While I disagree with a majority of the FCC's decision, I would like to point out for small market broadcasters to survive, they may need the chance to utilize duopolies and other means to stay in business. And while I am concerned about the broad sweeping changes the FCC made, I remain cognizant of the fact that small market broadcasters may potentially need to utilize the very changes we may revoke today, and I will work with my colleagues to find market relief for these small broadcasters when warranted.

Over the next several months we will continue to argue the merits of this issue. However, I will only support any legislation that protects diversity, localism, and Montana's small businesses.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Enhancement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in Berkeley, CA. On May 12, 2003, the victim, a 23-year-old male Sikh wearing a turban, was assaulted while on an evening walk at the University of California. The attacker, and his two male companions, started to walk past the victim, then yelled, ''Taliban, look out!'' The suspect punched the victim in the nose then pushed him to the ground. The suspect later pulled the victim back to his feet and the men left the scene on foot.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

CMS' PROPOSED CHANGES TO THE 75 PERCENT RULE

Mr. NELSON of Nebraska. Mr. President, I would like to express my concern with a proposed rule by the Centers for Medicare and Medicaid Services, CMS, that would threaten the ability of rehabilitation hospitals to continue to provide critical care.

In my home State of Nebraska, Madonna Rehabilitation Hospital in Lincoln is a nationally recognized premier rehabilitation facility that offers specialized programs and services for those who have suffered brain injuries, strokes, spinal cord injuries, and other rehabilitating injuries. If this proposed rule goes into effect, Madonna would not be able to offer the same critical care to its patients as it currently does.

When CMS first looked at whether facilities would qualify as an IRF, a list of criteria was created to determine eligibility. They current criteria, generally referred to as the 75 percent rule, were established in 1984 and have not been updated since then. To qualify as an IRF under the 75 percent rule, 75 percent of a facility's patients must be receiving treatment for one of 10 specified conditions. Because the rule has not been updated in almost 20 years, newer rehabilitation specialties are not reflected and, therefore, are not counted in determining facility compliance with the 75 percent rule.

Since the 75 percent rule was implemented, IRFs have argued that the list of conditions should be expanded to reflect advances in modern rehabilitation medicine. The need for new rehabilitation specialties to treat cardiac, pulmonary, cancer, and other conditions was not even foreseeable when the 75 percent rule was implemented. Yet CMS has repeatedly refused to update the rule—even after implementing a payment system that specifically recognizes many more conditions than the 10 listed in the 75 percent rule.

On September 9, 2003, CMS published proposed modifications to the outdated 75 percent rule. I commend CMS for recognizing the need to update the regulation. Unfortunately, I believe that the proposed changes do not go far enough and may have serious consequences for Medicare beneficiaries and other patients who need inpatient rehabilitative care.

On its face, it appears that CMS expanded the rule by increasing the number of conditions from 10 to 12 and by lowering the percentage threshold from 75 percent to 65 percent. However, this ''expansion'' is illusory. The proposed rule will, by CMS's own estimate, reduce Medicare payments to IRFs by $223 million annually and shift hundreds of thousands of patients—both Medicare and non-Medicare—into alternative care settings that may be inappropriate.

It is worth noting that Congress gave CMS a directive to implement the rehabilitation prospective payment system in a budget-neutral manner. Yet this rule—without any congressional directive—seriously cuts rehabilitation hospital funding.

Although CMS expanded the number of conditions from 10 to 12, it did so by replacing one of the existing conditions—polyarthritis—with three new conditions that collectively are much more narrow than the original condition. CMS acknowledges that the industry historically has understood hip and knee replacement cases to fall within the definition of ''polyarthritis.'' Unfortunately, CMS now proposes to count joint replacement cases only if the patient has made no improvement after an ''aggressive and sustained course of outpatient therapy.''

This means that, instead of being directly transferred from an acute care hospital to an IRF, the patient will be forced into a skilled nursing facility, SNF, and/or outpatient therapy before being eligible for inpatient rehabilitation. IRFs would become a setting of last resort, and patients who might have returned to function after a brief IRF stay will be forced to endure weeks if not months, of therapy in other settings that may be inappropriate before being admitted to an IRF.

CMS also proposes to lower the threshold from 75 percent to 65 percent for a three-year period to give facilities time to come into compliance with the new criteria. Although this change is an improvement, it simply does not go far enough to prevent a significant negative impact on rehabilitation patients and providers.

RAND data indicate that only about 25 percent of IRFs, at most, could meet a 65-percent threshold under the current list of 10 conditions. Since the proposed rule actually narrows the agency's interpretation of arthritis-related conditions, the percentage of facilities that could comply with the revised list of conditions is probably lower. This means that, even under a 65 percent standard, at least 75 percent of facilities will be deemed out of compliance if CMS finalizes the proposed rule.

The proposed rule glosses over the negative impact that this dramatic shift will have on patients by assuming that all sites of care are equally effective and equally available. But I am very concerned about the impact that the proposed rule would have on patients living in rural areas, where alternative sites of rehabilitative care may be unavailable or highly inconvenient. Where SNF beds are scarce and few home health providers offer physical therapy services, these patients could be forced to travel long distances for daily outpatient care in a weakened state, risking reinjury and rehospitalization.

Because compliance with the proposed rule will hinge on an IRF's total patient population, not just its Medicare population, CMS estimates that the proposed rule ''may have an effect'' on approximately 200,000 non-Medicare patients. CMS was not able to quantify or describe this effect because of inadequate information. In my opinion, it would be irresponsible to implement this rule without further studying its likely impact on Medicare beneficiaries, non-Medicare patients, rehabilitation providers, and the Medicare Program.

The Medicare Payment Advisory Commission, MedPAC, agrees that the rule needs to be updated. In a July 7, 2003, letter to CMS Administration Tom Scully, MedPAC Chair Glenn Hackburth proposed that CMS lower the threshold to 50 percent for at least a year to enable an expert panel of clinicians to reach a consensus on the diagnoses to be included in the 75 percent rule.