let me make clear that we do not intend to create another grandfathering period if the legislation is not enacted before June 8, 2005. The intent of this bill, even if it passes after June 8, is to effectively make permanent the MMA-mandated moratorium.

But this bill does more than simply prevent the establishment of new, physician-owned specialty hospitals. It also takes steps to mitigate ill incentives in the inpatient PPS, by making the PPS more accurate for all providers of hospital care—community hospitals and 'grandfathered' specialty hospitals alike.

Medicare spends about \$100 billion per year on inpatient hospital services, and it's important that this system be accurate. Accordingly, MedPAC recommended a number of steps to improve the accuracy of the Medicare inpatient payment system. These recommendations should mitigate incentives for all hospitals to choose healthy patients over sick ones, and to focus on some diagnoses at the expense of others.

Medicare pays hospitals for inpatient services based on roughly 500 Diagnosis Related Groups (DRGs), which bundle services needed to treat a patient with a particular disease. DRGs cover most routine operating costs attributable to patient care, including routine nursing services, room and board, and diagnostic and ancillary services. Under current law, just over five percent of the base payment for all DRGs is set aside for inpatient outlier payments, even though some DRGs have almost no outlier cases. The Hospital Fair Competition Act directs the Secretary to adjust the DRG relative weights to

account for differences in the prevalence of high-cost outlier cases, thereby removing their disproportionate impact on the payment system.

The bill also improves accuracy of the DRG weights. Currently DRG weights are based on the national average of hospital charges for a particular DRG. The rate of growth for these charges may vary dramatically, depending on the service. For example, MedPAC has found that hospital mark-ups for ancillary services (e.g., supplies, operating room time) tend to be higher than those of routine services (e.g., room and board, nursing care). As these ancillary and routine charges grow at different rates, the DRGs reflect that growth, gradually skewing the system away from the true costs of providing care. In short, a charge-based system causes Medicare to pay too much for some services, not enough for others. The Hospital Fair Competition Act directs the Secretary to substitute the charge-based system with one based on hospitals' costs, as well as base the DRG weights on the national average of hospitals' relative values in each DRG.

Mind you, we believe that the Secretary currently has the authority to make the payment changes outlined above. The Hospital Fair Competition Act simply directs the Secretary to do so. We also believe the Secretary has the authority to promulgate regulations defining what a "whole hospital" is. When Congress passed the "whole hospital exception", it did not intend to allow self-referral to facilities that are effectively the equivalent of a hospital wing or department. We believe the Secretary can and should exercise his authority to close the "whole hospital" loophole by regulation.

Mr. President, some say that the proliferation of physician-owned specialty hospitals is a function of physicians' desire for control over their workplace. They argue that physicians typically have no say in day-to-day hospital operations, and thus little incentive to improve the quality or efficiency of the care they provide in the hospital. MedPAC's recommendations for "gainsharing" stand to alleviate some of that concern, by giving physicians more control over their workplace.

Gainsharing arrangements allow physicians and hospitals to improve hospital efficiency without the undesirable effects of physician self-referral. In a gainsharing arrangement, hospitals and physicians share cost-savings gained by means such as streamlining the purchase of medical devices, substituting less-costly items used in surgical procedures, and maximizing operating room efficiency. While gainsharing arrangements must be developed carefully so as not to compromise quality of patient care, gain sharing has the potential to align physician-hospital incentives so that care

can be delivered in the most cost-effective manner.

I realize that gainsharing arrangements are not a panacea toward improving physician-hospital relations. We can and should do more to give providers of all types a better stake in improving their workplace and the quality of care they provide. That's why I am pushing initiatives to tie Medicare payment to quality, so that—unlike the current system—the best providers are not paid the same rates as mediocre ones. This system of paying for quality stands to improve accountability across the spectrum of Medicare provider types, and give both patients and the government more for their money.

We all know that Medicare's long-term fiscal future is much in doubt. Hardly a day passes without a warning about Medicare's finances and the retirement of the Baby Boom generation that will complicate the long-term financial picture of the program.

Given these warnings, it's imperative that we make the most of the resources at hand, and—where possible—make Medicare a better more responsible buyer of health care. By leveling the playing field regarding patient referrals; improving the accuracy of Medicare's inpatient hospital payments; and giving physicians a larger stake in their hospital workplaces, this bill stands to do that.

Chairman GRASSLEY and I believe these changes will go a long way toward improving much of what ails hospital payment under Medicare, and we urge our colleagues' support for this important legislation.

By Mr. McCAIN:

S. 1003. A bill to amend the Act of December 22, 1974, and for other purposes; to the Committee on Indian Affairs.

Mr. McCAIN. Mr. President, today I am introducing legislation to amend the Navajo-Hopi Land Settlement Act of 1974 in order to bring the relocation process to an orderly conclusion. I look forward to working with all affected parties on this bill and will work with them to ensure it takes into account their views. This bill will phase out the Navajo-Hopi relocation program by September 30, 2008, and at that time transfer all remaining responsibilities to the Secretary of the Interior. It provides a time certain for eligible Navajo and Hopi individuals to apply for and receive relocation benefits and after that time the Federal Government will no longer be obligated to provide replacement homes for those individuals. Under this legislation, the funds that would have been used to provide replacement homes to such individuals will be held in trust by the Secretary for distribution to the individual or their heirs.

The Navajo-Hopi Land Settlement Act of 1974 was enacted to resolve long-standing disputes that have divided the Navajo and Hopi Indian Tribes for over

a century. The origins of this dispute can be traced directly to the creation of the 1882 reservation for the Hopi Tribe and the subsequent creation of the 1934 Navajo Reservation. At the time these reservations were established, Navajo families lived within the lands set aside for the Hopi Tribe and Hopi families lived within lands set aside for the Navajo Nation and tensions between the two tribes continued to heighten. In 1958 Congress, in an effort to resolve this dispute, passed legislation that authorized the tribes to file suit in Federal court to quiet title the 1882 reservation and to their respective claims and rights. That legislation gave rise to over 35 years of continuous litigation between the tribes in an effort to resolve their respective rights and claims to the land.

In 1974, Congress enacted the Navajo-Hopi Land Settlement Act which established Navajo and Hopi negotiating teams under the auspices of a Federal mediator to negotiate a settlement to the 1882 reservation land dispute. The act also authorized the tribes to file suit in Federal court to quiet title the 1934 reservation and to file claims for damages arising out of the dispute against each other or the United States. The act also established a three member Navajo-Hopi Indian Relocation Commission to oversee the relocation of members of the Navajo Nation who were living on lands partitioned to the Hopi Tribe and members of the Hopi Tribe who were living on lands partitioned to the Navajo Nation. Since its establishment, the relocation program has been an extremely difficult and contentious process.

When this program was first established, the estimated cost of providing relocation benefits to approximately 6,000 Navajos estimated eligible for relocation was roughly \$40 million. These figures woefully underestimated the number of families impacted by relocation and the tremendous delays that have plagued this program. By 1996, the United States had expended over \$350 million to relocate more than 11,000 Navajo and Hopi tribal members. At that time, there remained over 640 eligible families who had never received relocation benefits and an additional 50 to 100 families who had never applied for relocation benefits. There were also over 130 eligibility appeals pending. Without question, the funding for this settlement has far exceeded the original cost estimates by more than 1000 percent. Since 1975, Congress has appropriated over \$440 million for this program.

At its inception, the relocation program was intended to be a temporary program that was established to fulfill a specific mission and we cannot continue to fund it with no end in sight. Moreover, I am convinced that our current Federal budgetary pressures require us to ensure that the Navajo-Hopi relocation housing program is brought to an orderly and certain conclusion. It is for that reason that I am

introducing the Navajo-Hopi Land Settlement Act Amendments of 2005. This legislation will phase out the Navajo-Hopi Indian relocation program by September 30, 2008, and transfer the remaining responsibilities under the act to the Secretary of the Interior. Under the bill, the relocation commissioner shall transfer to the Secretary such funds as are necessary to construct replacement homes for any eligible head of household who has left the Hopi partitioned land but who has not received a replacement home by September 30, 2008. These funds will be held in trust by the Secretary of the Interior for distribution to such individual or their heirs. In addition, the bill includes provisions establishing an expedited procedure for handling appeals of final eligibility determinations.

This bill is similar to the legislation I introduced during the 104th Congress. S. 1111 proposed to phase out the relocation program by September 2001. A hearing was held on that bill and comments were received from the affected parties. At that time, many of the witnesses stated that with limited exception, the program could come to a resolution under the time line proposed in S. 1111. Opposition to passing the legislation was based in part on the incomplete process of approval of the accommodation lease agreements between the Hopi Tribe and individual Navajos who were still living on the Hopi partitioned lands. That action has since occurred and the Commission has had eight additional years to conclude its responsibilities. Therefore, it is now time for the Congress to act to bring the long and difficult process of relocation to an orderly conclusion.

I ask unanimous consent that the full 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. 1003

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 "Navajo-Hopi Land Settlement Amendments of 2005".

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

Sec. 1. Short title; table of contents.

TITLE I—AMENDMENTS TO THE NAVAJO-HOPI LAND SETTLEMENT ACT OF 1974

Sec. 101. Repeal of sections.

Sec. 102. Definitions; division of land.

Sec. 103. Joint ownership of minerals.

Sec. 104. Actions.

Sec. 105. Paiute Indian allotments.

Sec. 106. Partitioned and other designated land.

Sec. 107. Resettlement land for Navajo Tribe.

Sec. 108. Office of Navajo and Hopi Indian Relocation.

Sec. 109. Report.

Sec. 110. Relocation of households and members.

Sec. 111. Relocation housing.

Sec. 112. Payment for use of land.

Sec. 113. Effect of Act.

- Sec. 114. Actions for accounting, fair value of grazing, and claims for damages to land.
- Sec. 115. Joint use.
- Sec. 116. Religious ceremonies; piping of water.
- Sec. 117. Access to religious shrines.
- Sec. 118. Exclusion of payments from certain Federal determinations of income.
- Sec. 119. Authorization of exchange.
- Sec. 120. Severability.
- Sec. 121. Authorization of appropriations.
- Sec. 122. Funding and construction of high school and medical center.
- Sec. 123. Environmental impact; wilderness study; cancellation of leases and permits.
- Sec. 124. Attorney fees and court costs.
- Sec. 125. Lobbying.
- Sec. 126. Navajo Rehabilitation Trust Fund.
- Sec. 127. Availability of funds for relocation assistance.

TITLE II—PERSONNEL OF THE OFFICE OF NAVAJO AND HOPI INDIAN RELOCATION

- Sec. 201. Retention preference.
- Sec. 202. Separation pay.
- Sec. 203. Federal retirement.

TITLE III—TRANSFER OF FUNCTIONS AND SAVINGS PROVISIONS

- Sec. 301. Definitions.
- Sec. 302. Transfer of functions.
- Sec. 303. Transfer and allocations of appropriations.
- Sec. 304. Effect of title.

TITLE I—AMENDMENTS TO THE ACT OF DECEMBER 22, 1974

SEC. 101. REPEAL OF SECTIONS.

(a) IN GENERAL.—The Act of December 22, 1974 (25 U.S.C. 640d et seq.) is amended in the first undesignated section by striking “That, (a) within” and all that follows through the end of the section.

(b) ADDITIONAL REPEALS.—Sections 2 through 5 and sections 26 and 30 of the Act of December 22, 1974 (25 U.S.C. 640d-1 through 640d-4; 88 Stat. 1723; 25 U.S.C. 640d-28) are repealed.

SEC. 102. DEFINITIONS; DIVISION OF LAND.

Section 6 of the Act of December 22, 1974 (25 U.S.C. 640d-5) is amended—

(1) by striking “SEC. 6. The Mediator” and all that follows through subsection (f) and inserting the following:

“SECTION 1. DEFINITIONS.

“In this Act:

“(1) DISTRICT COURT.—The term ‘District Court’ means the United States District Court for the District of Arizona.

“(2) SECRETARY.—The term ‘Secretary’ means the Secretary of the Interior.

“(3) TRIBE.—The term ‘Tribe’ means—

“(A) the Navajo Indian Tribe; and

“(B) the Hopi Indian Tribe.

“SEC. 2. DIVISION OF LAND.

“(a) DIVISION.—

“(1) IN GENERAL.—The land located within the boundaries of the reservation established by Executive order on December 16, 1982, shall be divided into parcels of equal acreage and quality—

“(A) to the maximum extent practicable; and

“(B) in accordance with the final order issued by the District Court on August 30, 1978 (providing for the partition of the surface rights and interest of the Tribes).

“(2) VALUATION OF PARCELS.—For the purpose of calculating the value of a parcel produced by a division under paragraph (1), the Secretary shall—

“(A) take into account any improvement on the land; and

“(B) consider the grazing capacity of the land to be fully restored.

“(3) COMPENSATION BY TRIBES.—If the partition under paragraph (1) results in parcels of unequal value, as determined by the Secretary, the Tribe that receives the more valuable parcel shall pay to the other Tribe compensation in an amount equal to the difference in the values of the parcels, as determined by the Secretary.

“(4) COMPENSATION BY FEDERAL GOVERNMENT.—If the District Court determines that the failure of the Federal Government to fulfill an obligation of the Government decreased the value of a parcel under paragraph (1), the Government shall pay to the recipient of the parcel compensation in an amount equal to the difference between—

“(A) the decreased value of the parcel; and

“(B) the value of the fully restored parcel.”;

(2) by striking “(g) Any” and inserting the following:

“(b) LICENSE FEES AND RENTS.—Any”; and

(3) by striking “(h) Any” and inserting the following:

“(c) GRAZING AND AGRICULTURAL USE.—Any”.

SEC. 103. JOINT OWNERSHIP OF MINERALS.

Section 7 of the Act of December 22, 1974 (25 U.S.C. 640d-6) is amended—

(1) by striking “SEC. 7. Partition” and inserting the following:

“SEC. 3. JOINT OWNERSHIP OF MINERALS.

“(a) IN GENERAL.—Partition”; and

(2) in the second sentence, by striking

“All” and inserting the following:

“(b) JOINT MANAGEMENT.—All”.

SEC. 104. ACTIONS.

Section 8 of the Act of December 22, 1974 (25 U.S.C. 640d-7) is amended—

(1) by striking “SEC. 8. (a) Either Tribe” and inserting the following:

“SEC. 4. ACTIONS.

“(a) ACTIONS IN DISTRICT COURT.—Either Tribe”;

(2) in subsection (b)—

(A) in the first sentence, by striking “(b) Lands, if any,” and inserting the following:

“(b) ALLOCATION OF LAND.—

“(1) NAVAJO RESERVATION.—Any land”;

(B) in the second sentence, by striking

“Lands, if any,” and inserting the following:

“(2) HOPI RESERVATION.—Any land”; and

(C) in the third sentence, by striking “Any

lands” and inserting the following:

“(3) JOINT AND UNDIVIDED INTERESTS.—Any

land”;

(3) in subsection (c)—

(A) by striking “(c)(1) Either” and inserting

the following:

“(c) EXCHANGE OF LAND.—

“(1) IN GENERAL.—Either”;

(B) in paragraph (2), by striking “(2) In the

event” and inserting the following:

“(2) INTERESTS OF TRIBES.—If”;

(C) in paragraph (3), by striking “(3) Nei-

ther” and inserting the following:

“(3) DEFENSE.—Neither”; and

(D) by striking “section 18” each place it

appears and inserting “section 14”;

(4) in subsection (d), by striking “(d) Noth-

ing” and inserting the following:

“(d) EFFECT OF SECTION.—Nothing”;

(5) in subsection (e), by striking “(e) The”

and inserting the following:

“(e) PAYMENT OF LEGAL FEES, COURT

COSTS, AND OTHER EXPENSES.—The”; and

(6) by striking subsection (f).

SEC. 105. PAIUTE INDIAN ALLOTMENTS.

Section 9 of the Act of December 22, 1974 (25 U.S.C. 640d-8) is amended by striking

“SEC. 9. Notwithstanding” and inserting the following:

“SEC. 5. PAIUTE INDIAN ALLOTMENTS.

“Notwithstanding”.

SEC. 106. PARTITIONED AND OTHER DESIGNATED LAND.

Section 10 of the Act of December 22, 1974 (25 U.S.C. 640d-9) is amended—

(1) by striking “SEC. 10. (a) Subject” and inserting the following:

“SEC. 6. PARTITIONED AND OTHER DESIGNATED LAND.

“(a) NAVAJO TRUST LAND.—Subject”;

(2) in subsection (a), by striking “section 9 and subsection (a) of section 17” and inserting “sections 5 and 13(a)”;

(3) in subsection (b)—

(A) by striking “(b) Subject” and inserting the following:

“(b) HOPI TRUST LAND.—Subject”;

(B) by striking “section 9 and subsection (a) of section 17” and inserting “sections 5 and 13(a)”;

(C) by striking “section 3 or 4” and inserting “section 1”; and

(D) by striking “section 8” and inserting “section 4”;

(4) in subsection (c)—

(A) by striking “(c) The” and inserting the following:

“(c) PROTECTION OF RIGHTS AND PROPERTY.—The”; and

(B) by striking “pursuant thereto” and all that follows through the end of the subsection and inserting “pursuant to this Act”;

(5) in subsection (d), by striking “(d) With”

and inserting the following:

“(d) PROTECTION OF BENEFITS AND SERVICES.—With”; and

(6) in subsection (e)—

(A) by striking “(e)(1) Lands” and inserting the following:

“(e) TRIBAL JURISDICTION OVER PARTITIONED LAND.—

“(1) IN GENERAL.—Land”;

(B) by adjusting the margins of subparagraphs (A) and (B) of paragraph (1) appropriately; and

(C) in the matter following subparagraph

(B)—

(i) by striking “The provisions” and inserting the following:

“(2) RESPONSIBILITY OF SECRETARY.—The provisions”; and

(ii) by striking “life tenants and”.

SEC. 107. RESETTLEMENT LAND FOR NAVAJO TRIBE.

(a) IN GENERAL.—Section 11(a) of the Act of December 22, 1974 (25 U.S.C. 640d-10(a)) is amended—

(1) by striking “SEC. 11. (a) The Secretary” and inserting the following:

“SEC. 7. RESETTLEMENT LAND FOR NAVAJO TRIBE.

“(a) TRANSFER OF LAND.—

“(1) IN GENERAL.—The Secretary”;

(2) by striking “(1) transfer not to exceed two hundred and fifty thousand acres of

lands” and inserting the following:

“(A) transfer not more than 250,000 acres of

land”;

(3) by striking “Tribe: *Provided*, That” and all that follows through “as possible.” and

inserting “Tribe; and”;

(4) in the first paragraph designated as

paragraph (2)—

(A) by striking “(2) on behalf” and inserting the following:

“(B) on behalf”; and

(B) by striking the second sentence;

(5) in the matter following paragraph (1)(B) (as redesignated by paragraph (4))—

(A) in the first sentence—

(i) by striking “Subject to” and all that follows through “all rights” and inserting the following:

“(4) REQUIREMENTS OF TRANSFER.—

“(A) IN GENERAL.—Subject to this paragraph, all rights”; and

(ii) by striking “paragraph (1)” and inserting “paragraph (1)(A)”;

(B) in the second sentence, by striking “So long as” and inserting the following:

“(B) COAL LEASE APPLICATIONS.—

“(i) IN GENERAL.—If”;

(C) in the third sentence, by striking “If such adjudication” and inserting the following:

“(ii) ISSUANCE OF LEASES.—If an adjudication under clause (i)”;

(D) in the fourth sentence, by striking “The leaseholders rights and interests” and inserting the following:

“(iii) RIGHTS AND INTERESTS OF LEASEHOLDERS.—The rights and interests of a holder of a lease described in clause (i)”;

(E) in the fifth sentence, by striking “If any” and inserting the following:

“(C) CLAIMS UNDER MINING LAW.—If any”;

(6) by inserting after paragraph (1)(B) (as redesignated by paragraph (4)) the following:

“(2) EXCHANGE OF LAND.—
“(A) IN GENERAL.—In order to facilitate a transfer of land under paragraph (1)(A), the Secretary may exchange land described in paragraph (1)(A) for State or private land of equal value.

“(B) UNEQUAL VALUE.—If the State or private land described in subparagraph (A) is of unequal value to the land described in paragraph (1)(A), the recipient of the land that is of greater value shall pay to the other party to the exchange under subparagraph (A) compensation in an amount not to exceed the lesser of—

“(i) the difference between the values of the land exchanged; or

“(ii) the amount that is 25 percent of the total value of the land transferred from the Secretary to the Navajo Tribe.

“(C) RESPONSIBILITY OF SECRETARY.—The Secretary shall ensure that the amount of a payment under subparagraph (B) is as minimal as practicable.

“(3) TITLE TO LAND ACCEPTED.—The Secretary shall accept title to land under paragraph (1)(B) on behalf of the United States in trust for the benefit of the Navajo Tribe as a part of the Navajo reservation.”; and

(7) in the second paragraph designated as paragraph (2)—

(A) in the first sentence—

(i) by striking “(2) Those” and inserting the following:

“(5) STATE RIGHTS.—

“(A) IN GENERAL.—The”; and

(ii) by striking “subsection 2 of this section” and inserting “paragraph (1)(B)”;

(B) in the second sentence, by striking “The” and inserting the following:

“(B) STATE INTERESTS.—The”.

(b) PROXIMITY OF LAND; EXCHANGES OF LAND.—Section 11(b) of the Act of December 22, 1974 (25 U.S.C. 640d-10(b)) is amended by striking “(b) A border” and inserting the following:

“(b) PROXIMITY OF LAND TO BE TRANSFERRED OR ACQUIRED.—A border”.

(c) SELECTION OF LAND.—Section 11(c) of the Act of December 22, 1974 (25 U.S.C. 640d-10(c)) is amended—

(1) by striking “(c) Lands” and inserting the following:

“(c) SELECTION OF LAND TO BE TRANSFERRED OR ACQUIRED.—Land”; and

(2) by striking the period at the end and inserting the following: “: *Provided further*, That the authority of the Commissioner to select lands under this subsection shall terminate on September 30, 2008.”.

(d) REPORTS.—Section 11(d) of the Act of December 22, 1974 (25 U.S.C. 640d-10(d)) is amended by striking “(d) The” and inserting the following:

“(d) REPORTS.—The”.

(e) PAYMENTS.—Section 11(e) of the Act of December 22, 1974 (25 U.S.C. 640d-10(e)) is amended by striking “(e) Payments” and inserting the following:

“(e) PAYMENTS.—Payments”.

(f) ACQUISITION OF TITLE TO SURFACE AND SUBSURFACE INTERESTS.—Section 11(f) of the Act of December 22, 1974 (25 U.S.C. 640d-10(f)) is amended—

(1) by striking “(f)(1) For” and inserting the following:

“(f) ACQUISITION OF TITLE TO SURFACE AND SUBSURFACE INTERESTS.—

“(1) IN GENERAL.—For”;

(2) in paragraph (2), by striking “(2) If” and inserting the following:

“(2) PUBLIC NOTICE; REPORT.—If”; and

(3) in paragraph (3), by striking “(3) In any case where” and inserting the following:

“(3) RIGHTS OF SUBSURFACE OWNERS.—If”.

(g) LAND NOT AVAILABLE FOR TRANSFER.—Section 11(g) of the Act of December 22, 1974 (25 U.S.C. 640d-10(g)) is amended by striking “(g) No” and inserting the following:

“(g) LAND NOT AVAILABLE FOR TRANSFER.—No”.

(h) ADMINISTRATION OF LAND TRANSFERRED OR ACQUIRED.—Section 11(h) of the Act of December 22, 1974 (25 U.S.C. 640d-10(h)) is amended—

(1) by striking “(h) The lands” and inserting the following:

“(h) ADMINISTRATION OF LAND TRANSFERRED OR ACQUIRED.—

“(1) IN GENERAL.—The land”; and

(2) by adding at the end the following:

“(2) RELOCATION.—

“(A) IN GENERAL.—In order to facilitate relocation of a member of a Tribe, the Commissioner may grant a homesite lease on land acquired under this section to a member of the extended family of a Navajo Indian who is certified as eligible to receive benefits under this Act.

“(B) EXCEPTION.—The Commissioner may not use any funds available to the Commissioner to carry out this Act to provide housing to an extended family member described in subparagraph (A).”.

(i) NEGOTIATIONS REGARDING LAND EXCHANGES AND LEASES.—Section 11(i) of the Act of December 22, 1974 (25 U.S.C. 640d-10(i)) is amended—

(1) by striking “(i) The” and inserting the following:

“(i) NEGOTIATIONS REGARDING LAND EXCHANGES AND LEASES.—The”; and

(2) by striking “section 23” and inserting “section 19”.

SEC. 108. OFFICE OF NAVAJO AND HOPI INDIAN RELOCATION.

Section 12 of the Act of December 22, 1974 (25 U.S.C. 640d-11) is amended—

(1) by striking “SEC. 12. (a) There is hereby” and inserting the following:

“SEC. 8. OFFICE OF NAVAJO AND HOPI INDIAN RELOCATION.

“(a) ESTABLISHMENT.—There is”;

(2) in subsection (b), by striking “(b) The” and inserting the following:

“(b) APPOINTMENT.—The”;

(3) in subsection (c)—

(A) by striking “(c)(1)(A) Except” and inserting the following:

“(c) CONTINUATION OF POWERS.—

“(1) POWERS AND DUTIES OF COMMISSIONER; EXISTING FUNDS.—

“(A) POWERS AND DUTIES OF COMMISSIONER.—Except”;

(B) in paragraph (1)(B), by striking “(B) All” and inserting the following:

“(B) EXISTING FUNDS.—All”; and

(C) in paragraph (2), by striking “(2) There are hereby” and inserting the following:

“(2) TRANSFER OF POWERS.—There are”;

(4) in subsection (d)—

(A) by striking “(d)(1) Subject” and inserting the following:

“(d) POWERS OF COMMISSIONER.—

“(1) IN GENERAL.—Subject”;

(B) by adjusting the margins of subparagraphs (A) and (B) of paragraph (1) appropriately;

(C) in paragraph (2), by striking “(2) The” and inserting the following:

“(2) CONTRACTS.—The”; and

(D) in paragraph (3), by striking “(3) There” and inserting the following:

“(3) AUTHORIZATION OF APPROPRIATIONS.—There”;

(5) in subsection (e)—

(A) by striking “(e)(1)” and inserting the following:

“(e) ADMINISTRATION.—

“(1) ADMINISTRATIVE, FISCAL, AND HOUSEKEEPING SERVICES.—

(B) in paragraph (1)—

(i) in the first sentence, by striking “The” and inserting the following:

“(A) IN GENERAL.—The”; and

(ii) in the second sentence, by striking “In any” and inserting the following:

“(B) ASSISTANCE FROM DEPARTMENTS AND AGENCIES.—In any”; and

(C) in paragraph (2), by striking “(2) On” and inserting the following:

“(2) FAILURE TO PROVIDE ASSISTANCE.—On”;

(6) by striking subsection (f) and inserting the following:

“(f) TERMINATION.—

“(1) IN GENERAL.—The Office of Navajo and Hopi Indian Relocation shall terminate on September 30, 2008.

“(2) TRANSFER OF OFFICE DUTIES.—On the date of termination of the Office, any duty of the Office that has not been carried out, as determined in accordance with this Act, shall be transferred to the Secretary in accordance with title III of the Navajo-Hopi Land Settlement Amendments of 2005.”; and

(7) by adding at the end the following:

“(g) OFFICE OF RELOCATION.—

“(1) ESTABLISHMENT.—Effective on October 1, 2006, there is established in the Department of the Interior an Office of Relocation.

“(2) DUTIES.—The Secretary, acting through the Office of Relocation, shall carry out the duties of the Office of Navajo and Hopi Indian Relocation that are transferred to the Secretary in accordance with title III of the Navajo-Hopi Land Settlement Amendments of 2005.

“(3) TERMINATION.—The Office of Relocation shall terminate on the date on which the Secretary determines that the duties of the Office have been carried out.”.

SEC. 109. REPORT.

Section 13 of the Act of December 22, 1974 (25 U.S.C. 640d-12) is amended—

(1) by striking “SEC. 13. (a) By no” and inserting the following:

“SEC. 9. REPORT.

“(a) IN GENERAL.—Not”; and

(2) in subsection (b)—

(A) by striking “(b) The” and inserting the following:

“(b) INCLUSIONS.—The”; and

(B) by striking “contain, among other matters, the following:” and inserting “include”.

SEC. 110. RELOCATION OF HOUSEHOLDS AND MEMBERS.

Section 14 of the Act of December 22, 1974 (25 U.S.C. 640d-13) is amended—

(1) by striking “SEC. 14. (a)” and inserting the following:

“SEC. 10. RELOCATION OF HOUSEHOLDS AND MEMBERS.

“(a) AUTHORIZATION.—”;

(2) in subsection (a)—

(A) in the first sentence—

(i) by striking “Consistent” and inserting the following:

“(1) IN GENERAL.—Consistent”;

(ii) by striking “section 8” each place it appears and inserting “section 4”; and

(iii) by striking “section 3 or 4” and inserting “section 1”;

(B) by striking the second sentence;

(C) in the third sentence, by striking “No further” and inserting the following:

“(2) SETTLEMENTS OF NAVAJO.—No further”;

(D) in the fourth sentence, by striking “No further” and inserting the following:

“(3) SETTLEMENTS OF HOPI.—No further”; and

(E) in the fifth sentence, by striking “No individual” and inserting the following:

“(4) GRAZING.—No individual”;

(3) in subsection (b)—

(A) by striking “(b) In addition” and inserting the following:

“(b) ADDITIONAL PAYMENTS TO HEADS OF HOUSEHOLDS.—In addition”;

(B) by striking “section 15” and inserting “section 11”; and

(C) by striking “section 13” and inserting “section 9”;

(4) in subsection (c), by striking “(c) No” and inserting the following:

“(c) PAYMENTS FOR PERSONS MOVING AFTER A CERTAIN DATE.—No”; and

(5) by adding at the end the following:

“(d) PROHIBITION.—No payment for benefits under this Act may be made to any head of a household if, as of September 30, 2005, that head of household has not been certified as eligible to receive the payment.”.

SEC. 111. RELOCATION HOUSING.

Section 15 of the Act of December 22, 1974 (25 U.S.C. 640d-14) is amended—

(1) by striking “SEC. 15. (a)” and inserting the following:

“SEC. 11. RELOCATION HOUSING.

“(a) PURCHASE OF HABITATION AND IMPROVEMENTS.—”;

(2) in subsection (a)—

(A) in the first sentence, by striking “The Commission” and inserting the following:

“(1) IN GENERAL.—The Commission”; and

(B) in the second sentence—

(i) by striking “The purchase” and inserting the following:

“(2) PURCHASE PRICE.—The purchase”; and

(ii) by striking “as determined under clause (2) of subsection (b) of section 13”;

(3) in subsection (b)—

(A) by striking “(b) In addition” and inserting the following:

“(b) REIMBURSEMENT FOR MOVING EXPENSES AND PAYMENT FOR REPLACEMENT DWELLING.—In addition”;

(B) by striking “shall.” and inserting “shall—”; and

(C) in paragraph (1), by inserting “and” after the semicolon at the end;

(4) in subsection (c)—

(A) by striking “(c) In implementing” and inserting the following:

“(c) STANDARDS; CERTAIN PAYMENTS.—

“(1) STANDARDS.—In carrying out”; and

(B) in the second sentence—

(i) by striking “No payment” and inserting the following:

“(2) CERTAIN PAYMENTS.—No payment”;

(ii) by striking “section 8” and inserting “section 4”; and

(iii) by striking “section 3 or 4” and inserting “section 1”;

(5) in subsection (d)—

(A) by striking “(d) The” and inserting the following:

“(d) METHODS OF PAYMENT.—The”;

(B) by striking “(1) Should” and inserting the following:

“(1) HOME OWNERSHIP OPPORTUNITY PROJECTS.—Should”;

(C) by striking “(2) Should” and inserting the following:

“(2) PURCHASED AND CONSTRUCTED DWELLINGS.—Should”; and

(D) by striking “(3) Should” and inserting the following:

“(3) FAILURE TO ARRANGE RELOCATION.—Should”;

(6) in subsection (e)—

(A) by striking “(e) The” and inserting the following:

“(e) DISPOSAL OF ACQUIRED DWELLINGS AND IMPROVEMENTS.—The”;

(B) by striking “section 8” and inserting “section 4”; and

(C) by striking “section 3 or 4” and inserting “section 1”;

(7) in subsection (f), by striking “(f) Notwithstanding” and inserting the following:

“(f) PREFERENTIAL TREATMENT.—Notwithstanding”; and

(8) by striking subsection (g) and inserting the following:

“(g) BENEFITS HELD IN TRUST.—

“(1) IN GENERAL.—Not later than September 30, 2008, the Commissioner shall notify the Secretary of the identity of any head of household that, as of that date—

“(A) is certified as eligible to receive benefits under this Act;

“(B) does not reside on land that has been partitioned to the Tribe of which the head of household is a member; and

“(C) has not received a replacement home.

“(2) TRANSFER OF FUNDS.—Not later than September 30, 2008, the Commissioner shall transfer to the Secretary any funds not used by the Commissioner to make payments under this Act to eligible heads of households.

“(3) DISPOSITION OF TRANSFERRED FUNDS.—

“(A) IN GENERAL.—The Secretary shall hold any funds transferred under paragraph (2) in trust for the heads of households described in paragraph (1)(A).

“(B) PAYMENT AMOUNTS.—Of the funds held in trust under subparagraph (A), the Secretary shall make payments to heads of households described in paragraph (1)(A) in amounts that would have been made to the heads of households under this Act before September 30, 2008—

“(i) on receipt of a request of a head of household, to be used for a replacement home; or

“(ii) on the date of death of the head of household, if the head of household does not make a request under clause (i), in accordance with subparagraph (C).

“(C) DISTRIBUTION OF FUNDS ON DEATH OF HEAD OF HOUSEHOLD.—If the Secretary holds funds in trust under this paragraph for a head of household described in paragraph (1)(A) on the death of the head of household, the Secretary shall—

“(i) identify and notify any heir of the head of household; and

“(ii) distribute the funds held by the Secretary for the head of household to any heir—

“(I) immediately, if the heir is at least 18 years old; or

“(II) if the heir is younger than 18 years old on the date on which the Secretary identified the heir, on the date on which the heir attains the age of 18.

“(h) NOTIFICATION.—

“(1) IN GENERAL.—Not later than 180 days after the date of enactment of the Navajo-Hopi Land Settlement Amendments of 2005, the Commissioner shall notify each eligible head of household who has not entered into a lease with the Hopi Tribe to reside on land partitioned to the Hopi Tribe, in accordance with section 700.138 of title 25, Code of Federal Regulations (or a successor regulation).

“(2) LIST.—On the date on which a notice period referred to in section 700.139 of title 25, Code of Federal Regulations (or a successor regulation), expires, the Commissioner shall submit to the Secretary and the United States Attorney for the District of Arizona a list containing the name and address of each eligible head of household who—

“(A) continues to reside on land that has not been partitioned to the Tribe of the head of household; and

“(B) has not entered into a lease to reside on that land.

“(3) CONSTRUCTION OF REPLACEMENT HOMES.—Before July 1, 2008, but not later than 90 days after receiving a notice of the imminent removal of a relocatee from land provided to the Hopi Tribe under this Act from the Secretary or the United States Attorney for the District of Arizona, the Commissioner may begin construction of a replacement home on any land acquired under section 6.

“(i) APPEALS.—

“(1) IN GENERAL.—The Commissioner shall establish an expedited hearing procedure for any appeal relating to the denial of eligibility for benefits under this Act (including regulations promulgated pursuant to this Act) that is pending on, or filed after, the date of enactment of Navajo-Hopi Land Settlement Amendments of 2005.

“(2) FINAL DETERMINATIONS.—The hearing procedure established under paragraph (1) shall—

“(A) provide for a hearing before an impartial third party, as the Commissioner determines necessary; and

“(B) ensure that a final determination is made by the Office of Navajo and Hopi Indian Relocation for each appeal described in paragraph (1) by not later than January 1, 2008.

“(3) NOTICE.—

“(A) IN GENERAL.—Not later than 30 days after the date of enactment of the Navajo-Hopi Land Settlement Amendments of 2005, the Commissioner shall provide written notice to any individual that the Commissioner determines may have the right to a determination of eligibility for benefits under this Act.

“(B) REQUIREMENTS FOR NOTICE.—The notice provided under subparagraph (A) shall—

“(i) specify that a request for a determination of eligibility for benefits under this Act shall be presented to the Commission not later than 180 days after the date on which the notice is issued; and

“(ii) be provided—

“(I) by mail (including means other than certified mail) to the last known address of the recipient; and

“(II) in a newspaper of general circulation in the geographic area in which an address referred to in subclause (I) is located.

“(j) PROCUREMENT OF SERVICES.—

“(1) IN GENERAL.—Notwithstanding any other provision of this Act, to ensure the full and fair evaluation of the requests referred to in subsection (i)(3)(A) (including an appeal hearing before an impartial third party referred to in subsection (i)(2)(A)), the Commissioner may enter into such contracts or agreements to procure such services, and employ such personnel (including attorneys), as the Commissioner determines to be necessary.

“(2) DETAIL OF ADMINISTRATIVE LAW JUDGES OR HEARING OFFICERS.—The Commissioner may request the Secretary to act through the Director of the Office of Hearings and Appeals to make available to the Office of Navajo and Hopi Indian Relocation an administrative law judge or other hearing officer with appropriate qualifications to review the requests referred to in subsection (i)(3)(A), as determined by the Commissioner.

“(k) APPEAL TO UNITED STATES CIRCUIT COURT OF APPEALS.—

“(1) IN GENERAL.—Subject to paragraph (3), any individual who, under the procedures established by the Commissioner pursuant to this section, is determined not to be eligible to receive benefits under this Act may appeal that determination to the United States Circuit Court of Appeals for the Ninth Circuit (referred to in this subsection as the ‘Circuit Court’).

“(2) REVIEW.—

“(A) IN GENERAL.—The Circuit Court shall, with respect to each appeal described in paragraph (1)—

“(i) review the entire record (as certified to the Circuit Court under paragraph (3)) on which a determination of the ineligibility of the appellant to receive benefits under this Act was based; and

“(ii) on the basis of that review, affirm or reverse that determination.

“(B) STANDARD OF REVIEW.—The Circuit Court shall affirm any determination that the Circuit Court determines to be supported by substantial evidence.

“(3) NOTICE OF APPEAL.—

“(A) IN GENERAL.—Not later than 30 days after a determination of ineligibility under paragraph (1), an affected individual shall file a notice of appeal with—

“(i) the Circuit Court; and

“(ii) the Commissioner.

“(B) CERTIFICATION OF RECORD.—On receipt of a notice under subparagraph (A)(ii), the Commissioner shall submit to the Circuit Court the certified record on which the determination that is the subject of the appeal was made.

“(C) REVIEW PERIOD.— Not later than 60 days after receiving a certified record under subparagraph (B), the Circuit Court shall conduct a review and file a decision regarding an appeal in accordance with paragraph (2).

“(D) BINDING DECISION.—A decision made by the Circuit Court under this subsection shall be final and binding on all parties.”.

SEC. 112. PAYMENT FOR USE OF LAND.

Section 16 of the Act of December 22, 1974 (25 U.S.C. 640d-15) is amended—

(1) by striking “SEC. 16. (a) The Navajo” and inserting the following:

“SEC. 12. PAYMENT FOR USE OF LAND.

“(a) IN GENERAL.—The Navajo”;

(2) in subsection (a), by striking “sections 8 and 3 or 4” and inserting “sections 1 and 4”;

(3) in subsection (b)—

(A) by striking “(b) The” and inserting the following:

“(b) PAYMENT.—The”; and

(B) by striking “sections 8 and 3 or 4” and inserting “sections 1 and 4”.

SEC. 113. EFFECT OF ACT.

Section 17 of the Act of December 22, 1974 (25 U.S.C. 640d-16) is amended—

(1) by striking “SEC. 17. (a)” and inserting the following:

“SEC. 13. EFFECT OF ACT.

“(a) TITLE, POSSESSION, AND ENJOYMENT.—”;

(2) in subsection (a)—

(A) in the first sentence, by striking “Nothing” and inserting the following:

“(1) IN GENERAL.—Nothing”; and

(B) in the second sentence, by striking “Such” and inserting the following:

“(2) RESIDENCE ON OTHER RESERVATIONS.—Any”; and

(3) in subsection (b), by striking “(b) Nothing” and inserting the following:

“(b) FEDERAL EMPLOYEES.—Nothing”.

SEC. 114. ACTIONS FOR ACCOUNTING, FAIR VALUE OF GRAZING, AND CLAIMS FOR DAMAGES TO LAND.

Section 18 of the Act of December 22, 1974 (25 U.S.C. 640d-17) is amended—

(1) by striking “SEC. 18. (a) Either” and inserting the following:

“SEC. 14. ACTIONS FOR ACCOUNTING, FAIR VALUE OF GRAZING, AND CLAIMS FOR DAMAGES TO LAND.

“(a) ACTIONS BY TRIBES.—Either”;

(2) in subsection (a), by striking “section 3 or 4” and inserting “section 1”;

(3) in subsection (b)—

(A) by striking “(b) Neither” and inserting the following:

“(b) DEFENSES.—Neither”; and

(B) by striking “section 3 or 4” and inserting “section 1”;

(4) in subsection (c)—

(A) by striking “(c) Either” and inserting the following:

“(c) FURTHER ORIGINAL, ANCILLARY, OR SUPPLEMENTARY ACTS TO ENSURE QUIET ENJOYMENT.—

“(1) IN GENERAL.—Either”; and

(B) in the second sentence, by striking “Such actions” and inserting the following:

“(2) ACTION THROUGH CHAIRMAN.—An action under paragraph (1)”;

(5) in subsection (d)—

(A) by striking “(d) Except” and inserting the following:

“(d) UNITED STATES AS PARTY; JUDGMENTS AGAINST THE UNITED STATES—

“(1) IN GENERAL.—Except”; and

(B) in the second sentence, by striking “Any judgment or judgments” and inserting the following:

“(2) EFFECT OF JUDGMENTS.—Any judgment”; and

(6) in subsection (e), by striking “(e) All” and inserting the following:

“(e) REMEDIES.—All”.

SEC. 115. JOINT USE.

Section 19 of the Act of December 22, 1974 (25 U.S.C. 640d-18) is amended—

(1) by striking “SEC. 19. (a) Notwithstanding” and inserting the following:

“SEC. 15. JOINT USE.

“(a) REDUCTION OF LIVESTOCK.—

“(1) IN GENERAL.—Notwithstanding”;

(2) in subsection (a)(1) (as designated by paragraph (1))—

(A) by striking “section 3 or 4” and inserting “section 1”;

(B) in the second sentence, by striking “The Secretary is directed to” and inserting the following:

“(2) CONSERVATION PRACTICES AND METHODS.—The Secretary shall”;

(3) in subsection (b)—

(A) by striking “(b) The” and inserting the following:

“(b) SURVEY LOCATION OF MONUMENTS AND FENCING OF BOUNDARIES.—The”; and

(B) by striking “sections 8 and 3 or 4” each place it appears and inserting “sections 1 and 4”;

(4) in subsection (c)—

(A) by striking “(c)(1) Surveying” and inserting the following:

“(c) SURVEYING, MONUMENTING, AND FENCING; LIVESTOCK REDUCTION PROGRAM.—

“(1) SURVEYING, MONUMENTING, AND FENCING.—Surveying”;

(B) in paragraph (1)—

(i) by striking “section 4” and inserting “section 1”;

(ii) by striking “section 8” and inserting “section 4”;

(C) in paragraph (2), by striking “(2) The” and inserting the following:

“(2) LIVESTOCK REDUCTION PROGRAM.—The”.

SEC. 116. RELIGIOUS CEREMONIES; PIPING OF WATER.

Section 20 of the Act of December 22, 1974 (25 U.S.C. 640d-19) is amended by striking “SEC. 20. The members” and inserting the following:

“SEC. 16. RELIGIOUS CEREMONIAL USES; PIPING OF WATER.

The members”.

SEC. 117. ACCESS TO RELIGIOUS SHRINES.

Section 21 of the Act of December 22, 1974 (25 U.S.C. 640d-20) is amended by striking “SEC. 21. Notwithstanding” and inserting the following:

“SEC. 17. ACCESS TO RELIGIOUS SHRINES.

Notwithstanding”.

SEC. 118. EXCLUSION OF PAYMENTS FROM CERTAIN FEDERAL DETERMINATIONS OF INCOME.

Section 22 of the Act of December 22, 1974 (25 U.S.C. 640d-21) is amended—

(1) by striking “SEC. 22. The availability” and inserting the following:

“SEC. 18. EXCLUSION OF PAYMENTS FROM CERTAIN FEDERAL DETERMINATIONS OF INCOME.

“(a) IN GENERAL.—The availability”; and

(2) by striking “None of the funds” and inserting the following:

“(b) FEDERAL AND STATE INCOME TAXES.—None of the funds”.

SEC. 119. AUTHORIZATION OF EXCHANGE.

Section 23 of the Act of December 22, 1974 (25 U.S.C. 649d-22) is amended—

(1) by striking “SEC. 23. The Navajo” and inserting the following:

“SEC. 19. AUTHORIZATION OF EXCHANGE.

“(a) IN GENERAL.—The Navajo”; and

(2) in the second sentence—

(A) by striking “In the event that the Tribes should” and inserting the following:

“(b) NEGOTIATED EXCHANGES.—If the Tribes”; and

(B) by striking “sections 14 and 15” and inserting “sections 10 and 11”.

SEC. 120. SEVERABILITY.

Section 24 of the Act of December 22, 1974 (25 U.S.C. 640d-23) is amended by striking “SEC. 24. If” and inserting the following:

“SEC. 20. SEVERABILITY.

“If”.

SEC. 121. AUTHORIZATION OF APPROPRIATIONS.

Section 25 of the Act of December 22, 1974 (25 U.S.C. 640d-24) is—

(1) moved so as to appear at the end of the Act; and

(2) amended to read as follows:

“SEC. 27. AUTHORIZATION OF APPROPRIATIONS.

“(a) RELOCATION OF HOUSEHOLDS AND MEMBERS.—There is authorized to be appropriated to carry out section 10(b) \$13,000,000.

“(b) RELOCATION OF HOUSEHOLDS AND MEMBERS.—There are authorized to be appropriated to carry out section 11 such sums as are necessary for each of fiscal years 2006 through 2008.

“(c) RETURN TO CARRYING CAPACITY AND INSTITUTION OF CONSERVATION PRACTICES.—There is authorized to be appropriated to carry out section 15(a) \$10,000,000.

“(d) SURVEY LOCATION OF MONUMENTS AND FENCING OF BOUNDARIES.—There is authorized to be appropriated to carry out section 15(b) \$500,000.”.

SEC. 122. FUNDING AND CONSTRUCTION OF HIGH SCHOOL AND MEDICAL CENTER.

Section 27 of the Act of December 22, 1974 (25 U.S.C. 640d-25) is amended by striking “SEC. 27.” and all that follows through “(c) The Secretary” and inserting the following:

“SEC. 21. FUNDING AND CONSTRUCTION OF HIGH SCHOOL AND MEDICAL CENTER.

“The Secretary”.

SEC. 123. ENVIRONMENTAL IMPACT; WILDERNESS STUDY; CANCELLATION OF LEASES AND PERMITS.

Section 28 of the Act of December 22, 1974 (25 U.S.C. 640d-26) is amended—

(1) by striking “SEC. 28. (a) No action” and inserting the following:

“SEC. 22. ENVIRONMENTAL IMPACT; WILDERNESS STUDY; CANCELLATION OF LEASES AND PERMITS.

“(a) IN GENERAL.—No action”;

(2) in subsection (b), by striking “(b) Any” and inserting the following:

“(b) EFFECT OF WILDERNESS STUDY.—Any”; and

(3) by adding at the end the following:

“(c) CONSTRUCTION REQUIREMENTS.—

“(1) IN GENERAL.—Any construction activity under this Act shall be carried out in accordance with sections 3 through 7 of the Act

of June 27, 1960 (16 U.S.C. 469a-1 through 469c).

“(2) COMPLIANCE WITH OTHER REQUIREMENTS.—If a construction activity meets the requirements under paragraph (1), the activity shall be considered to be in accordance with any applicable requirement of—

“(A) Public Law 89-665 (80 Stat. 915); and
“(B) the Act of June 8, 1906 (34 Stat. 225, chapter 3060).”.

SEC. 124. ATTORNEY FEES AND COURT COSTS.

Section 29 of the Act of December 22, 1974 (25 U.S.C. 640d-27) is amended—

(1) by striking “SEC. 29. (a)” and inserting the following:

“SEC. 23. ATTORNEY FEES AND COURT COSTS.

“(a) IN GENERAL.—”;
(2) in subsection (a)—
(A) by striking “In any” and inserting the following:

“(1) IN GENERAL.—In any”; and
(B) by striking “For each” and inserting the following:

“(2) AUTHORIZATION OF APPROPRIATIONS.—For each”;

(3) in subsection (b)—
(A) by striking “(b) Upon” and inserting the following:

“(b) AWARD BY COURT.—
“(1) IN GENERAL.—On”; and
(B) in the second sentence, by striking “Any party” and inserting the following:

“(2) REIMBURSEMENT OF UNITED STATES.—Any party”;

(4) in subsection (c), by striking “(c) To” and inserting the following:

“(c) EXCESS DIFFERENCE.—To”; and
(5) in subsection (d)—
(A) by striking “(d) This” and inserting the following:

“(d) APPLICATION OF SECTION.—This”; and
(B) by striking “section 8 or 18(a) of this Act” and inserting “section 4 or section 14(a)”.

SEC. 125. LOBBYING.

Section 31 of the Act of December 22, 1974 (25 U.S.C. 640d-29) is amended—

(1) by striking “SEC. 31. (a) Except” and inserting the following:

“SEC. 24. LOBBYING.

“(a) IN GENERAL.—Except”; and
(2) in subsection (b), by striking “(b) Subsection” and inserting the following:

“(b) APPLICABILITY.—Subsection”.

SEC. 126. NAVAJO REHABILITATION TRUST FUND.

The first section designated as section 32 of the Act of December 22, 1974 (25 U.S.C. 640d-30) is amended—

(1) by striking “SEC. 32. (a) There” and inserting the following:

“SEC. 25. NAVAJO REHABILITATION TRUST FUND.

“(a) ESTABLISHMENT.—There”;
(2) in subsection (b), by striking “(b) All” and inserting the following:

“(b) DEPOSIT OF INCOME INTO FUND.—All”;
(3) in subsection (c), by striking “(c) The” and inserting the following:

“(c) INVESTMENT OF FUNDS.—The”;
(4) in subsection (d)—

(A) by striking “(d) Funds” and inserting the following:

“(d) AVAILABILITY OF FUNDS.—Funds”;

(B) in paragraph (1), by striking “proceedings,” and inserting “proceedings;”;

(C) in paragraph (2), by striking “Act, or” and inserting “Act; or”;

(5) in subsection (e)—

(A) by striking “(e) By December 1” and inserting the following:

“(e) EXPENDITURE OF FUNDS.—

“(1) IN GENERAL.—Not later than December 1”; and

(B) in the second sentence, by striking “Such framework is to be” and inserting the following:

“(2) REQUIREMENT.—The framework under paragraph (1) shall be”;

(6) in subsection (f)—
(A) by striking “(f) The” and inserting the following:

“(f) TERMINATION.—

“(1) IN GENERAL.—The”; and

(B) in the second sentence, by striking “All funds” and inserting the following:

“(2) TRANSFER OF REMAINING FUNDS.—All funds”; and

(7) in subsection (g)—

(A) by striking “(g) There is hereby” and inserting the following:

“(g) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There is”;

(B) in the first sentence, by striking “1990, 1991, 1992, 1993, 1994, and 1995” and inserting “2006 through 2008”; and

(C) in the second sentence, by striking “The income” and inserting the following:

“(2) INCOME FROM LAND.—The income”.

SEC. 127. AVAILABILITY OF FUNDS FOR RELOCATION ASSISTANCE.

The second section designated as section 32 of the Act of December 22, 1974 (25 U.S.C. 640-31) is amended by striking “SEC. 32. Nothing” and inserting the following:

“SEC. 26. AVAILABILITY OF FUNDS FOR RELOCATION ASSISTANCE.”

“Nothing”.

TITLE II—PERSONNEL OF THE OFFICE OF NAVAJO AND HOPI INDIAN RELOCATION

SEC. 201. RETENTION PREFERENCE.

The second sentence of section 3501(b) of title 5, United States Code, is amended—

(1) by striking “or” after “Senate” and inserting a comma;

(2) by striking “or” after “Service” and inserting a comma; and

(3) by inserting “, or to an employee of the Office of Navajo and Hopi Indian Relocation” before the period.

SEC. 202. SEPARATION PAY.

(a) IN GENERAL.—Chapter 55 of title 5, United States Code, is amended by adding at the end the following:

“§ 5598 Separation pay for certain employees of the Office of Navajo and Hopi Indian Relocation

“(a) IN GENERAL.—Except as provided in subsections (b) and (c), the Commissioner of the Office of Navajo and Hopi Indian Relocation shall establish a program to offer separation pay to employees of the Office of Navajo and Hopi Indian Relocation (referred to in this section as the ‘Office’) in the same manner as the Secretary of Defense offers separation pay to employees of a defense agency under section 5597.

“(b) SEPARATION PAY.—

“(1) IN GENERAL.—Under the program established under subsection (a), the Commissioner of the Office may offer separation pay only to employees within an occupational group or at a pay level that minimizes the disruption of ongoing Office programs at the time that the separation pay is offered.

“(2) REQUIREMENT.—Any separation pay offered under this subsection—

“(A) shall be paid in a lump sum;

“(B) shall be in an amount equal to \$25,000, if paid on or before December 31, 2007;

“(C) shall be in an amount equal to \$20,000, if paid after December 31, 2007, and before January 1, 2009;

“(D) shall be in an amount equal to \$15,000, if paid after December 31, 2008, and before January 1, 2010;

“(E) shall not—

“(i) be a basis for payment;

“(ii) be considered to be income for the purposes of computing any other type of benefit provided by the Federal Government; and

“(F) if an individual is otherwise entitled to receive any severance pay under section 5595 on the basis of any other separation,

shall not be payable in addition to the amount of the severance pay to which that individual is entitled under section 5595.

“(c) PROHIBITION.—No amount shall be payable under this section to any employee of the Office for any separation occurring after December 31, 2009.”.

(b) CONFORMING AMENDMENT.—The chapter analysis for chapter 55 of title 5 is amended by adding at the end the following:

“5598. Separation pay for certain employees of the Office of Navajo and Hopi Indian Relocation.”.

SEC. 203. FEDERAL RETIREMENT.

(a) CIVIL SERVICE RETIREMENT SYSTEM.—

(1) IMMEDIATE RETIREMENT.—Section 8336(j)(1)(B) of title 5, United States Code, is amended by inserting “or was employed by the Office of Navajo and Hopi Indian Relocation during the period beginning on January 1, 1985, and ending on the date of separation of that employee” before the final comma.

(2) COMPUTATION OF ANNUITY.—Section 8339(d) of title 5, United States Code, is amended by adding at the end the following:

“(8) The annuity of an employee of the Office of Navajo and Hopi Indian Relocation described in section 8336(j)(1)(B) shall be determined under subsection (a), except that with respect to service of that employee on or after January 1, 1985, the annuity of that employee shall be in an amount equal to the sum of—

“(A) the product obtained by multiplying—
“(i) 2½ percent of the average pay of the employee; and

“(ii) the quantity of service of the employee on or after January 1, 1985, that does not exceed 10 years; and

“(B) the product obtained by multiplying—
“(i) 2 percent of the average pay of the employee; and

“(ii) the quantity of the service of the employee on or after January 1, 1985, that exceeds 10 years.”.

(b) FEDERAL EMPLOYEES RETIREMENT SYSTEM.—

(1) IMMEDIATE RETIREMENT.—Section 8412 of title 5, United States Code, is amended by adding at the end the following:

“(i) An employee of the Office of Navajo and Hopi Indian Relocation is entitled to an annuity if that employee—

“(1) has been continuously employed in the Office of Navajo and Hopi Indian Relocation during the period beginning on January 1, 1985, and ending on the date of separation of that individual; and

“(2)(A) has completed 25 years of service at any age; or

“(B) has attained the age of 50 years and has completed 20 years of service.”.

(2) COMPUTATION OF BASIC ANNUITY.—Section 8415 of title 5, United States Code, is amended—

(1) by redesignating subsection (l) as subsection (m);

(2) by redesignating the second subsection designated as subsection (k) as subsection (l); and

(3) by adding at the end the following:

“(n) The annuity of an employee retiring under section 8412(i) shall be determined in accordance with subsection (d), except that with respect to service during the period beginning on January 1, 1985, the annuity of the employee shall be an amount equal to the sum of—

“(1) the product obtained by multiplying—
“(A) 2 percent of the average pay of the employee; and

“(B) the quantity of the total service of the employee that does not exceed 10 years; and

“(2) the product obtained by multiplying—
“(A) 1½ percent of the average pay of the employee; and

“(B) the quantity of the total service of the employee that exceeds 10 years.”.

TITLE III—TRANSFER OF FUNCTIONS AND SAVINGS PROVISIONS

SEC. 301. DEFINITIONS.

In this title:

(1) **FEDERAL AGENCY.**—The term “Federal agency” has the meaning given the term “agency” in section 551(1) of title 5, United States Code.

(2) **FUNCTION.**—The term “function” means any duty, obligation, power, authority, responsibility, right, privilege, activity, or program.

(3) **OFFICE.**—The term “Office” means the Office of Navajo and Hopi Relocation (including any component of that office).

SEC. 302. TRANSFER OF FUNCTIONS.

Effective on the date of enactment of this Act, there is transferred to the Secretary of the Interior any function of the Office that has not been carried out by the Office on the date of enactment of this Act, as determined by the Secretary of the Interior in accordance with the Act of December 22, 1974 (25 U.S.C. 640 et seq.) (as amended by title I).

SEC. 303. TRANSFER AND ALLOCATIONS OF APPROPRIATIONS.

(a) **IN GENERAL.**—Except as otherwise provided in this Act and the amendments made by this Act, any asset, liability, contract, property, record, or unexpended balance of appropriations, authorizations, allocations, and other funds made available to carry out the functions transferred by this title shall be transferred to the Secretary of the Interior, subject to section 1531 of title 31, United States Code.

(b) **USE OF FUNDS.**—Any unexpended funds transferred under subsection (a) shall be used only for the purposes for which the funds were originally authorized and appropriated.

SEC. 304. EFFECT OF TITLE.

(a) **CONTINUING EFFECT OF LEGAL DOCUMENTS.**—Any legal document relating to a function transferred by this title that is in effect on the date of enactment of this Act shall continue in effect in accordance with the terms of the document until the document is modified or terminated by—

- (1) the President;
- (2) the Secretary of the Interior;
- (3) a court of competent jurisdiction; or
- (4) operation of Federal or State law.

(b) **PROCEEDINGS NOT AFFECTED.**—This title shall not affect any proceeding (including a notice of proposed rulemaking, an administrative proceeding, and an application for a license, permit, certificate, or financial assistance) relating to a function transferred under this title that is pending before the Office of Navajo and Hopi Relocation on the date of enactment of this Act.

By Mr. BINGAMAN (for himself, Ms. SNOWE, Mr. ROCKEFELLER, Mrs. HUTCHISON, Mr. REID, and Mr. JEFFORDS):

S. 1007. A bill to prevent a severe reduction in the Federal medical assistance percentage determined for a State for fiscal year 2006; to the Committee on Finance.

Mr. BINGAMAN. Mr. President, today I am introducing legislation with Senators SNOWE, ROCKEFELLER, HUTCHISON, REID, and JEFFORDS that would increase Medicaid Federal matching payments to 28 States by addressing a problem with the Medicaid funding formula that is expected to result in a majority of States in the country having their Federal matching rate drop this coming fiscal year.

Our legislation, the “Medicaid Formula Fairness Act of 2005,” would protect these 28 States from decreases in the amount of Federal funding they can expect to receive in fiscal year 2006. For the vulnerable low-income children, pregnant women, disabled, and senior citizens that the Medicaid programs in those 28 States serve. This legislation may be the only thing preventing them from losing their health benefits and joining the ranks of our Nation’s uninsured, which is already at 45 million people.

In New Mexico, more than one-in-five or over 400,000 New Mexicans are uninsured and the State is facing a \$78 million reduction in the federal Medicaid matching rate for fiscal year 2006. This is not the result of a dramatic upswing in the economy in New Mexico. The most recent poverty data from the U.S. Census Bureau actually indicates an upswing in the percentage of New Mexicans in poverty at 18 percent—the second highest poverty rate in the country.

Thus, at the very time when there are more people in need of medical care through the Medicaid program, the Federal Government is apparently reducing its assistance through Medicaid. So how is this possible?

The first problem is with the Medicaid matching formula itself. It is based on per capita income, which was established as a proxy for both need and State capacity many years ago. We now have much better data on what should be the factors in the Medicaid formula, including poverty and total taxable resource measures, but the old proxy of per capita income remains.

Despite numerous reports from the General Accounting Office, the HHS inspector general, and outside organizations calling for such an update to the Federal Medicaid formula, nothing has happened over the years. Rather than fighting that battle again, our legislation acknowledges that we are stuck with per capita income as the formula factor. Instead, we take issue with how that factor is dropping Federal matching rates across the Nation while the national poverty rate continues to rise. Again, how is this possible?

In the fall of 2004, the Centers for Medicare and Medicaid Services, CMS, published the Federal Medical Assistance Percentage, or FMAP, for fiscal year 2006 based on per capital income, PCI, data from 2001, 2002, and 2003. According to the Federal Funds Information for States, FFIS, Issue Brief in September 2004, changes in the FMAP will cause States to lose a net \$527 million in Federal matching funds in the Medicaid Program with decreases of \$867 million to 29 States partially offset by increases for 9 States.

CMS acknowledges that 29 States will lose Federal funding, nine States will gain, and the balance of the States will not be impacted by the Medicaid changes because the latter group of 12 States are already at the statutory minimum FMAP of 50 percent.

Federal law dictates that the FMAP is determined based on the “three most recent calendar years for which satisfactory data are available from the Department of Commerce.” Thus, for fiscal year 2006, the PCI data used is from the years 2001, 2002, and 2003. The Federal intent of a 3-year rolling average is to limit the fluctuations that States might experience since only one-third of the formula is changed on a yearly basis. In other words, Congress felt it important enough to limit the fluctuations in the matching rate through the 3-year rolling average of PCI data that the result is the use of data from 2001 for the calculation of the fiscal year 2006 FMAP.

However, as analysis by the Oklahoma Health Care Authority indicates, in the case of the calculation, of the fiscal year 2006 FMAP, the U.S. Department of Commerce’s Bureau of Economic Analysis, BEA, performed a comprehensive revision of its calculation of PCI in 2003, as it does every 4 to 5 years, and provided revised data for previous years as well. As a result, CMS changed the 2001 and 2002 PCI data for States in the calculation. Consequently, all 3 years of the PCI data were being changed rather than just one-third.

The result is rather dramatic fluctuations—mostly negative—to State FMAP calculations. As the FFIS Issue Brief indicated, “Fifteen States are projected to have changes of greater than one percentage point in fiscal year 2006, compared to only three for FY 2005.” Not since 1998 have the fluctuations been this dramatic.

According to the Congressional Research Service (CRS), the average change in the FMAP between fiscal year 2001 and fiscal year 2002 was -0.26 percentage points, for fiscal year 2003 it was $+0.32$, for fiscal year 2004 it was $+0.12$, and for fiscal year 2005 it was -0.09 . Thus, over this 4-year period, the average change in the national FMAP was less than 0.2 percentage points. However, due in part to the rebenchmarking of data by BEA, the fiscal year 2006 change in the FMAP will be -0.55 percentage points. Compared to average change over the preceding 4 years, the fiscal year 2006 FMAP change will be almost three times as dramatic.

As a result, 29 States will absorb a decline in the FMAP for fiscal year 2006. The Oklahoma Health Care Authority estimates that this will cost those States \$860 million. The largest projected percentage point decreases are for Alaska, -7.42 , Wyoming, -3.67 , New Mexico, -3.15 , Oklahoma, -2.27 , Maine, -1.99 , West Virginia, -1.66 , North Dakota, -1.64 , Vermont, -1.62 , Utah, -1.38 , Montana, -1.36 , Alabama, -1.32 , Louisiana, -1.25 , Nevada, -1.14 , and Mississippi, -1.08 .

The largest dollar declines would be experienced by the states of New Mexico, $-$79$ million, Louisiana, $-$72$ million, Alaska, $-$69$ million, Tennessee, $-$68$ million, Oklahoma, $-$66$ million,

Alabama, —\$55 million, and Maine, —\$47 million.

FFIS adds, “While the changes in FY 2006 are significant, for many states they only add to previous reductions. Thirteen states (Alaska, Kentucky, Louisiana, Maine, Montana, New Mexico, North Dakota, Oklahoma, Rhode Island, Vermont, West Virginia, Wisconsin, and Wyoming) will experience three consecutive reductions—from the fiscal relief FMAP to the base FMAP in FY 2004 to a second reduction in FY 2005 and a third in FY 2006. The cumulative 5-year reduction for a number of States is large, and for many unprecedented—Wyoming (–10.37), Alaska (–9.97), North Dakota (–4.14), Vermont (–3.91), Oklahoma (–3.33), Maine (–3.22), and South Dakota (–3.24).”

The loss in funds to these 29 States is already resulting in planned cuts in benefits and services to Medicaid eligible recipients, such as low-income children, pregnant women, the elderly and disabled, and decreased reimbursement to Medicaid providers, including physicians, hospitals, nursing homes, community health centers, etc.

In an effort to minimize the dramatic fluctuations in the Fiscal Year 2006 FMAP, this legislation would limit the loss of States in the FMAP to 0.5 percentage points, which restores \$442 million of the lost Medicaid dollars to 18 States. The bill would also give 10 additional States a higher FMAP if changes to PCI for 2001 and 2002 were not retroactively applied by CMS. This translates to approximately \$229 million for a total of \$671 million. This is still far less than the \$860 million lost to the 29 States by FMAP reductions.

Therefore, this legislation I am introducing with Senator SNOWE and others does not hold States entirely harmless. However, it does limit the losses in Federal Medicaid matching funds that States are expected to absorb due to problems with the use of per capita income as a factor in the Medicaid formula but also in how it is used. Our legislation mitigates those problems, and does so with the expressed intent of preventing millions of additional Americans from joining the ranks of the uninsured as many of our States will be forced to undertake cuts to the Medicaid program to make up for lost Federal funding.

Specifically, the bill allows States to get the better of: 1. the FMAP as calculated by CMS; 2. a recalculated FMAP without retroactively changing the 2001 and 2002 per capita income data; or, 3. a hold harmless limiting the reduction in the FMAP to 0.5 percentage points.

In New Mexico, for example, the “Medicaid Formula Fairness Act of 2005” would restore \$66 million of the \$78 million that New Mexico is scheduled to lose due to the drop in the Federal Medicaid matching rate. The other 27 States that would benefit from the legislation and the estimated amount they would receive are as follows: Texas—\$113 million, New Mexico—\$66

million, Alaska—\$64 million, Oklahoma—\$52 million, Louisiana—\$43 million, Maine—\$35 million, Alabama—\$34 million, West Virginia—\$27 million, Tennessee—\$27 million, Florida—\$25 million, Mississippi—\$22 million, Arizona—\$22 million, Nevada—\$17 million, Arkansas—\$14 million, Utah—\$14 million, North Carolina—\$14 million, Wyoming—\$13 million, Vermont—\$10 million, Wisconsin—\$9 million, Rhode Island—\$8 million, Georgia—\$8 million, Oregon—\$6 million, North Dakota—\$6 million, Montana—\$6 million, South Carolina—\$6 million, Idaho—\$5 million, South Dakota—\$3 million, and Kansas—\$2 million.

I would like to thank the Oklahoma Health Care Authority, including Mike Fogarty and Stephen Weiss, for their outstanding work in analyzing the problem with the Fiscal Year 2006 FMAP and for their technical assistance and counsel toward the introduction of this legislation. I would also like to thank Senators SNOWE, ROCKEFELLER, HUTCHISON, REID, and JEFFORDS for providing bipartisan support as original cosponsors of this important legislation.

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

There be no objection, the material was ordered to be printed in the RECORD.

S. 1007

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 “Medicaid Formula Fairness Act of 2005”.

SEC. 2. LIMITATION ON SEVERE REDUCTION IN THE MEDICAID FMAP FOR FISCAL YEAR 2006.

(a) LIMITATION ON REDUCTION.—In no case shall the FMAP for a State for fiscal year 2006 be less than the greater of the following:

(1) HALF PERCENTAGE POINT DECREASE.—The FMAP determined for the State for fiscal year 2005, decreased by 0.5 percentage points.

(2) COMPUTATION WITHOUT RETROACTIVE APPLICATION OF REBENCHMARKED PER CAPITA INCOME.—The FMAP that would have been determined for the State for fiscal year 2006 if the per capita incomes for 2001 and 2002 that was used to determine the FMAP for the State for fiscal year 2005 were used.

(b) SCOPE OF APPLICATION.—The FMAP applicable to a State for fiscal year 2006 after the application of subsection (a) shall apply only for purposes of titles XIX and XXI of the Social Security Act (including for purposes of making disproportionate share hospital payments described in section 1923 of such Act (42 U.S.C. 1396r–4) and payments under such titles that are based on the enhanced FMAP described in section 2105(b) of such Act (42 U.S.C. 1397ee(b))) and shall not apply with respect to payments under title IV of such Act (42 U.S.C. 601 et seq.).

(c) DEFINITIONS.—In this section:

(1) FMAP.—The term “FMAP” means the Federal medical assistance percentage, as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(2) STATE.—The term “State” has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 3. REPEAL.

Effective as of October 1, 2006, section 2 is repealed and shall not apply to any fiscal year after fiscal year 2006.

AMERICAN HOSPITAL ASSOCIATION,
Washington, DC, March 28, 2005.

Hon. JEFF BINGAMAN,
U.S. Senate,
Washington, DC.

DEAR SENATOR BINGAMAN: On behalf of our 4,700 hospital, health care system, and other health care provider members, and our 31,000 individual members, the American Hospital Association (AHA) is writing to express our support for your legislation to limit FY 2006 Medicaid federal medical assistance percentage (FMAP) reductions.

Recently the Bureau of Economic Affairs in the Department of Commerce re-benchmarked per capita income for states, and the Centers for Medicare & Medicaid Services (CMS) retroactively applied the changes. The Medicaid FMAP uses a three-year rolling average to smooth out dramatic changes in the states’ matching rates from year-to-year. By retroactively applying the new benchmark, however, CMS undermined the rationale of the three-year rolling average; therefore 22 states will see their FMAP drop by more than 0.5 percentage points in FY 2006—a reduction of an estimated \$752 million in FY 2006. About \$550 million of this is due to the retroactive recalculation.

The prospect of more Medicaid hospital payment reductions due to decreased federal Medicaid funding is a serious threat to the viability of hospitals and the patients they serve. We realize that it is critical that states provide their share of the state-federal Medicaid funding match in order for vulnerable citizens to obtain and retain health care coverage and health services. Your legislation would help states by limiting the FMAP drop to 0.5 percent, restoring \$468 million of the funds that are lost due to the recalculation of per capita income.

We applaud your leadership on this issue and support enactment of this legislation.

Sincerely,

RICK POLLACK,
Executive Vice President.

Ms. SNOWE. Mr. President, I am pleased to join Senator BINGAMAN today, along with Senators ROCKEFELLER, HUTCHISON, REID, and JEFFORDS, in introducing the Medicaid Formula Fairness Act of 2005. This legislation will provide a temporary increase in Medicaid Federal matching payments to 28 States and thereby avoid a significant loss funds which would otherwise occur due to a precipitous and unpredicted drop in the Federal matching rate for these States next year.

Medicaid provides essential medical care to low-income children, pregnant women, parents of dependent children, senior citizens, and people with disabilities and functions as a critical safety net for our most vulnerable populations. Enrollment in the Medicaid program has grown by nearly one-third since the beginning of 2001, as the numbers of those in poverty and individuals without private health insurance continues to increase. In Maine, where we have an older and less wealthy population, more than 300,000 people were enrolled in Medicaid last year. One in five individuals in the State now receives health care services through MaineCare, the State’s Medicaid program.

States have experienced severe fiscal stress during the last few years, with sharp declines in revenues and budget shortfalls. This economic downturn, from which many States are only now emerging, has continued to leave many families jobless and without health insurance, forcing to turn to Medicaid. This has put an enormous strain on the States such as Maine which are already strapped with budget shortfalls. Many States reduced Medicaid benefits last year and even more restricted Medicaid eligibility in an effort to satisfy their budgetary obligations.

The formula for calculating the Federal matching rate, known as the Federal Medical Assistance Percentage, FMAP, which determines the Federal Government's share of Medicaid expenditures, has contributed to the Medicaid problems that States are facing. The FMAP formula is designed so that the Federal Government pays a larger portion of Medicaid costs in States with a per capita income lower than the national average. Since Maine is a relatively poor State with a disproportionately large low-income elderly population, it has had a favorable Federal-State match in recent years, 66 percent in 2004. This translated to \$1.4 billion in Federal dollars last year—two-thirds of MaineCare's \$2 billion in Medicaid spending.

The size of Maine's Medicaid population means that any change in the FMAP has a disproportionately significant impact on Maine's budget. This year, Maine's Federal matching rate decreased from 66.01 percent to 64.89 percent, a drop of more than one percent. The change in FMAP for FY2006 is even greater and will cause 28 States, including Maine, to lose a significant amount of Federal matching funds next year. Maine's Federal matching rate will drop nearly two points, from 64.89 percent to 62.9 percent next year, which will result in Maine losing \$46.7 million in Federal matching funds.

Under existing Federal law, the FMAP is determined based on the three most recent calendar years for which data is available from the Department of Commerce. This 3 year "look back" captures a period of time that is not necessarily reflective of a State's current financial situation. The FMAP for FY 2003, for example, was calculated in 2001 for the fiscal year beginning October 2002. The FY 2003 FMAP was determined on the basis, of State per capita income over the 3 year period of 1998 through 2000, when State economies were growing significantly. Yet in 2003, when this matching rate was in effect, a serious economic downturn was affecting many State budgets, and that downturn has contributed greatly to the growth of Medicaid for several years now.

We recognized this situation in the last Congress and provided for State fiscal relief by providing a temporary increase in the Federal Medicaid matching rate, which provided \$10 bil-

lion in fiscal relief to States during fiscal 2003 and 2004, when we passed the Jobs and Growth Tax Relief Reconciliation Act of 2003 but that temporary Federal fiscal relief has now ended.

This Congress has reached a budget agreement which, among its terms, calls for reductions of \$10 billion in Medicaid spending over the next 5 years. At this time, therefore, it is especially crucial that we continue to provide sufficient Federal matching funds for Medicaid, which has worked so well over the last 40 years. Our legislation is intended to be just a short term fix, for fiscal year 2006. It is my hope that we will see the creation of a Medicaid Commission to undertake a comprehensive review of the Medicaid program and make recommendations on how to make Federal matching payments more equitable with respect to the States and the populations they serve, as well as how to make them more responsive to changes in States' economic conditions.

However, today, states such as Maine are facing dramatic and unpredictable fluctuations to their State FMAP formulas. This legislation would limit the percentage decrease to a half percentage point for fiscal year 2006 and help mitigate the drastic effects that a severe loss Federal funding would have on our Medicaid population next year.

I therefore urge my colleagues to join us supporting this legislation to help sustain funding for Medicaid in fiscal year 2006 to help ensure that this critical health care safety net remains intact next year for those who need it most.

AMENDMENTS SUBMITTED AND PROPOSED

SA 619. Mr. LAUTENBERG submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, to authorize funds for Federal-aid highways, highway safety programs, and transit programs, and for other purposes; which was ordered to lie on the table.

SA 620. Ms. LANDRIEU submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 621. Ms. LANDRIEU submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 622. Ms. LANDRIEU submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 623. Ms. LANDRIEU submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 624. Mrs. MURRAY submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 625. Mr. LAUTENBERG (for himself and Mr. DODD) submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra.

SA 626. Ms. MURKOWSKI submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 627. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 628. Mrs. CLINTON submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 629. Mrs. BOXER submitted an amendment intended to be proposed by her to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 630. Mr. KENNEDY (for himself and Mr. KERRY) submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 631. Mr. BOND submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 632. Mr. HATCH submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 633. Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 634. Mr. DAYTON (for himself, Mr. LUGAR, Mr. DURBIN, Mr. COLEMAN, Mr. HARKIN, Mr. GRASSLEY, Mr. BINGAMAN, and Mr. SALAZAR) submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 635. Mr. BYRD submitted an amendment intended to be proposed by him to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 636. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 637. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 638. Mr. CARPER submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 639. Mr. LAUTENBERG submitted an amendment intended to be proposed by him to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 640. Mr. CONRAD (for himself and Mr. DORGAN) submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 641. Mr. CONRAD (for himself and Mr. DORGAN) submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 642. Mr. CONRAD (for himself and Mr. DORGAN) submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.

SA 643. Mr. CONRAD (for himself and Mr. DORGAN) submitted an amendment intended to be proposed to amendment SA 605 proposed by Mr. INHOFE to the bill H.R. 3, supra; which was ordered to lie on the table.