By reauthorizing the Magnuson-Stevens Act in the 109th Congress, we will have more time in the 110th Congress to devote to other ocean issues, including considering the recommendations of the Joint Oceans Commission Initiative.

It is a rare day that I agree with our President, but several months ago he said, ''Overfishing is harmful. It's harmful to our country and it's harmful to the world.'' I agree wholeheartedly and understand that this legislation takes corrective action to curtail overfishing, especially in our most depleted fisheries.

I support the bill, encourage my colleagues to do so as well.

POSTAL ACCOUNTABILITY AND ENHANCEMENT ACT

SPEECH OF

HON. JOHN M. McHUGH

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Friday, December 8, 2006

Mr. MCHUGH. Mr. Speaker, as I noted during the December 8, 2006, debate on H.R. 6407, the Postal Accountability and Enhancement Act, this legislation reflects the final version of H.R. 22, the Postal Accountability and Enhancement Act as passed by the House and Senate.

H.R. 22 passed the House on July 26, 2005 by a vote of 410–20, and the Senate then passed H.R. 22 with an amendment by Unanimous Consent on February 9, 2006. Given that H.R. 6407 is the blended result of the two Chamber's versions of H.R. 22, I believe it is important to make note of the Committee on Government Reform's report on H.R. 22, 109–66, part I, as reported on April 28, 2005.

This committee report is relevant to understanding the provisions of H.R. 6407, particularly because many of the provisions of H.R. 6407 are unchanged from H.R. 22 as reported by the Government Reform Committee. For those looking for additional legislative history on H.R. 6407, the Government Reform Committee report accompanying H.R. 22, 109–66, part I, will provide useful explanations and information.

HONORING MS. GERMAINE BROUSSARD

HON. FRANK R. WOLF

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 27, 2006

Mr. WOLF. Mr. Speaker, it is an honor on behalf of Rep. TOM DAVIS and myself to recognize Ms. Germaine Broussard of McLean, Virginia, for her dedication to sending many cookies and other packages to U.S. troops overseas.

Ms. Broussard is known as the Cookie Lady to those who have benefitted from her kindness. She has already baked and shipped over 51,000 cookies to servicemembers. She has dedicated many hours of her free time and her own resources toward baking cookies to thank U.S. troops.

I am proud to call attention to the dedication of Ms. Broussard. I would also like to share a recent article from The Stars and Stripes which describes Ms. Broussard's hard work.

[From the Stars and Stripes, Nov. 21, 2006]

VA. WOMAN COOKING UP EATS GALORE FOR TROOPS

(By Kirsten Brown)

Washington.—When Lt. j.g. Gregory Trach, 34, received an e-mail from Germaine Broussard two years ago asking permission to send cookies to his ship, he thought little of it.

''Thank you for your support of the U.S. military,'' he responded, then dismissed the request as a thoughtful but meaningless gesture.

A few weeks later, the USS Shreveport received 12 boxes packed with more than 1,800 chocolate chip, peanut butter, oatmeal and sugar cookies. Shocked, Trach sent Broussard a second e-mail: ''We thought you were kidding!''

That was Trach's first brush with ''the Cookie Lady.''

So far, Broussard, 39, has baked and shipped more than 51,000 cookies to servicemembers. The McLean, Va., resident calls her mostly one-woman program ''Troop Treats.''

It felt like Christmas to Lt. Col. Skip Goodwillie, 45, each time he and his unit opened a box from Broussard. Goodwillie, who is in the Army Reserves, was stationed northeast of Baghdad at Kir Kush military base when he started getting cookies.

''It was just wonderful to have mail call and hear, 'Hey Skip, the Cookie Lady sent us another box,''' Goodwillie said. ''It was wonderful for our morale.''

The Cookie Lady does get donations, but she pays for most of it out of her own pocket. After her job as a Smith Barney business development associate, Broussard comes home to start mixing batter about 7 p.m. She pulls the last cookies from the oven between 1 and 3 a.m.

''Some people can be a little hesitant about why am I doing this,'' Broussard said. ''I had wanted to do something, but with the Red Cross, you donate money, and they send the box. But our family has always used home-baked cookies, bread, whatever, to be able to say thank you.''

Broussard also sends necessities such as travel-sized shampoo, soap, toothpaste, mouthwash and other treats, including DVDs, Cocoa Rice Krispies and cheesecake mix. ''It's a small piece of home,'' she said.

Embedded teddy bears are also part of her effort. Broussard's six ''Battle Buddies'' bears are dressed in camouflage and she could fill an album with pictures of beaming soldiers posing with their brown battle buddy.

Broussard will soon launch her second holiday project, ''Operation Santa's Little Helpers,'' which enlists children to write cheery cards to the troops. These notes are tucked in red or blue stockings along with presents such as Slinky toys, Silly Putty, playing cards and, of course, candy.

In junior high school, Broussard earned only a ''B'' in her home economics class. ''I don't use a standard one-cup measuring method,'' she said. ''It's just a little of this, little of that. The home ec teacher went crazy. I'd love to go back to that teacher and say, hmm! Wonder who's right now?''

POSTAL ACCOUNTABILITY AND ENHANCEMENT ACT

SPEECH OF

HON. DANNY K. DAVIS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, December 8, 2006

Mr. DAVIS of Illinois. Mr. Speaker, as was noted during the December 8, 2006, debate on H.R. 6407, the Postal Accountability and Enhancement Act, this landmark postal reform legislation reflects the final version of H.R. 22, the Postal Accountability and Enhancement Act as passed by the House and Senate.

H.R. 22 passed the House on July 26, 2005 by a vote of 410–20, and the Senate then passed H.R. 22 with an amendment by unanimous consent on February 9, 2006. H.R. 6407 represents the combination of the Senate and House versions of H.R. 22. As such, the Committee on Government Reform's Report on H.R. 22, 109–66, Part I, as reported on April 28, 2005 is relevant and necessary to understanding the provisions of H.R. 6407, particularly because many of the provisions of H.R. 6407 are unchanged from H.R. 22 as reported by the Government Reform Committee. For those looking for additional legislative history on H.R. 6407, the Government Reform Committee Report accompanying H.R. 22, 109–66, Part I, will provide useful explanations and information.

TAX RELIEF AND HEALTH CARE ACT OF 2006

SPEECH OF

HON. WILLIAM M. THOMAS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Friday, December 8, 2006

Mr. THOMAS. Mr. Speaker, allow me to recite from explanatory material prepared for H.R. 6111, the Tax Relief and Health Care Act of 2006.

DIVISION B—MEDICARE AND OTHER HEALTH PROVISIONS

Section 1. Short title of division

Current law

No provision.

Explanation of provision

This division may be cited as the ''Medicare Improvements and Expansion Act of 2006''.

TITLE I—MEDICARE IMPROVED QUALITY AND PROVIDER PAYMENTS

Section 101. Physician payment and quality improvement

Current law

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2006 is $37.8975.

The conversion factor is the same for all services. It is updated each year according to a formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculation of the formula. These include: (1) the sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians services; and (3) the update adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line

with the SGR target. In no case can the adjustment factor be less than minus seven percent or more than plus three percent.

The law specifies a formula for calculating the SGR. It is based on changes in four factors: (1) estimated changes in fees; (2) estimated change in the average number of Part B enrollees (excluding Medicare Advantage beneficiaries); (3) estimated projected growth in real gross domestic product (GDP) growth per capita; and (4) estimated change in expenditures due to changes in law or regulations. In order to even out large fluctuations, MMA changed the GDP calculation from an annual change to an annual average change over the preceding 10 years (a ''10-year rolling average'').

The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. It was also slated to in subsequent years; however, legislation kept this from occurring. Most recently, the Deficit Reduction Act froze the 2006 conversion factor at the 2005 level. A negative 5 percent update is slated to occur in 2007.

Explanation of provision

The conversion factor for 2007 would be the conversion factor otherwise applicable for 2007 divided by the product of: (i) 1 plus the Secretary's estimate of the percentage increase in the MEI for 2007 (divided by 100), and (ii) 1 plus the Secretary's estimate of the update adjustment factor for 2007. These changes would not be considered in the computation of the conversion factor for 2008.

The provision would also implement a voluntary quality reporting system for Medicare payments for covered professional services tied to the reporting of claims data. Physicians and other eligible professionals (including physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, registered dietitians or nutritional professionals as defined under current law, physical therapists, occupational therapists, and qualified speech-language pathologists) who report the quality information would be eligible for a bonus incentive payment (BIP) for services between July 1, 2007 to December 31, 2007. The Secretary would also address a mechanism whereby an eligible professional could provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database) as identified by the Secretary.

For covered professional services furnished beginning July 1, 2007 and ending December 31, 2007, the quality reporting measures are those identified as physician quality measures under the CMS Physician Voluntary Reporting Program (PVRP) as published on the CMS public website as of the date of enactment of this provision. The Secretary may modify these quality measures if changes are based on the results of a consensus-based process meeting in January of 2007 and if such changes are published on the CMS website by April 1, 2007. The Secretary may subsequently refine the quality measures (without notice or opportunity for public comment) up until July 1, 2007 by publishing modifications or refinements to previously published quality measures but may not change the quality measures.

Eligible professionals who (1) furnish services for which there are established quality measures as determined by this provision and (2) satisfactorily submit quality measures would be paid a single additional bonus payment amount equal to 1.5% of the allowed charges for covered professional services furnished during the reporting period. The bonus incentive payments would be paid from the Supplemental Medical Insurance Trust Fund (Part B). These bonus incentive payments would not be taken into account in the calculations and determination of payments for providers in health professional shortage areas or Physician Scarcity Areas, nor would these bonus payments be taken into account in computing allowable charges under this subsection.

The Secretary would presume that if an eligible professional submits data for a measure, then the measure is applicable to the professional. However, the Secretary may validate (by sampling or other means as the Secretary determines to be appropriate) to determine if an eligible professional reports measures applicable to such professional services. If the Secretary determines that an eligible professional has not reported applicable measures, the Secretary would not pay the bonus.

Satisfactory reporting of data determines whether the provider is eligible for the bonus payment. If there are no more than 3 quality measures that are applicable to the professional services furnished, the provider must report each measure for at least 80 percent of the cases to meet the criteria. If there are 4 or more quality measures that are applicable, the provider must report at least 3 of the quality measures for at least 80 percent of the cases.

In specifying the form and manner for the submission of data on quality measures under the physician quality reporting system to be implemented under section 1848(k) of the Social Security Act (as added by section 101(b) of the legislation), the House intends that the Secretary of Health and Human Services should recognize reporting of quality measures under demonstrations including the Physician Group Practice demonstration project (under section 1866A of the Social Security Act) and the Medicare Care Management Performance demonstration project (under section 649 of the Medicare Prescription Drug, Improvement, and Modernization Act) as permissible forms and manners of reporting under the system.

The provision also places a limit on bonus payments. No provider would receive payments in excess of the product of the total number of quality measures for which data are submitted and three times the average per measure payment amount. The average per measure payment amount would be estimated by the Secretary and would equal (the total amount of allowed charges under Medicare part B for all covered professional services furnished during the reporting period on claims for which quality measures are reported) divided by (the total number of quality measure for which data are reported during the reporting period under the physician reporting system).

The Secretary would provide for education and outreach to eligible professionals regarding these changes. The Secretary would implement these provisions acting through the Administrator of the Centers for Medicare and Medicaid Services (CMS).

This provision would allow no administrative or judicial review, under the existing Medicare appeals process or through a Provider Reimbursement Review Board as currently codified in statute, of the determination of measures, satisfactory reporting, payment limitation, or bonus incentive payment. A determination under the provisions of this section would not be treated as a determination under current appeals processes for Medicare.

For 2008, the quality measures would change to a set of measures adopted or endorsed by a consensus organization (such as the National Quality Forum or the AQA, originally known as the Ambulatory Care Quality Alliance) that may include measures that have been submitted by a physician specialty developed through a consensus-based process (such as through the American Medical Association (AMA) convened Physician Consortium for Performance Improvement) as identified by the Secretary. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing.

The CMS administrator would publish a proposed set of quality measures for 2008 in the Federal Register no later than August 15, 2007 with a public comment period. The final set of measures appropriate for eligible professionals to use to submit quality data in 2008 would be published no later than November 15, 2007.

The Secretary would be required to establish a Physician Assistance and Quality Initiative (PAQI) Fund which would be available to the Secretary for physician payment and quality improvement initiatives. Such initiatives may include application of an adjustment to the update to the conversion factor. The amount available to the Fund would be $1.35 billion for 2008. The Secretary would be required to provide for expenditures from the Fund for the obligation of the entire amount (to the maximum extent feasible) for payment for physicians services furnished in 2008. The specified amount available to the Fund would be made to the Fund from the Part B trust fund as expenditures are made from the Fund. The amounts in the Fund are to be available in advance of appropriations, but only if the total amount obligated to the Fund does not exceed the amount available to it. The Secretary may obligate funds from the Fund only if the Secretary determines (and the CMS Chief actuary and the appropriate budget officer certifies) that there are sufficient amounts available in the Fund. If the expenditures from the fund affect the conversion factor for a year, this would not affect the computation of the conversion factor for a subsequent year. Congress intends that CMS would continue to develop quality measures for reporting for 2008. The amounts in the fund are available at the Secretary's discretion to make payments for physician services provided in calendar year 2008 in a manner the Secretary sees fit, including for quality purposes.

The Secretary would be required to transfer $60 million from the Part B trust fund to the CMS Program Management Account for the period of FY 2007, FY 2008, and FY 2009 for the purposes of implementing this section.

Reason for change

Physicians are scheduled to receive a negative 5 percent update in 2007. The physician update should be addressed to prevent access issues to physician services. In addition, the update should include additional payment for quality reporting in 2007. The House encourages all physicians to participate in quality reporting and encourages CMS to continue to develop measures in consultation with the physician community and the existing structures available through the National Quality Foundation and the AQA.

Section 102. Extension of floor on Medicare work geographic adjustment

Current law

Medicare's physician fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to a national average. An area with costs above the national average would have an index greater than 1.00 while an area with costs below the average would have an index below 1.00. The physician work geographic adjustment factor is based on a sample of median hourly earnings in six professional specialty occupational categories. Unlike the other geographic adjustments, the work adjustment factor reflects only one-quarter of the cost differences in an area. The practice expense adjustment factor is based on employee wages, office rents, medical equipment and supplies. The malpractice adjustment factor reflects differences in malpractice insurance costs. The Secretary is required to periodically review and adjust the geographic indices.

MMA required the Secretary to increase the value of any work geographic index that was below 1.00 to 1.00 for services furnished on or after January 1, 2004 and before January 1, 2007.

Explanation of provision

The requirement is extended for an additional year, for services provided before January 1, 2008.

Reason for change

To provide a one-year extension to increase the value of any work geographic index that was below 1.00 to 1.00 to allow for higher adjustments under the work component in certain areas.

Section 103. Update of the composite rate component of the basic case-mix adjusted prospective payment system for dialysis services

Current law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by the Office of the Inspector General of the Department of Health and Human Services.

The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate. The DRA increased the composite rate component of the basic case-mix adjusted system for services beginning January 1, 2006 by 1.6 percent, over the amount paid in 2005. For 2006, the base composite rate is $130.40 for independent ESRD facilities and $134.53 for hospital-based ESRD facilities. The total drug add-on adjustment, with inflation, is 14.5%.

Explanation of provision

The composite rate component of the basic case-mix adjusted system shall be increased by 1.6 percent above the 2005 rate, for services furnished on or after January 1, 2006 and before April 1, 2007. For services furnished on or after April 1, 2007, the composite rate component of the basic case-mix adjusted system shall be increased by 1.6 percent, above the amount of such rate for services furnished on March 31, 2007.

Not later than January 1, 2009, GAO shall submit a report to The House on the costs for home hemodialysis treatment and patient training for both home hemodialysis and peritoneal dialysis. The report shall include recommendations for a payment methodology that measures, and is based on, the cost of providing such services and takes into account the case mix of patients.

Reason for change

Unlike other facilities, dialysis facilities do not have an inflation update for labor and capital costs. This provision addresses that inequity. The National Institutes of Health (NIH) is conducting a clinical trial on dialysis, partially in the home settings. This report would develop recommendations on how payments could incentivize the use of home dialysis.

Section 104. Extension of Treatment of certain physician pathology services under Medicare

Current law

In general, independent laboratories cannot directly bill for the technical component of pathology services provided to Medicare beneficiaries that are inpatients or outpatients of acute care hospitals. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) permitted independent laboratories with existing arrangements with acute care hospitals to bill Medicare separately for the technical component of pathology services provided to inpatients and outpatients. The arrangement between the hospital and the independent laboratory had to be in effect as of July 22, 1999. The direct payments for these services applied to services furnished during 2001 and 2002. Despite expiration of the BIPA moratorium after 2002, CMS directed the carriers to continue the moratorium until they received further instructions from CMS. MMA continued this policy for 2005 and 2006.

Explanation of provision

The provision is extended through 2007.

Reason for change

The provision expires on December 31, 2006 and independent laboratories will no longer be able to directly bill Medicare for the technical component for physician pathology services.

Section 105. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas

Current law

Generally, hospitals that provide clinical diagnostic laboratory tests under Part B are reimbursed under a fee schedule. MMA specified that hospitals with under 50 beds in qualified rural areas (low density population rural areas) would receive 100 percent reasonable cost reimbursement for clinical diagnostic tests covered under Part B that are provided as outpatient services. The provision applied to services furnished during a cost-reporting period beginning during the 2–year period starting July 1, 2004.

Explanation of provision

The provision is modified to apply to services furnished during a cost-reporting period beginning during the 3–year period starting July 1, 2004. The provision is effective as if included in the enactment of MMA.

Reason for change

The MMA provision expired and this extends it for one more cost reporting year.

Section 106. Hospital Medicare reports and clarifications

(a) Correction of Mid-Year Reclassification Expiration

Current law

Generally speaking, the Medicare Geographic Classification Review Board's (MGCRB) classification decisions are required to extend geographic reclassification for 3 years in the inpatient prospective payment system (IPPS) and end on September 30th each year.

Explanation of provision

This provision corrects the mid year expiration of certain hospital geographic reclassifications.

Reason for change

The provision creates consistency in the end dates for reclassification decisions for hospitals to be consistent with the Federal Fiscal Year. It is the intent of the House authors that group reclassifications made by the MGCRB that begin April 1, 2007 would be unaffected by this provision, with the exception of the continuing reclassifications of hospitals whole individual reclassifications would have lapsed prior to April 1 2007.

(b) Revision of the Medicare Wage Index Classification System

Current law

As directed by Medicare statute, the amount of a hospital's operating and capital payments will vary according to the relative level of hospital wages in its geographic area compared to the national average. The geographic areas or hospital labor markets that have been used by Medicare are urban areas as established by the Office of Management and Budget (OMB). Essentially, a hospital's payment will depend upon whether it is in an urban area (and if so, which one) and the wage data reported by the hospitals in that area. Counties that are not in an urban area are grouped into one statewide rural labor market. Also, with modifications, the hospital wage data are used to adjust for geographic cost differences in Medicare's payment systems for other services, such as inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), home health agency (HHA), skilled nursing facility (SNF), and hospice care. Unlike these other providers, IPPS hospitals have an administrative process, through appeals to the MGCRB (The Medicare Geographic Classification Review Board), to reclassify to different geographic areas. Other statutory provisions affecting a hospital's geographic designation also have been established.

Explanation of provision

The Medicare Payment Advisory Commission (MedPAC) would be required to submit a report to The House no later than June 30, 2007 on the wage index classification system used in Medicare's prospective payment systems, including IPPS. This report would include recommendations for alternatives to the current methods used to compute the wage index. $2 million in funds from the Treasury would be appropriated to MedPAC for FY2007 for these activities. The Secretary would be required to include in the proposed rule making process for FY2009 one or more proposals to revise the IPPS wage adjustment, after taking into account MedPAC's recommendations. The proposals would consider problems associated with labor market definitions; modification or elimination of geographic reclassifications and other adjustments; the use of Bureau of Labor Statistics data to calculate relative wages; minimizing variations in wage index adjustments between and within metropolitan statistical areas and rural areas; the feasibility of applying all components of the proposal to other settings, including HHAs and SNFs; methods to minimize the volatility of wage index adjustments while maintaining the budget neutrality; the effect on health care providers and on each region of the country; implementation of proposal, including the transition methods; and occupational mix issues such as staffing practices, effect on

quality of care and alternative recommendations.

(c) Elimination of unnecessary report

Historically, under IPPS, hospitals in different geographic areas have had their Medicare payments calculated using different per discharge amounts. For example, at one point, hospitals in large urban areas had been paid on the basis of a larger per discharge amount than hospitals in smaller urban areas or those in rural areas. This classification system had changed over time. By FY1995, discharge amounts were calculated for large urban hospitals and all other hospitals. The implementation of the MMA permanently equalized the per discharge payment rates for all hospitals except for those in Puerto Rico.

Starting in 1987, the Secretary has been required to submit a report to The House that includes an initial estimate of the percentage update (change factor) in the per discharge payment amounts. The Secretary's estimate is required to take into consideration the recommendations of Medicare's payment commission and may vary for hospitals in different geographic areas

Explanation of provision

This provision would eliminate the requirement that the Secretary include recommendations with respect to the update factors no later than March 1 before the beginning of the fiscal year.

Section 107. Extension of payment rule for brachytherapy

Current law

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established that brachytherapy devices consisting of radioactive sources (or seeds) would be paid on the basis of a hospital's cost for such device (computed by reducing a hospital's charges to costs) for services furnished starting January 1, 2004 until January 1, 2007. The Secretary was directed to create additional groups of covered Outpatient Department Services (OPD) that classify such devices separately from other services (or group of services) in a manner that reflects the number, isotope, and radioactive intensity, including separate groups for palladium-103 and iodine-125 devices. Starting January 1, 2007, CMS will continue to pay separately for brachytherapy sources, but will base payment on the source-specific median costs. CMS has not created new brachytherapy source codes to differentiate stranded from nonstranded brachytherapy sources. The historical data used to establish the source-specific median costs should reflect utilization of stranded brachytherapy sources.

Explanation of provision

This provision would extend payment for brachytherapy sources on the basis of a hospital's costs (adjusted from its charges) established under MMA until January 1, 2008. The provision would direct the Secretary to create additional groups of covered OPD services in a manner that reflects the number, isotope, and radioactive intensity, including separate groups for palladium-103 and iodine-125 devices and for stranded and nonstranded devices furnished on or after July 1, 2007. These provisions may be implemented by program instruction or otherwise.

Reason for change

This provision allows brachytherapy devices to continue to be paid based on a hospital's cost, to allow CMS further time to collect data in order to base payments on the source-specific median costs after one year, and requires CMS to establish additional groups of services for stranded and nonstranded devices.

Section 108. Payment process under the competitive acquisition program (CAP)

Current law

MMA revised the way Medicare pays for Part B drugs. Beginning in 2005, payments for these drugs are based on an average sales price (ASP) payment methodology, which sets payments at the weighted average ASP plus 6%; the Secretary has the authority to reduce the ASP payment amount if the widely available market price is significantly below the ASP. Alternatively, beginning in 2006, drugs can be provided through a newly established competitive acquisition program (CAP). The intent of the program is to enable physicians to acquire certain drugs from an approved CAP vendor thereby enabling them to reduce the time they spend buying and billing for drugs and finance risk.

Explanation of provision

The provision deletes the requirement that payments to CAP contractors are conditioned upon the administration of the drugs and biologicals. It specifies that payment may only be made to the contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary. Further, the Secretary is required to establish a post-payment review process to assure that payment is made for a drug or biological only if it has been administered. The process may be established by program instruction or otherwise and may include the use of statistical sampling. The Secretary is required to recoup, offset or collect any overpayments determined by the Secretary.

The section further clarifies that nothing in this provision is to be construed as requiring any additional competition by entities under the CAP program. Further the provision is not to be construed as requiring any additional process for elections by physicians under the program or additional selection by a selecting physician of a CAP contractor. The House, however, intends that the normal competitive bidding process and physician election as authorized by the MMA should continue as authorized by that law. The provision applies to payments for drugs and biologicals supplied on or after April 1, 2007. Additionally, it applies, for claims that are unpaid as of April 1, 2007, to drugs and biologicals supplied on or after July 1, 2006 and before April 1, 2007.

In addition, the House would like to clarify an additional issue regarding Medicare Part B drugs. The Social Security Act (SSA) currently provides the Secretary of Health and Human Services with the authority to revise the list of compendia that are used to determine Medicare Part B coverage of oncology drugs for off-label uses. Of the three compendia currently listed in statute, one no longer is published and another will soon be published under a different name. To address this situation, requests for official recognition of additional compendia have been made by the public. The Medicare Coverage and Advisory Committee (MCAC) has reviewed and voted on the desirable characteristics of new compendia; however, the Centers for Medicare and Medicaid Services (CMS) has not yet acted on the MCAC's review.

A current list of compendia which contain the most current clinical information about which drugs show the greatest promise of treating various diseases is critical to ensure that beneficiaries have access to the most appropriate therapies. Correcting and expanding the list of compendia organizations recognized by CMS for Medicare Part B coverage purposes is a major step forward in accomplishing that objective. While preserving the list of functioning compendia currently covered by the SSA, the House directs the Secretary to act as soon as possible to update the list of three compendia, and report back to the House no later than January 30, 2007.

The House is also concerned by reports that some Medicare beneficiaries have trouble accessing IVIG therapies from providers. It is our hope that the Office of the Inspector General (OIG) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) studies focused on IVIG are promptly completed. The House hopes the Secretary would promptly review such studies, and report to the House regarding the adequacy of supply and Medicare reimbursement related to the cost of acquiring IVIG and the complexity of IVIG infusions. The House strongly urges the Secretary to continue the IVIG pre-administration fee until the Secretary either assures the House that Medicare reimbursement is adequate or a new payment methodology is implemented to address concerns regarding access to IVIG.

Reason for change

To provide clarification in order to allow for a post-payment review process to ensure that payment is made for a drug or biological only if the drug or biological is delivered for administration to a beneficiary. The House intends for CMS to implement this provision by not matching a claim for drugs to a claim with drug administration prior to being paid. The post payment review is intended to sufficiently protect against inappropriate claims.

Section 109. Quality reporting for hospital outpatient services and ambulatory surgical center services

(a) Outpatient Hospital Services

Current law

Each year the hospital outpatient department (OPD) fee schedule is increased by a factor that is generally based on the hospital market basket (MB) percentage increase. In certain years, the MB has been reduced by percentage points as specified by statute.

Explanation of provision

Starting in 2009 and for each subsequent year, a hospital paid under the inpatient prospective payment system (IPPS) that does not submit required measures will receive an OPD fee schedule increase of the MB minus 2.0 percentage points. A reduction under this provision would only apply to payments for the year involved and would not be taken into account when computing the OPD fee schedule increase in a subsequent year.

Each IPPS hospital is required to submit data on measures under this section in the form, manner, and timing specified by the Secretary. The Secretary would be required to develop appropriate measures for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties. To the extent feasible and practicable, the measures shall include those set forth by one or more national consensus building entitles. Nothing would prevent the Secretary from selecting all hospital quality measures or a subset of such measures. The Secretary would be able to replace any measures as appropriate, such as where all hospitals are effectively in compliance or the measures have subsequently been shown not to represent the best clinical practice.

The Secretary would be required to establish procedures for making the submitted data available to the public. These procedures would ensure that a hospital has the opportunity to review data prior to being made available to the public. The Secretary would be required to report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care on the Internet website of the Centers for

Medicare and Medicaid Services. Other conforming amendments would also be established.

Reason for change

The Provision promotes the development of quality measures for outpatient medical services and services provided in ASC's. The House intends the measures to be developed in consultation with affected entities and quality organizations.

(b) Application to Ambulatory Surgical Centers

Current law

Presently, Medicare pays for surgery-related facility services in an ambulatory surgical center (ASC) based on a fee schedule. The Medicare Prescription Drug, Improvement, and Modernization Act of 2006 (MMA) required the Secretary to implement a revised payment system for ASCs no later than January 1, 2008, taking into account recommendations issued by a required report from the Government Accountability Office (GAO). The GAO report, which has just been issued, was required to examine the relative costs of ASC services to those in hospital outpatient departments. GAO was also required to recommend whether CMS should use the outpatient prospective payment system as the basis for the revised ASC system. Total payments under the new system should be equal to total projected payments under the old system.

Explanation of provision

In the revised payment system, the Secretary would be able to provide for a reduction in any annual update of 2.0 percentage points for failure to report required quality measures. A reduction under this provision would only apply to payments for the year involved and would not be taken into account when computing any annual increase factor in subsequent years. Except as otherwise provided by the Secretary, the provisions of subparagraphs (B), (C), (D), and (E) of the newly established Section 1833(t)(17) concerning the form and submission of data, the development of outpatient measures, the replacement of measures, and the availability of quality measures in a hospital outpatient setting would apply to ASC services.

Reason for change

The Provision promotes the development of quality measures for outpatient medical services and services provided in ASC's. The House intends the measures to be developed in consultation with affected entities and quality organizations.

(c) Effective date

Current law

No provision.

Explanation of provision

The amendments made by the section would apply to payment for services furnished starting January 1, 2009.

Section 110. Reporting of anemia quality indicators for Medicare part B cancer anti-anemia drugs

Current law

Medicare Part B covers certain drugs used as anticancer chemotherapeutic agents and certain oral anti-emetic drugs used as part of an anticancer chemotherapeutic regimen. It also covers epoetin alpha for patients with kidney disease; the drug may also be used to counter anemia for cancer patients.

Explanation of provision

The provision requires that all claims submitted for drugs for treatment of anemia in connection with cancer must include information on the hemoglobin or hematocrit levels for the individual. The information is to be submitted in the form and manner specified by the Secretary. The provision applies to drugs furnished on or after January 1, 2008. The Secretary is required to address the implementation of the provision in the physician fee schedule regulations for 2008.

Reason for change

Since 1989, ESRD facilities have provided lab values on red blood cell counts to CMS to ensure that anemia is addressed. This requires physician offices and hospital outpatient departments to provide the same information.

Section 111. Clarification of hospice satellite designation

Current law

Section 1814(i)(2)(A) of the Social Security Act limits total Medicare payment amounts to individual hospice providers by an absolute dollar amount, or ''cap amount.'' This amount is based on the number of Medicare patients the agency serves and is calculated by dividing total payments to a hospice per year by the total number of beneficiaries served to get the per beneficiary payment amount. If the per beneficiary payment amount does not exceed the cap amount, the hospice may retain all payments. If the result exceeds the cap amount, the hospice must repay excess funds to the Medicare program. For purposes of calculating whether or not a hospice exceeds the cap amount, increasing the number of beneficiaries a hospice serves reduces the per beneficiary payment amount. A lower per beneficiary payment amount reduces the likelihood that a hospice will exceed the annual hospice cap and be required to repay excess funds to the Medicare program.

Explanation of provision

For purposes of calculating the hospice cap for 2004, 2005 and 2006 and for hospice care provided after November 1, 2003 and before December 27, 2005, this provision would designate hospice with provider number 290–1511 as a multiple location of hospice with provider number 29–1500.

Reason for change

To prevent application of the Hospice cap in this circumstance.

TITLE II—MEDICARE BENEFICIARY PROTECTIONS

Section 201. Extension of exceptions process for Medicare therapy caps

Current law

The Balanced Budget Act of 1997 established annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient services provided by hospitals.

Beginning in 1999, there were two beneficiary limits. The first was a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the Medicare economic index (MEI) rounded to the nearest multiple of $10.

The Balanced Budget Refinement Act of 1999 (BBRA) suspended application of the limits for 2000 and 2001. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) extended the suspension through 2002. Implementation of the provision was delayed until September 2003. The caps were implemented from September 1, 2003 through December 7, 2003. MMA reinstated the moratorium from December 8, 2003 through December 31, 2005.

The caps went into effect again beginning January 1, 2006. The 2006 caps are each $1,740. However, DRA required the Secretary to implement an exceptions process for expenses incurred in 2006. Under the process, a Part B enrollee, or a person acting on behalf of the enrollee, can request an exception from the physical therapy and occupational therapy caps. The individual may obtain such exception if the provision of services is determined medically necessary. The exceptions process only applies for 2006.

Explanation of provision

The provision extends the exceptions process through 2007.

In addition, during consideration of the bill, the issue of whether speech language pathologists should have a separate provider number was raised in order to better report more accurately on the bill's quality reporting program. The House urges CMS to investigate this issue.

Reason for change

Provides a one-year extension of the exceptions process established under the Deficit Reduction Act (DRA) to allow patients to apply for additional therapy services if their treatment is expected to exceed the annual cap. During consideration of the bill, the issue of whether speech language pathologists should have a separate provider number was raised in order to better report more accurately on the bill's quality reporting program. The House urges CMS to investigate this issue in order to promote quality initiatives.

Section 202. Payment for administration of part D vaccines

Current law

Medicare Part B covers pneumoccoccal vaccine and its administration, influenza vaccine and its administration, and hepatitis B vaccine and its administration when furnished to a high or intermediate risk individual. Medicare Part D covers other vaccines licensed under the Public Health Servvice Act.

Explanation of provision

The provision specifies that during 2007, the costs of administering Part D vaccines will be paid under Part B, as if it were the administration of a hepatitis B vaccine. Beginning in 2008, Part D coverage will include the administration costs.

Reason for change

CMS has chosen not to reimburse providers for administering vaccines that are covered under the new Medicare prescription drug benefit (Part D). If doctors and their staff are not being paid to provide these vaccines, it will undoubtedly create access problems to these important preventive medicines. This provision ensures that providers will be paid for their services through Part B funds in 2007 and through Part D thereafter.

Section 203. OIG study of never events

Current law

No provision.

Explanation of provision

The Office of the Inspector General (OIG) in the Department of Health and Human Services would be required to conduct a study on the incidence of never events for Medicare beneficiaries, including types of such events and payments by any party, including beneficiaries, of such events. This study would also include the extent to which Medicare paid, denied or recouped payment for such services as well as the administrative process of the Centers for Medicare and Medicaid Services (CMS) to identify such events and to deny or recoup associated payments. The OIG would be required to audit a representative sample of claims and medical

records of the events; would be able to request access to claims and records from any Medicare contractor; and would not be able to release individually identifiable or facility specific information. The OIG would be required to submit a report to The House no later than two years from enactment. This report would include recommendations for legislative or administrative action on the processes to identify, deny or recoup payments for never events, the potential process for public disclosure of never events which ensure patient privacy and permit the use of disclosed information for root cause analysis. $3 million of funds in the Treasury will be appropriated which will be available until January 1, 2010. Never event are those that are listed and endorsed as ''serious reportable events'' by the National Quality Forum as of November 16, 2006.

Reason for change

This would provide useful information on serious adverse medical events where a patient was harmed but the Medicare program nevertheless reimbursed the facility where the serious injury occurred.

Section 204. Medicare medical home demonstration project

Current law

No provision.

Explanation of provision

The Secretary is required to establish a medical home demonstration project in Medicare law for the purpose of redesigning the healthcare delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations (i.e., those with multiple chronic illnesses that require regular monitoring, advising, or treatment).

Under the project, case management fees would be paid to personal physicians, and incentive payments would be paid to physicians participating in practices that provide ''medical home'' services. Medical homes are physician practices in charge of targeting beneficiaries for project participation. They are responsible for: (1) providing safe and secure technology to promote patient access to personal health information; (2) developing a health assessment tool for the targeted individuals; and (3) providing training for personnel involved in the coordination of care.

The project is to operate for three years in urban, rural, and underserved areas in up to 8 states and would include physician practices with fewer than three full-time equivalent physicians, as well as larger practices, particularly in rural and underserved areas.

In addition to meeting Medicare requirements for physicians, personal physicians who provide first contact and continuous care for their patients must be board certified. Personal physicians must also have staff and resources to manage the comprehensive and coordinated health care of each of their patients. Participating physicians may be specialists or subspecialists for patients requiring ongoing care for specific conditions, multiple chronic conditions, (e.g., severe asthma, complex diabetes, cardiovascular disease, and rheumatologic disorder) or for those with a prolonged illness.

Personal physicians must perform (or provide for the performance of): (1) advocates for and provides ongoing support, oversight, and guidance to implement a plan of care; that provides an integrated, coherent, cross discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient involved and other appropriate medical personnel or agencies (such as home health agencies); (2) uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care (based on patient-specific factors); (3) uses health information technology that may include remote monitoring and patient registries; and (4) encourages patients to engage in management of their own health through education and support systems.

Payments for care management to personal physicians are to be provided under a care management fee under Section 1848 of the Social Security Act. The Secretary would be required to develop a care management fee code and a value for these payments using the relative value scale update committee (RUC) process.

Payments for a medical home shall be based on the payment methodology applied to physician group practices under section 1866A of the Social Security Act. Under this methodology, 80 percent of Medicare reductions (determined by using assumptions with respect to the reductions in the occurrence of health complications, hospitalization rates, medical errors, and adverse drug reactions) resulting from the medical home participation (as reduced by the total project-related care management fees), would be paid to the medical home. Project payments are to be paid from Part B.

The Secretary would be required to provide a yearly project evaluation and submit it to The House on a date specified by the Secretary. In addition, the Secretary would be required to submit to The House a project evaluation no later than one year after project completion.

Reason for change

The proposal tests the effectiveness of the medical home model to provide targeted and coordinated care to patients suffering from one or more chronic conditions. A personal physician and physician practice work together to manage these patients.

Section 205. Medicare DRA technical corrections

(a) PACE clarification

Current law

The House appropriated $10 million for FY2006 for the outlier funds for rural Program of All-Inclusive Care for the Elderly (PACE) providers. Outlier costs are those inpatient and other costs in excess of $50,000 incurred within a given 12–month period by a PACE provider for an eligible participant who resides in a rural area. These appropriated funds would remain available for expenditure through FY2010.

Explanation of provision

The provision clarifies that the appropriated $10 million would be applied to fiscal years 2006 through 2010, rather than only for FY2006. It also specifies that the funds would remain available for obligation, rather than for expenditure, through FY2010.

Reason for change

CMS has issued the start-up grants but cannot obligate the outlier payments yet because CMS does not know to whom the outlier payments will be distributed.

(b) Miscellaneous technical corrections

(1) Correction of Margin (Section 5001)

Current law

No provision.

Explanation of provision

Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 5001(a) of the Deficit Reduction Act of 2005 (Public Law 109–171), is amended by moving clause (viii) (including subclauses (I) through (VII) of such clause) 6 ems to the left.

(2) Reference Correction (Section 5114)

Current law

P.L. 109–171 provision modified the first sentence of Section 1842(b)(6)(F) of the Social Security Act to add a new paragraph H to 1842(b)(6) so that a federally qualified health center (FQHC) would be paid directly for FQHC services provided by a health care professional under contract with that FQHC.

Explanation of provision

Instead of modifying Section 1842(b)(6)(F) to add paragraph H, the amendment would modify Section 1842(b)(6) of the Social Security Act.

(c) Effective date

These amendments would become effective as if they had been included in DRA 2005, enacted on February 8, 2006.

Section 206. Limited continuous open enrollment of original Medicare fee-for-service enrollees into Medicare Advantage non-prescription drug plans

Current law

Since the inception of Medicare Part C, beneficiaries had been allowed to enroll into and/or disenroll from Medicare Advantage (MA) plans on a monthly basis throughout the year. Beneficiaries were able to change plans as often as they wanted because The House had delayed (on three occasions) a provision, that locked Medicare beneficiaries into their plan choice after their enrollment period ended. However, since The House has not further delayed its implementation, the lock-in began to take affect on July 1, 2006.

Explanation of provision

This provision allows Medicare beneficiaries who are enrolled in traditional fee-for-service but not enrolled in a prescription drug plan to enroll in a Medicare Advantage plan that does not offer drug coverage after their enrollment period ended. These beneficiaries would be allowed to make this change once during the year, after their enrollment period had ended. This provision would sunset in two years.

Reason for change

This provision, allows qualified beneficiaries to enroll in certain MA plans throughout the year.

TITLE III—MEDICARE PROGRAM INTEGRITY EFFORTS

Section 301. Offsetting adjustment in Medicare Advantage Stabilization Fund

Current law

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established a stabilization fund to provide incentives for plans to enter into and to remain in the Medicare Advantage (MA) regional program. Money in the fund is available to the Secretary for expenditures from January 1, 2007 to December 31, 2013.

Initially $10 billion is to be provided to the stabilization fund and additional amounts are to be added to the fund from a portion of any average per capita monthly savings amounts. The Secretary is responsible for determining the amounts that may be given to MA plans from this fund, based on statutory requirements. For example, the national bonus payment will be available to an MA organization that offers an MA regional plan in every MA region in the year, but only if there was no national plan in the previous year.

Explanation of provision

This provision would delay the initial availability of the stabilization fund until January 1, 2012, and reduce the amount of the fund to $3.5 billion.

Reason for change

The payment changes made by the MMA have strengthened the MA program, thereby increasing enrollment in, and availability of, MA plans. In 2003, just 54 percent of seniors had access to an MA plan. Today, nearly 100

percent of beneficiaries have access to at least two MA plans and the average county provides seniors with a choice of 12 MA plans. Attracting plans to the MA program today is not an issue. The stabilization fund has been rendered unnecessary under the current payment system.

Section 302. Extension and expansion of recovery audit contractor program under the Medicare Integrity Program

(a) Use of recovery audit contractors

Current law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–73) authorized a 3-year demonstration project using recovery audit contractors to identify both under and overpayments made to Part A & B Medicare providers and recoup overpayments in the Medicare program. The demonstration is being conducted as part of the Medicare Integrity Program, created by Section 1893 of the Social Security Act, which enables the Secretary to enter into contracts with entities to carry out a range of activities designed to prevent health care fraud and abuse in Parts A & B of the Medicare program. The Medicare Integrity Program was established by the Health Insurance Portability and Accountability Act of 1996 along with the Health Care Fraud and Abuse Control Program. The program is financed via the Federal Hospital Insurance Trust Fund.

Explanation of provision

Section 302 would allow the Centers for Medicare and Medicaid Services (CMS) to continue using recovery audit contractors to identify both under and overpayments made under Medicare Parts A & B and recoup any overpayments made to providers. To pay the contractors, the Secretary would be required to use only those funds recovered by the contractors. From these recoveries, the bill would require the Secretary to pay the contractors in two ways: (1) on a contingent basis for collecting overpayments; and (2) in amounts that the Secretary may specify for identifying underpayments. A portion of the recovered funds to the CMS program management account would be available for activities conducted under the recovery audit contractor program. Any remaining recovered amounts—those recoveries that are not paid to the contractors or applied to the CMS program management account—would be used to reduce expenditures under Medicare Parts A & B. Each contract would be required to provide that audit and recovery activities be conducted during the fiscal year and retrospectively for not more than 4 fiscal years. The Secretary would be allowed to waive Medicare statutory provisions to pay for the services of the recovery audit contractors.

By January 1, 2010, the Secretary would be required to contract with enough recovery audit contractors to cover Medicare activities in all states. When awarding contracts, the Secretary would be required to contract only with recovery audit contractors that have the staff with the appropriate clinical knowledge of and experience with Medicare payment rules and regulations, or recovery audit contractors that will contract with another entity that has the staff with the appropriate knowledge of and experience with Medicare payment rules and regulations. The Secretary shall give preference to entities with more than three years direct management experience and a demonstrated proficiency in audits with private insurers, health care providers, health plans, or state Medicaid programs. Recovery audit contractors cannot be fiscal intermediaries, carriers, or Medicare Administrative Contractors, and the recovery of overpayments by these contractors would not prohibit the Secretary or the Attorney General from prosecuting allegations of fraud and abuse arising from these overpayments.

Finally, the Secretary would be required to submit a report to The House annually on the use of these recovery audit contractors. Specifically the report would include information on the performance of these contractors as it relates to identifying over and underpayments and in collecting overpayments. The report would also be required to include an evaluation of the comparative performance of these contractors and any Medicare savings that have accrued as a result of their activities.

(b) Access to Coordination of Benefits Contractor Database

Current law

The Coordination of Benefits (COB) Contractor consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits.

Explanation of provision

For the purpose of carrying out their audit and recovery activities, the Secretary of HHS would provide recovery audit contractors with access to the database of the Coordination of Benefits Contractors of the Centers for Medicare and Medicaid Services during the current fiscal year and for a period of up to 4 fiscal years prior to the current fiscal year.

(c) Conforming Amendments to Current Demonstration Project

Current law

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires that the Secretary's demonstration project using recovery audit contractors last for no longer than three years. After the completion of the program, the Secretary shall submit to The House a report on the project and its impact on savings to the Medicare program.

Explanation of provision

The provision would continue the use of recovery audit contractors until all contracts could be entered into. The provision would also eliminate the requirement that the Secretary submit to The House a report not later than 6 months after the project's completion on the impact of recovery audit contractors' activities on Medicare savings.

Reason for change

Recovery audit contractors provide a valuable service in identifying and recovering improper payments in the Medicare program. The services provided by these auditors are highly skilled and specialized, and were never utilized by the Medicare program prior to the current demonstration. The results of the demonstration document that significant amounts of funds have been returned to Medicare, and are expected to be returned to the program in the future. In fact, the Congressional Budget Office expects that this program would reduce net Medicare spending—that is, recoveries of overpayments would exceed the payments to contractors, program management costs, and outlays to correct underpayments. Based on the results of the demonstration, extension and national expansion of the recovery audit program will result in the return of substantial funds to Medicare in an efficient and cost effective manner.

Section 303. Funding for the Health Care Fraud and Abuse Control Account

(a) Departments of Health and Human Services and Justice

Current law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–91) established section 1128C of the Social Security Act, which authorized the creation of a national health care fraud and abuse control program headed by the Secretary of HHS and the Attorney General. In Section 1817(k) of the Social Security Act, HIPAA created an expenditure account within the Medicare Federal Hospital Insurance Trust Fund called the Health Care Fraud and Abuse Control (HCFAC) Account. Within the HFCFAC account, the legislation appropriated funds to HHS and DOJ at an amount of $104 million in FY97 and for FY98 through FY03 at annual increases of 15 percent above the preceding year. For each fiscal year after 2003, the annual appropriation available to HHS and DOJ was to be capped at the FY 2003 level of $240.6 million. The legislation also established a separate funding stream within the HCFAC account to support activities undertaken by the FBI. Funding for the FBI was increased from $47 million in FY97 to $114 million in FY03. The legislation capped FBI funding at the FY03 level for FY03 and beyond.

Explanation of provision

Section 303 would extend appropriations for the Health Care Fraud and Abuse Control Program through FY06 and beyond. For FY98 through FY03, the annual appropriation to HHS and DOJ is the limit for the preceding fiscal year increased by 15 percent. This bill would extend the annual appropriation for FY04 through FY06 to the FY03 level. For fiscal years 2007 through 2010, the annual appropriation would be the limit for the preceding year plus the percentage increase in the consumer price index for all urban consumers. For each fiscal year beyond 2010, the legislation would cap the appropriation at the FY10 level.

For the Office of the Inspector General of HHS, Section 303 would extend the annual appropriation of $160 million through FY06. For FY07, the bill would increase the FY06 appropriation to OIG by the percentage increase in the consumer price index. For fiscal years 2008, 2009, and 2010, the annual appropriation would increase by the limit for the preceding year plus the percentage increase in the consumer price index for all urban consumers. For each fiscal year after FY10, the legislation would cap the appropriation at the FY10 level.

Reason for change

Funding levels are capped under law, and increased funding will be provided to continue activities covered by the HCFAC Account to help combat waste, fraud and abuse.

(b) Federal Bureau of Investigations

Current law

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–91) established section 1128C of the Social Security Act, which authorized the creation of a national health care fraud and abuse control program headed by the Secretary of HHS and the Attorney General. In Section 1817(k) of the Social Security Act, HIPAA created an expenditure account within the Medicare Federal Hospital Insurance Trust Fund called the Health Care Fraud and Abuse Control (HCFAC) Account. Within the HFCFAC account, the legislation appropriated funds to HHS and DOJ at an amount of $104 million in FY97 and for FY98 through FY03 at annual increases of 15 percent above the preceding year. For each fiscal year after 2003, the annual appropriation available to HHS and

DOJ was to be capped at the FY 2003 level of $240.6 million. The legislation also established a separate funding stream within the HCFAC account to support activities undertaken by the FBI. Funding for the FBI was increased from $47 million in FY97 to $114 million in FY03. The legislation capped FBI funding at the FY03 level for FY03 and beyond.

Explanation of provision

Section 303 would extend the annual appropriation to the Federal Bureau of Investigations (FBI). For fiscal years 2003 through 2006, the annual appropriation to the FBI for fraud and abuse activities would be capped at the FY02 level of $114 million. For fiscal years 2007 through 2010, the annual appropriation would be the limit for the preceding year plus the percentage increase in the consumer price index for all urban consumers. For each fiscal year after 2010, the legislation would cap the appropriation at the FY2010 level.

Reason for change

Funding levels are capped under law, and increased funding will be provided to continue activities covered by the HCFAC Account.

Section 304. Implementation funding

Current law

No current law.

Explanation of provision

For implementation of provisions and amendments made by this title and titles I and II of this division, other than the section requiring the Inspector General in the Department of Health and Human Services to conduct a study of never events, the provision would require the Secretary of Health and Human Services to transfer $45,000,000 to the CMS Program Management Account for FY2007 and FY2008, from the Federal Hospital Insurance Trust Fund, and the Federal Supplementary Medical Insurance Trust, in appropriate proportions.

TITLE IV—MEDICAID AND OTHER HEALTH PROVISIONS

Section 401. Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program

Current law

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is known as transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. The House expanded work-related TMA under Section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families who lose Medicaid for work-related reasons for at least six, and up to 12, months. The sunset date for Section 1925 has been extended a number of times, most recently through December 31, 2006 by the Deficit Reduction Act of 2005.

Under Section 510 of the Social Security Act, federal law appropriated $50 million annually for each of the fiscal years 1998–2003 for matching grants to states to provide abstinence education and, at state option, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on groups that are most likely to bear children out-of-wedlock. Funds must be requested by states when they apply for Maternal and Child Health Services (MCH) Block Grant funds and must be used exclusively for the teaching of abstinence. States must match every $4 in federal funds with $3 in state funds.

A state's allotment of abstinence education block grant program funding is based on the proportion of low-income children in the state as compared to the national total. Funding for the abstinence education block grant has been extended a number of times, most recently through December 31, 2006 by the Deficit Reduction Act of 2005.

Explanation of provision

The provision would extend TMA under Section 1925 of the Social Security Act through June 30, 2007. It would also fund the abstinence education block grant program through June 30, 2007 at the level provided through the third quarter of FY2006.

Section 402. Grants for research on vaccine against Valley Fever

Current law

Under existing National Institutes of Health (NIH) authority, the National Institute on Allergy and Infectious Diseases has supported projects to study coccidioidomycosis, known as Valley Fever. Grants have included projects to study the organism that causes Valley Fever; to improve the ability to evaluate vaccine candidates; to support the clinical development of potential drug therapies; and to support acquisition of equipment and facilities for research on the disease, among others.

Explanation of provision

The Secretary is required to conduct research on the development of a vaccine against coccidioidomycosis, known as Valley Fever. Grants may not be made on or after October 1, 2012. This does not have any legal effect on payments for grants for which amounts appropriated under this section were obligated prior to October 1, 2012.

To carry out this section, $40 million is authorized for fiscal years 2007–2012.

Section 403. Change in Threshold for Medicaid Indirect Hold Harmless Provision of Broad-Based Health Care Taxes

Current law

Under federal law and regulations, a state's ability to use provider-specific taxes to fund their state share of Medicaid expenditures is limited. If states establish provider-specific taxes, those taxes cannot generally exceed 25 percent of the state (or non-federal) share of Medicaid expenditures and the state cannot provide a guarantee to the providers that the taxes will be returned to them. However, there is what is referred to as a ''safe harbor.'' If the taxes returned to a provider are less than 6 percent of the provider's revenues, the prohibition on guaranteeing the return of tax funds is not violated. Those taxes do not have to undergo the process, defined in section 433.68 of Title 42 of the Code of Federal Regulations, of determining if a guarantee exists. As a result, a state could impose a provider tax of 6 percent of revenues, return those revenues right back to those providers in the form of a Medicaid ''payment'' and receive a federal match for those amounts. In effect, the state has temporarily borrowed funds from the provider to receive additional federal funds. The President's FY2006 budget proposes to phase the 6 percent ''safe harbor'' for provider taxes down to 3 percent although no new regulation has been issued on this subject to date.

Explanation of provision

For the fiscal periods beginning on or after January 1, 2008 and ending before October 1, 2011, the ''safe harbor'' percentage would be reduced from 6 percent to 5.5 percent.

Section 404. DSH allotments for fiscal year 2007 for Tennessee and Hawaii

(A) Tennessee

Current law

Tennessee operates its Medicaid program under a comprehensive statewide waiver, the terms and conditions of which have been negotiated by the state and CMS. Medicaid demonstration waivers, authorized under Section 1115 of the Social Security Act, allow states a great deal of flexibility on how eligibility for Medicaid is determined, how Medicaid services are provided, and what those services are comprised of. States operating under a waiver are subject to a budget neutrality requirement intended to hold program spending under the waiver to estimates of amounts that would have been spent in the absence of the waiver. Because Tennessee receives its Medicaid funds under the provisions of the waiver, it does not receive federal matching for Medicaid payments to disproportionate share (DSH) hospitals nor do they receive an allotment for DSH payments (state by state allotments are calculated based on a formula in Medicaid law and represent a federal cap on the amount that the federal government will provide in DSH matching payments to any state.) DSH payments, however, continue to be counted as a component in Tennessee's budget neutrality calculation since, in the period prior to the waiver approval, the state was required to make DSH payments, and if the waiver had not been granted, the requirement to make those payments would continue to have applied.

Explanation of provision

The provision would establish a DSH allotment for the state of Tennessee for fiscal year 2007 equal to the greater of the amount that is reflected in the budget neutrality provision for the TennCare demonstration year ending in 2006 and $280 million. Federal matching payments to the state for DSH hospitals for fiscal year 2007 would, however, be limited to one-third of the DSH allotment. Those amounts would be considered TennCare project expenditures and would be subtracted from TennCare demonstration payments for Essential Access Hospital supplemental pool payments. The sum of the DSH payments and the Essential Access Hospital supplemental pool payments would be prohibited from exceeding the allotment amount. The state would be permitted to submit a state plan amendment describing the methodology to be used to identify DSH hospitals and to make payments to such hospitals.

(B) Hawaii

Current law

Like Tennessee, Hawaii operates its Medicaid program under a statewide waiver, the terms and conditions of which have been negotiated by the state and CMS. The state does not make DSH payment under their waiver program and does not have a DSH allotment in Medicaid law.

Explanation of provision

The provision would set a DSH allotment for Hawaii for fiscal year 2007 at $10 million. The Secretary shall permit Hawaii to submit an amendment to its State plan under this title that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals.

Section 405. Certain Medicaid DRA technical corrections

(a) Technical corrections relating to State option for alternative premiums and cost sharing (Sections 6041 through 6043)

Current law

P.L. 109–171 allows states to impose premiums and cost-sharing for any group of individuals for any type of service (except prescribed drugs which are treated separately), through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Preferred drugs are defined as those that are the least (or less) costly effective prescription drugs within a class of drugs (as defined by the state). Premium and cost-sharing rules for workers with disabilities were not changed in P.L. 109–171.

Individuals in families with income below 100% of the federal poverty line (FPL). Premiums and service-related cost-sharing imposed under this option are allowed to vary among classes or groups of individuals, or types of service. Explicit rules are provided by income level for those with income between 100–150% FPL and for those with income over 150% FPL.

States are allowed to condition the provision of medical assistance on the payment of premiums, and to terminate Medicaid eligibility on the basis of failure to pay a premium if that failure continues for at least 60 days. States may apply this provision to some or all groups of beneficiaries, and may waive premium payments in cases where such payments would be an undue hardship. In addition, the provision allows states to permit providers participating in Medicaid to require a Medicaid beneficiary to pay authorized cost-sharing as a condition of receiving care or services. Providers may be allowed to reduce or waive cost-sharing amounts on a case-by-case basis.

For the purposes of cost-sharing, two income-related groups are identified: (1) individuals in families with income between 100 and 150% FPL, and (2) individuals in families with income over 150% FPL. For both groups, the total aggregate amount of all cost-sharing (including special cost-sharing rules for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state.

Treatment of non-preferred drug cost-sharing. Special cost-sharing for prescribed drugs is subject to the general 5% aggregate cap on cost-sharing for individuals with income between 100–150% FPL and for individuals with income over 150% FPL who are not otherwise exempt from service-related cost-sharing.

Treatment of non-emergency cost-sharing. Individuals exempt from premiums or service-related cost-sharing under other provisions of P.L. 109–171 may be subject to nominal copayments for non-emergency services in an ER, only when no cost-sharing is imposed for care in hospital outpatient departments or by other alternative providers in the area served by the hospital ER. For non-exempt populations with income between 100–150% FPL, cost-sharing for non-emergency services in an ER cannot exceed twice the nominal amounts. For non-exempt populations with income exceeding 150% FPL, no cost-sharing limit is specified for non-emergency care in an ER. Aggregate caps on cost-sharing (described above) still apply.

Definition of non-emergency services. The term ''non-emergency services'' means any care or services furnished in an emergency department of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under Medicare law (Section 1867 of the Social Security Act).

Exemption from cost-sharing for newly eligible children with disabilities. Section 6062 of P.L. 109–171 created a new optional Medicaid eligibility group for children with disabilities under age 19 who meet the severity of disability required under the Supplemental Security Income program (SSI) without regard to any income or asset eligibility requirements applicable under SSI for children, and whose family income does not exceed 300% FPL. (States can exceed 300% FPL, without federal matching funds for such coverage.) Special premium and cost-sharing rules apply to this new group of eligibles.

Explanation of provision

The definition of preferred drugs would be amended to include those that are the most (or more) cost effective prescription drugs within a class of drugs (as defined by the state). In addition to separate cost-sharing provisions for prescribed drugs, the amendment would clarify that separate cost-sharing provisions also apply to nonemergency services provided in an emergency room.

Individuals in families with income below 100% of the federal poverty line (FPL). The amendment would exempt from the general cost-sharing rules in new Section 1916A (a) all individuals in families with income below 100% of the federal poverty line (FPL). However, Section 1916 of Title XIX (nominal cost-sharing provisions) would still apply to this income group, as would the comparability rule regarding amount, duration and scope of available benefits (Section 1902(a)(10)(B)). States would still have the option to impose the special cost-sharing rules for prescribed drugs and non-emergency care provided in an emergency room to individuals in families with income below 100% FPL.

The amendment would exempt individuals in families with income below 100% FPL from the provisions defining enforceability of premiums and other cost-sharing. Protections regarding payment of premiums and cost-sharing in Section 1916(c)(3) and Section 1916(e) would continue to apply to this income group.

The amendment would apply the total aggregate cap of 5% of family income to individuals in families with income below 100% FPL for applicable cost-sharing with respect to nominal amounts (as defined in Section 1916), and prescribed drugs and emergency room copayments for non-emergency care (as defined in new Sections 1916A(c) and 1916A(e)).

Treatment of non-preferred drug cost-sharing. The amendment would clarify that no cost-sharing for preferred drugs can be imposed on individuals exempt from service-related cost-sharing under the general cost-sharing provisions (identified in new Section 1916A(a)). It would also clarify that no more than nominal cost-sharing amounts may be imposed for non-preferred drugs on individuals exempt from services-related cost-sharing under the general cost-sharing provisions.

Treatment of non-emergency cost-sharing. The amendment would clarify that for non-exempt persons with income between 100–150 percent FPL, cost-sharing for nonemergency care in an ER may not exceed twice the applicable nominal amount (up to the 5 percent aggregate cap). For persons with income below 100 percent FPL or who are exempt from service-related cost-sharing, cost-sharing for non-emergency care in an ER may not exceed the applicable nominal amount when no cost-sharing is imposed by the outpatient department or alternative providers. The 5 percent aggregate cap on all service-related costsharing for all income groups remains in effect.

Definition of non-emergency services. The amendment would strike the phrase ''the physician determines'' from the definition of non-emergency services as provided in P.L. 109–171.

Exemption from cost-sharing for newly eligible children with disabilities. The amendment would exempt this new optional eligibility group for children with disabilities established under P.L. 109–171 from the premium and service-related costsharing rules under new Section 1916A.

Correction of IV–B References. Among the groups explicitly exempted from the general cost-sharing provisions for premiums and cost-sharing, the amendment would change references to Title IV–B to mean child welfare services made available under Title IV–B on the basis of being a child in foster care.

Effective Date. The amendment specifies that all changes made by this amendment are effective as if included in the affected sections and subsections of P.L. 109–171.

(b) Clarifying Treatment of Certain Annuities (Section 6012)

Current law

Under Section 6012(b) of P.L. 109–171, the purchase of an annuity is treated as a disposal of an asset for less than fair market value unless certain criteria are met. One of these criteria is that the state be named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or be named in the second position after the community spouse or minor or disabled child and such spouse or a representative of such child does not dispose of any such remainder for less than fair market value.

Explanation of provision

The provision would strike the term ''annuitant'' and replace it with ''institutionalized individual.'' This change would become effective as if it had been included in DRA 2005, enacted on February 8, 2006.

(c) Additional Miscellaneous Technical Corrections

(1) Documentation (Section 6036)

Current law

Under Section 6036 of P.L. 109–171, states are prohibited from receiving federal Medicaid reimbursement for an individual who has not provided satisfactory documentary evidence of citizenship or nationality. Documents that provide satisfactory evidence are described in the law, as are exceptions to the documentation requirement.

Section 6036(a)(2) of the law specifies that the documentation requirements do not apply to an alien who is eligible for Medicaid:

And is entitled to or enrolled for Medicare benefits;

On the basis of receiving Supplemental Security Income (SSI) benefits; or

On such other basis as the Secretary may specify that satisfactory documentary evidence had been previously presented.

The provision applies to initial determinations and to redeterminations of eligibility for Medicaid made on or after July 1, 2006.

Explanation of provision

The provision would specify that the documentation requirements do not apply to an individual declaring to be a citizen or national of the United States who is eligible for Medicaid:

And is entitled to or enrolled for Medicare benefits;

And is receiving (1) Social Security benefits on the basis of a disability or (2) SSI benefits;

And with respect to whom (1) child welfare services are made available under Title IV–B of the Social Security Act or (2) adoption or foster care assistance is made available under Title IV–E; or

On such basis as the Secretary may specify that satisfactory documentary evidence has been previously presented.

The provision would also make reference corrections. These changes would be effective as if included in the Deficit Reduction Act of 2005.

In addition, effective 6 months after enactment, the provision would (1) require states to have procedures in effect for verifying the citizenship or immigration status of children in foster care under the responsibility of the state under Title IV–E or IV–B of the Social Security Act and (2) specify that in reviews of state programs under IV–E and IV–B, the requirements subject to review shall include determining whether the state program is in conformity with the requirement to verify citizenship or immigration status.

(2) Miscellaneous Technical Corrections

Current law

Section 5114(a)(2). This P.L. 109–171 provision modified the first sentence of Section 1842(b)(6)(F) of the Social Security Act to add a new paragraph H to 1842(b)(6) so that a federally qualified health center (FQHC) would be paid directly for FQHC services provided by a health care professional under contract with that FQHC.

Section 6003(b)(2). This P.L. 109–171 provision modified Section 1927 of the Social Security Act by referencing subsection (k) relating to Section 505(c) drugs.

Section 6031(b), 6032(b), and 6035(c). These sections referenced Section 6035(e) of P.L. 109–171, which does not exist, to provide exceptions to effective dates.

Section 6034(b). Section 6034 of P.L. 109–171 establishes the Medicaid Integrity Program. It references modifications made to the Social Security Act by Section 6033(a).

Section 6036(b). Section 6036 of P.L. 109–171 deals with improved enforcement of documentation requirements. Section 6036(b) references Section 1903(z) of the Social Security Act. This section does not exist.

Section 6015(a)(1). Section 6015 of P.L. 109–171 pertains to continuing care retirement community admissions contracts. It makes reference to clause (v) of Section 1919(c)(5)(A)(i)(II) of the Social Security Act.

Explanation of provision

Section 5114(a)(2). Instead of modifying Section 1842(b)(6)(F) to add paragraph H, the amendment would modify Section 1842(b)(6) of the Social Security Act.

Section 6003(b)(2). Instead of referencing subsection (k) of Section 1927 of the Social Security Act, the amendment would reference subsection (k)(1).

Section 6031(b), 6032(b), and 6035(c). Instead of referencing Section 6035(e), the amendment would reference the effective date exception in Section 6034(e) of P.L. 109–171.

Section 6034(b). Instead of referencing modifications made by Section 6033(a) of P.L. 109–171, the amendment would reference Section 6032(a).

Section 6036(b). Instead of referencing Section 1903(z) of the Social Security Act, the amendment would reference Section 1903(x).

Section 6015(a)(1). Instead of referencing clause (v) of Section 1919(c)(5)(A)(i)(II) of the Social Security Act, the amendment would reference subparagraph (B)(v).

REMARKS ON H. RES. 1106

HON. CYNTHIA McKINNEY

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, December 27, 2006

Ms. MCKINNEY. Mr. Speaker, I wish to enter the following into the CONGRESSIONAL RECORD:

ADDENDA TO A RESOLUTION INTRODUCING ARTICLES OF IMPEACHMENT AGAINST GEORGE WALKER BUSH, PRESIDENT OF THE UNITED STATES OF AMERICA, AND OTHER OFFICIALS: FURTHER ACTIONS BY THE PRESIDENT THAT WARRANT FURTHER INVESTIGATION AS POSSIBLE GROUNDS FOR IMPEACHMENT AS IDENTIFIED BY MANY SCHOLARS, LAWYERS AND CONCERNED CITIZENS

I. FAILURE TO ENSURE THE LAWS ARE FAITHFULLY EXECUTED

(1) Self-Exemption from Laws upon Signing.
(2) Suspension of Basic Legal Proceedings.
(3) Promoting Illegal War.
(4) Promoting Torture.
(5) Promoting Kidnappings and Renditions for Torture.
(6) Use of Illegal Weapons.

II. ABUSE OF OFFICE AND OF EXECUTIVE PRIVILEGE

(1) Obstructing Inquiry and Detection.
(2) Replacing the Veto with Signing Statements.

III. FAILURE TO PRESERVE, PROTECT AND DEFEND THE CONSTITUTION

(1) Suspension of Due Process.
(2) Unreasonable Searches and Seizures.
(3) Non-Cooperation with Congress.
(4) Establishment of an Unconstitutional, Parallel Legal System.

I. FAILURE TO ENSURE THE LAWS ARE FAITHFULLY EXECUTED

Under Article II, Section 3 of the Constitution of the United States of America, the President has a duty to ''take Care that the Laws be faithfully executed.'' George Walker Bush, during his tenure as President of the United States, has repeatedly violated the letter and spirit of laws and rules of criminal procedure used by civilian and military courts, and has violated or ignored regulatory codes and practices that carry out the law, has contravened the laws governing agencies of the executive and the purposes of these agencies, and in conducting the foreign affairs of the United States of America has proceeded in flagrant violation of the core body of international laws, to which the United States of America is bound by treaty.

With respect to domestic law, this conduct has included one or more of the following:

(1) Self-Exemption from Laws upon Signing. Since assuming the office of President of the United States, George Walker Bush has attached signing statements to more than one hundred bills before signing them, within which he has made over eight hundred challenges to provisions of laws passed by Congress, a figure that exceeds the total number of such challenges by all previous presidents combined, and has used this practice to exempt himself, as President of the United States, from enforcing or from being held accountable to provisions of the said laws.

(2) Suspension of Basic Legal Proceedings. In dereliction of his duty to uphold the law, George Walker Bush has systematically violated basic legal and criminal procedures that require any search, seizure, arrest or detention to be non-discriminatory, based on probable cause and sufficient evidence to warrant a stated charge, that provide access to legal counsel, arraignment and the option of bail within a period of days, and that require reasonable and non-coercive interrogations, rights of silence, as well as privy communications with counsel and with others, pending an outcome of either release or a speedy and public trial, conducted in accord with federal and state statutes on criminal and court process, the provisions of the Uniform Code of Military Justice, applicable international law, or appeals to higher courts that apply. By ordering mass arrests and indefinite detentions based on indiscriminate profiling of specific populations, George Walker Bush has also systematically violated laws prohibiting harmful extraditions, secret arrest and custody, and denial of defined and legal periods of detention or incarceration.

With respect to international law, this conduct has included one or more of the following:

(3) Promoting Illegal War. Abraham Lincoln wrote in 1848, ''Allow the President to invade a neighboring nation whenever he shall deem it necessary to repel an invaslon and you will allow him to do so whenever he may choose to say he deems it necessary for such purpose, and you will allow him to make war at pleasure. If today, he should choose to say he thinks it necessary to invade Canada, to prevent the British from invading us, how could you stop him? You may say to him, 'I see no probability of the British invading us,' but he will say to you, 'Be silent; I see it, if you don't.' '' In direct violation of Articles 41 and 42 of the United Nations Charter, a treaty ratified by the United States Senate in 1945 and therefore the supreme law of the land as according to Article VI of the Constitution, George Walker Bush has advanced and executed a policy based on so-called pre-emptive or preventive war, whereby the United States of America claims the right to unilaterally assault, invade or occupy other nations without first engaging in collective measures with other member states of the United Nations or first gaining the prior assent of the United Nations Security Council, and whereas George Walker Bush did apply this doctrine by launching a war of aggression against the sovereign nation of Iraq, resulting in the deaths of tens of thousands of Iraqi civilians and thousands of United States military personnel, without United Nations Security Council authorization, whereby said George Walker Bush, as President of the United States, by advancing a doctrine of preventive war and initiating and continuing the invasion and occupation of Iraq by United States forces did commit and was guilty of precisely such abuses as Abraham Lincoln foresaw.

(4) Promoting Torture. In direct violation of, and as part of a pattern of consistent attempts through executive orders, legal memoranda and alterations to regulations such as the Army Field Manual, to undermine the Federal Torture Statute [18 USC Sec. 2340A]; the Third Geneva Convention banning torture and abuse of Prisoners of War, as well as non-combatants and unarmed (''enemy'') combatants held in detention; and Articles 4 and 32 of the Fourth Geneva Convention, which expressly prohibit not merely torture but physical abuse of any kind being inflicted upon ''persons protected by the Convention,'' defined as ''those who, at a given moment and in any manner whatsoever, find themselves, in case of a conflict or occupation, in the hands of a Party to the conflict or Occupying Power of which they are not nationals,'' this language being written as a precaution against and in anticipation of alternate definitions of torture, these declarations and treaties being ratified by the United States Senate and therefore the supreme law of the land as according to Article VI of the Constitution, George Walker Bush, as President of the United States of America, has condoned and presided over a vast expansion of the use of torture against unarmed combatants and civilian non-combatants, both foreign and domestic, detained or kidnapped by forces or agents of the United States, leading to extreme pain, psychological trauma, disfigurement and in