

107TH CONGRESS
2D SESSION

S. _____

IN THE SENATE OF THE UNITED STATES

_____ introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To improve data collection and dissemination, treatment, and research relating to cancer, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “National Cancer Act
5 of 2002”.

6 **SEC. 2. FINDINGS.**

7 Congress makes the following findings:

8 (1) In 2002 an estimated 1,284,900 Americans
9 will have been diagnosed with some form of cancer.

10 (2) In 2002 an estimated 555,500 Americans
11 will die of cancer.

1 (3) In 2001 the National Institutes of Health
2 estimated the overall cost of cancer at
3 \$156,700,000,000.

4 (4) The National Cancer Institute estimates
5 that with the expected growth and aging of the
6 United States population, expenditures for cancer
7 treatment will nearly double over the next decade,
8 rising to just under \$100,000,000,000.

9 (5) In 2000, 62.6 percent of women over the
10 age of 50 had received a mammogram in the pre-
11 ceding year. In 2002 an estimated 205,000 Ameri-
12 cans will be newly diagnosed with breast cancer, and
13 40,000 will die of the disease.

14 (6) In 2000, 89 percent of women between the
15 ages of 18 and 44 have received a pap test in the
16 preceding 3 years. In 2002, an estimated 13,000
17 women will be newly diagnosed with cancer of the
18 uterine cervix, and 4,100 women will die of the dis-
19 ease.

20 (7) In 1999, only 19.1 percent of adults 50 and
21 older had received the recommended annual colon
22 cancer screening within the preceding year, and only
23 32.2 percent had received a colonoscopy or
24 sigmoidoscopy in the preceding 5 years. In 2002, an
25 estimated 148,300 Americans will be diagnosed with

1 cancer of the colon and rectum and 56,600 will die
2 of the disease.

3 (8) Older Americans are the most likely to be
4 diagnosed with cancer. In order to ensure high qual-
5 ity cancer care for our Nation's seniors, medicare re-
6 imbursements must reflect the true cost of treat-
7 ment in every treatment setting. Medicare payments
8 should accurately reflect the cost of drug and bio-
9 logics as well as the cost of administering drugs and
10 supportive care and therapies.

11 (9) Despite an aging population, the rates of
12 new cancer cases and deaths declined in the United
13 States between 1990 and 1997.

14 (10) Despite an aging population, death rates
15 for the 4 most common cancer sites—lung,
16 colorectal, breast, and prostate continue to drop.

17 (11) Despite an aging population, 1997 marked
18 the first time the total number of cancer deaths did
19 not rise from the previous year.

20 (12) In May 2001, Gleevec, the first in what is
21 expected to be a number of cancer treatments which
22 rely on molecular targeting, was approved for use by
23 the Food and Drug Administration. Gleevec appears
24 to be effective in stopping the growth of deadly

1 Chronic Myeloid Leukemia cells within 3 months of
2 use.

3 **SEC. 3. SENSE OF THE SENATE.**

4 It is the sense of the Senate that the United States
5 is at a point in history in which we must take the proper
6 steps to reach the goal of making cancer survivorship the
7 rule and cancer deaths rare by the year 2015.

8 **TITLE I—PUBLIC HEALTH**
9 **PROVISIONS**

10 **SEC. 101. NATIONAL PROGRAM OF CANCER REGISTRIES.**

11 (a) STRATEGIC PLAN.—Part M of title III of the
12 Public Health Service Act (42 U.S.C. 280e et seq.) is
13 amended by inserting after section 399B the following:

14 **“SEC. 399B-1. ENHANCING CANCER REGISTRIES AND PRE-**
15 **PARING FOR THE FUTURE.**

16 “(a) STRATEGIC PLAN.—

17 “(1) IN GENERAL.—The Secretary shall develop
18 a plan that outlines strategies by which the State
19 cancer registries funded with grants under section
20 399B and the Surveillance, Epidemiology, and End
21 Results program of the National Cancer Institute
22 can share information to ensure more comprehensive
23 cancer data.

24 “(2) REPORT.—Not later than 1 year after the
25 date of enactment of this section, the Secretary shall

1 submit to the appropriate committees of Congress a
2 report—

3 “(A) outlining the capabilities and data
4 collected by the State cancer registries funded
5 with grants under section 399B;

6 “(B) outlining the capabilities and data
7 collected by the Surveillance, Epidemiology, and
8 End Results program of the National Cancer
9 Institute; and

10 “(C) containing the plan described in para-
11 graph (1).

12 “(b) PREPARING CANCER REGISTRIES FOR THE FU-
13 TURE.—

14 “(1) IN GENERAL.—The Secretary shall enter
15 into a contract with the General Accounting Office
16 for the completion of a study and report identifying
17 specific indicators that State cancer registries should
18 maintain and disseminate in order to ensure max-
19 imum usefulness for patients, advocates, health care
20 providers, and researchers.

21 “(2) CONTENTS.—The study and report de-
22 scribed in paragraph (1) shall—

23 “(A) examine studies conducted by the Na-
24 tional Cancer Institute and the American Soci-
25 ety of Clinical Oncology;

1 “(B) describe the hardware and software
2 needed to collect and disseminate necessary reg-
3 istry data; and

4 “(C) examine strategies registries may
5 take to ensure data collection from the greatest
6 number of health care facilities possible.

7 “(3) REPORT.—Not later than 6 months after
8 the date of enactment of this section the Secretary
9 shall submit to Congress a report containing the re-
10 sults of the General Accounting Office study author-
11 ized under this section.”.

12 **SEC. 102. ENHANCING EXISTING SCREENING EFFORTS.**

13 (a) GRANT AND CONTRACT AUTHORITY OF
14 STATES.—Section 1501(b)(2) of the Public Health Service
15 Act (42 U.S.C. 300k(b)(2)) is amended to read as follows:

16 “(2) CERTAIN APPLICATIONS.—

17 “(A) STRATEGIES FOR COLORECTAL CAN-
18 CER SCREENING.—If any entity submits an ap-
19 plication to a State to receive an award of a
20 grant or contract pursuant to paragraph (1)
21 that includes strategies for colorectal cancer
22 screening and outreach, the State may give pri-
23 ority to the application submitted by that entity
24 in any case in which the State determines that
25 the quality of such application is equivalent to

1 the quality of the application submitted by the
2 other entities.

3 “(B) WOMEN DIAGNOSED WITH CANCER.—
4 If any entity submits an application to a State
5 to receive an award of a grant or contract pur-
6 suant to paragraph (1) that includes strategies
7 for the provision of treatment for uninsured
8 women diagnosed with cancer discovered in the
9 course of the screening, the State may give pri-
10 ority to the application submitted by that entity
11 in any case in which the State determines that
12 the quality of such application is equivalent to
13 the quality of the application submitted by the
14 other entities.”.

15 (b) BREAST AND CERVICAL CANCER PROGRAM.—
16 Section 1510(a) of the Public Health Service Act (42
17 U.S.C. 300n-5(a)) is amended by striking “for each of
18 the fiscal years 1995 through 2003.” and inserting “for
19 each of the fiscal years 2003 through 2007.”.

20 (c) REPORT ON THE COMPREHENSIVE COLORECTAL
21 CANCER INITIATIVE.—Not later than 6 months after the
22 date of enactment of this Act, the Director of the Centers
23 for Disease Control and Prevention shall submit to the
24 appropriate committees of Congress a report containing—

1 (1) an assessment of the success of the Com-
2 prehensive Colorectal Cancer Initiative (within the
3 Centers for Disease Control and Prevention) in—

4 (A) increasing public awareness of
5 colorectal cancer;

6 (B) increasing awareness of screening
7 guidelines among health care providers;

8 (C) monitoring national colorectal cancer
9 screening rates;

10 (D) promoting increased patient-provider
11 communication about colorectal cancer screen-
12 ing;

13 (E) supporting quantitative and qualitative
14 research efforts; and

15 (F) providing funding to State programs
16 to implement colorectal cancer priorities.

17 (2) recommendations about the resources need-
18 ed by the Centers for Disease Control and Preven-
19 tion in order to improve the areas described in para-
20 graph (1).

21 **SEC. 103. ENHANCE PAIN MANAGEMENT AND PALLIATIVE**
22 **CARE FOR CANCER PATIENTS.**

23 (a) **PATIENT EDUCATION PROGRAM.**—Part P of title
24 III of the Public Health Service Act (42 U.S.C. 280g et
25 seq.) is amended by adding at the end the following:

1 **“SEC. 3990. PAIN MANAGEMENT AND PALLIATIVE CARE**
2 **PROGRAM GRANTS AND STUDY.**

3 “(a) GRANTS AUTHORIZED.—The Secretary is au-
4 thorized to award grants to eligible entities to implement
5 programs to educate patients and their families about the
6 availability of effective medical techniques to reduce and
7 prevent pain and suffering for those with cancer. Such
8 programs shall focus on the entire course of cancer treat-
9 ment and care.

10 “(b) APPLICATION.—An eligible entity desiring a
11 grant under this section shall submit to the Secretary an
12 application at such time, in such manner, and containing
13 such information as the Secretary may require.

14 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section
16 such sums as may be necessary.

17 (b) PRACTITIONER EDUCATION PROGRAM.—Section
18 414 of the Public Health Service Act (42 U.S.C. 285a-
19 3) is amended by adding at the end the following:

20 “(d) REQUIREMENT.—A center described under sub-
21 section (a) shall maintain a program for disseminating to
22 patients and research participants, as well as their care-
23 givers, the latest information about pain and symptom
24 management and palliative care in order to receive funding
25 under this section.”.

1 (c) ELEVATING THE IMPORTANCE OF PAIN AND
2 SYMPTOM MANAGEMENT THROUGHOUT THE NATION'S
3 CANCER PROGRAMS.—

4 (1) NATIONAL CANCER PROGRAM.—Section 411
5 of the Public Health Service Act (42 U.S.C. 285a)
6 is amended—

7 (A) by striking “of (1) an expanded” and
8 inserting the following: “of—
9 “(1) an expanded”; and

10 (B) by striking “carcinogens” and all that
11 follows and inserting the following:

12 “(2) pain and symptom management for cancer
13 patients; and

14 “(3) the other programs and activities of the
15 Institute.”.

16 (2) CANCER CONTROL PROGRAMS.—Section
17 412(2) of the Public Health Service Act (42 U.S.C.
18 285a–1(2)) is amended—

19 (A) in subparagraph (A), by striking
20 “and” at the end; and

21 (B) by adding at the end the following:

22 “(C) appropriate methods of pain and
23 symptom management for individuals with can-
24 cer, including end-of-life care, and”.

1 (3) SPECIAL AUTHORITIES OF THE DIREC-
2 TOR.—Section 413(a)(2) of the Public Health Serv-
3 ice Act (42 U.S.C. 285a–2(a)(2)) is amended—

4 (A) in subparagraph (D) by striking “and”
5 at the end;

6 (B) in subparagraph (E) by striking the
7 period and inserting “; and”; and

8 (C) by adding at the end the following:

9 “(F) assess and improve pain and symptom
10 management of cancer throughout the course of
11 treatment.”.

12 (4) BREAST AND GYNECOLOGICAL CANCERS.—
13 Section 417 of the Public Health Service Act (42
14 U.S.C. 285a–6) is amended—

15 (A) in subsection (c)(1)—

16 (i) in subparagraph (D), by striking
17 “and” at the end;

18 (ii) in subparagraph (E), by striking
19 the period and inserting “; and”; and

20 (iii) by inserting after subparagraph
21 (E) the following:

22 “(F) basic, clinical, and applied research
23 concerning pain and symptom management.”;
24 and

25 (B) in subsection (d)—

1 (i) in paragraph (4), by striking
2 “and” at the end;

3 (ii) in paragraph (5), by striking the
4 period and inserting “and;”; and

5 (iii) by adding at the end the fol-
6 lowing:

7 “(6) basic, clinical, and applied research con-
8 cerning pain and symptom management.”.

9 (5) PROSTATE CANCER.—Section 417A(c)(1) of
10 the Public Health Service Act (42 U.S.C. 285a-
11 7(c)(1)) is amended—

12 (A) in subparagraph (F), by striking
13 “and” at the end;

14 (B) in subparagraph (G), by striking the
15 period and inserting “; and”; and

16 (C) by inserting after subparagraph (G)
17 the following:

18 “(H) basic and clinical research concerning
19 pain and symptom management.”.

20 **SEC. 104. SURVIVORSHIP RESEARCH PROGRAM.**

21 (a) IN GENERAL.—Subpart 1 of part C of title IV
22 of the Public Health Service Act (42 U.S.C. 285 et seq.)
23 is amended by adding at the end the following:

1 **“SEC. 417E. SURVIVORSHIP RESEARCH PROGRAM.**

2 “(a) ESTABLISHMENT.—There is established, within
3 the Institute, an Office on Cancer Survivorship (in this
4 section referred to as the ‘Office’), which may be headed
5 by an Associate Director, to implement and direct the ex-
6 pansion and coordination of the activities of the Institute
7 with respect to cancer survivorship research.

8 “(b) COLLABORATION AMONG AGENCIES.—In car-
9 rying out the activities described in subsection (a), the Of-
10 fice shall collaborate with other institutes, centers, and of-
11 fices within the National Institutes of Health that are de-
12 termined appropriate by the Office.

13 “(c) REPORT.—Not later than 1 year after the date
14 of enactment of this section, the Secretary shall prepare
15 and submit to the appropriate committees of Congress a
16 report providing a description of the survivorship activities
17 of the Office and strategies for future activities.”.

18 (b) FUNDING.—Section 417B(d)(2) of the Public
19 Health Service Act (42 U.S.C. 285a–8(d)(2)) is
20 amended—

21 (1) in subparagraph (B), by striking “and”
22 after the semicolon;

23 (2) in subparagraph (C), by striking “each sub-
24 sequent fiscal year.” and inserting “each fiscal year
25 through 2002; and”; and

26 (3) by adding at the end the following:

1 “(D) 11.5 percent, in the case of fiscal
2 year 2003 and 13 percent, in the case of fiscal
3 year 2004 and each subsequent fiscal year, of
4 which not less than 1.5 percent in fiscal year
5 2003, 2 percent in fiscal year 2004, and 3 per-
6 cent in fiscal year 2005 and each subsequent
7 fiscal year shall be for the Office on Survivor-
8 ship under section 417E.”.

9 **TITLE II—RESEARCH**
10 **PROVISIONS**

11 **SEC. 201. NATIONAL CANCER INSTITUTE.**

12 (a) OTHER TRANSACTIONS AUTHORITY.—Subpart 1
13 of Part C of title IV of the Public Health Service Act (42
14 U.S.C. 285 et seq.) is amended by adding at the end the
15 following:

16 **“SEC. 417D. OTHER TRANSACTIONS AUTHORITY.**

17 “Notwithstanding any other provision of this subpart,
18 the Director of the National Cancer Institute may co-fund
19 grant projects with private entities for any purpose de-
20 scribed in this subpart.”.

21 (b) NCI REPORT TO CONGRESS ON THE BYPASS
22 BUDGET.—Section 413 of the Public Health Service Act
23 (42 U.S.C. 285a–2) is amended—

24 (1) in subsection (b), by striking paragraph (9)
25 and inserting the following:

1 “(9) notwithstanding section 405(a), shall pre-
2 prepare and submit, directly to the President for review
3 and transmittal to the Committee on the Budget of
4 the Senate and the Committee on the Budget of the
5 House of Representatives, an annual budget esti-
6 mate (including an estimate of the number and type
7 of personnel needs for the Institute) for the National
8 Cancer Institute program, after reasonable oppor-
9 tunity for comment by the Secretary, the Director of
10 NIH, the Institute’s advisory council, and the Na-
11 tional Cancer Advisory Board.”; and

12 (2) by adding at the end the following:

13 “(c) The National Cancer Advisory Board shall ac-
14 cept comments on the budget described in subsection
15 (b)(9) from nongovernment organizations and shall com-
16 pile significant suggestions into a report for the Director
17 of the Institute pursuant to subsection (b)(9). The Direc-
18 tor of the Institute shall respond, as appropriate, to such
19 suggestions prior to submitting such budget.”.

20 (c) SENSE OF THE SENATE ON A CENTRAL INTER-
21 NAL REVIEW BOARD.—It is the sense of the Senate that—

22 (1) the current procedure of sending 1 clinical
23 trial through multiple local internal review boards
24 may not be the most efficient method for the protec-
25 tion of patients enrolled in the trial and may delay

1 the process of bringing life saving treatment to can-
2 cer patients;

3 (2) the National Cancer Institute should be
4 commended for its work in centralizing the internal
5 review board process; and

6 (3) the research community should continue to
7 streamline the internal review board process in order
8 to bring life saving treatments to patients as quickly
9 as possible.

10 (d) PATIENT AND PROVIDER OUTREACH OPPORTU-
11 NITIES WITH EXPERIMENTAL THERAPIES.—For the pur-
12 pose of enhancing patient access to experimental thera-
13 pies, the National Cancer Institute shall conduct the fol-
14 lowing activities:

15 (1) Integrate, to the maximum extent prac-
16 ticable, trials being conducted by private manufac-
17 turers into the National Cancer Institute's clinical
18 trials online database. Such integration may require
19 specific awareness-raising and outreach activities by
20 the National Cancer Institute to private industry.

21 (2) Establish an education program which pro-
22 vides patients and providers with—

23 (A) information about how to access and
24 use the National Cancer Institute clinical trials
25 database online; and

1 (B) information about the Food and Drug
2 Administration process for approving the use of
3 drugs and biologics for a single patient.

4 **TITLE III—MEDICARE**
5 **PROVISIONS**

6 **SEC. 301. SENSE OF THE SENATE REGARDING REIMBURSE-**
7 **MENT FOR ITEMS AND SERVICES USED IN**
8 **THE COARSE OF CANCER THERAPY.**

9 It is the sense of the Senate that—

10 (1) the medicare program under title XVIII of
11 the Social Security Act should neither over-reim-
12 burse nor under-reimburse for the cost of drugs and
13 biologics used in the course of cancer therapy;

14 (2) the medicare program should neither over-
15 reimburse nor under-reimburse for the skilled nurs-
16 ing services, supplies, and equipment that are essen-
17 tial to the delivery of high quality cancer care; and

18 (3) the goal of any change to medicare reim-
19 bursement policy for cancer care should be in the in-
20 terest of ensuring that medicare beneficiaries with
21 cancer have access to the highest quality care in the
22 greatest number of health care facilities available.

1 **SEC. 302. SENSE OF THE SENATE REGARDING PAYMENT**
2 **RATE FOR DRUGS AND BIOLOGICALS UNDER**
3 **THE MEDICARE HOSPITAL OUTPATIENT DE-**
4 **PARTMENT PROSPECTIVE PAYMENT SYSTEM.**

5 (a) FINDINGS.—The Senate finds the following:

6 (1) Payments for drugs and biologicals under
7 the medicare hospital outpatient department pro-
8 spective payment system under section 1833(t) of
9 the Social Security Act (42 U.S.C. 1395l(t)) should
10 be based on all of the costs of delivering outpatient
11 pharmacy therapy (involving the drug or biological)
12 in the outpatient hospital setting, including acquisi-
13 tion, storage, handling, processing, quality control,
14 disposal, and pharmacy overhead costs.

15 (2) The payment rates proposed by the Centers
16 for Medicare & Medicaid Services, in the “Medicare
17 Program; Changes to the Hospital Outpatient Pro-
18 spective Payment System and Calendar Year 2003
19 Payment Rates and Changes to Payment Suspension
20 for Unified Cost Report”; Proposed Rule, 67 Fed.
21 Reg, 52092 et seq. (August 9, 2002), for most drugs
22 and biologicals are based only on the estimated ac-
23 quisition cost of the drug or biological and do not
24 reflect other related costs.

1 (3) The methodology used by the Centers for
2 Medicare & Medicaid Services to estimate such ac-
3 quisition costs is flawed because the methodology—

4 (A) derives such estimates from what hos-
5 pitals charged for individual products on pa-
6 tient bills without appropriate adjustment for
7 hospital charging practices; and

8 (B) relies on data that are several years
9 old.

10 (4) The methodology described in paragraph (3)
11 substantially underestimates the acquisition costs of
12 newer, more expensive drugs and biologicals and this
13 underestimation disproportionately affects drugs and
14 biologicals used to treat cancer.

15 (5) Medicare beneficiary access may be jeopard-
16 ized in the outpatient hospital setting for those
17 drugs and biologicals for which medicare program
18 payments are substantially below the costs of deliv-
19 ery.

20 (6) The payment rates proposed for most drugs
21 and biologicals under the medicare hospital out-
22 patient department prospective payment system for
23 calendar year 2003 are less than the payment rates
24 established for such drugs and biologicals in 2002,

1 with the payment reductions exceeding 30 percent in
2 most cases.

3 (7) The methodology used to develop the pay-
4 ment rates in 2003 described in paragraph (6) pro-
5 duces erratic and unreliable results, including—

6 (A) the payment rate for 1 product in-
7 creasing 700 percent and the rates for many
8 others exceeding 100 percent of their average
9 wholesale price (AWP); and

10 (B) the payment rates for 9 drugs and
11 biologicals used in cancer therapy experiencing
12 rate reductions of between 50 and 90 percent.

13 (b) SENSE OF THE SENATE.—It is the sense of the
14 Senate that the Administrator of the Centers for Medicare
15 & Medicaid Services should address the consequences of
16 the proposed payments rates for drugs and biologicals in
17 2003 under the medicare hospital outpatient department
18 prospective payment system under section 1833(t) of the
19 Social Security Act (42 U.S.C. 1395l(t)) by either—

20 (1) revising the payment rates for drugs and
21 biologicals under such system; or

22 (2) suspending the proposed rule establishing
23 such payment rates and extending the period of data
24 collection for the purposes of establishing a more ra-

1 tional payment structure for drugs and biologicals
2 under such system in the future.

3 **SEC. 303. SENSE OF THE SENATE REGARDING COVERING**
4 **PALLIATIVE CARE THROUGHOUT CANCER**
5 **TREATMENT.**

6 (a) FINDINGS.—The Senate finds the following:

7 (1) Serious chronic pain is one of the most
8 widespread public health problems in the American
9 adult population.

10 (2) Because so few federal research dollars are
11 devoted to pain there are no exact figures, however,
12 best estimates indicate that up to 75,000,000 Amer-
13 icans suffer serious pain annually, 50,000,000 en-
14 during serious chronic pain (pain lasting six months
15 or longer), and 25,000,000 experiencing acute pain
16 (from injuries, accidents, surgeries, etc.).

17 (3) The medicare and medicaid programs pay
18 for pain medication when administered as part of
19 routine acute, skilled nursing, hospice, or other spe-
20 cialized health care benefits, such as doctor-adminis-
21 tered infusion medication.

22 (4) Without coverage for self-administered pre-
23 scription drugs to alleviate pain, many of the ap-
24 proximately 1,500 people that die from cancer each
25 day and the more than 9,000,000 cancer survivors

1 may need to live without appropriate access to ade-
2 quate pain care.

3 (b) SENSE OF THE SENATE.—It is the Sense of the
4 Senate that—

5 (1) patients experiencing pain should be identi-
6 fied at the earliest detection of discomfort to best
7 treat the condition before the pain becomes prohibi-
8 tive and debilitating;

9 (2) early treatment of pain will improve clinical
10 outcomes, quality of care and comfort, and ulti-
11 mately improve the quality of life for cancer pa-
12 tients;

13 (3) medicare beneficiaries experiencing pain,
14 even at the end of life, are frequently under-treated
15 for pain and other symptoms associated with cancer,
16 in part because of the lack of an outpatient prescrip-
17 tion drug benefit under the medicare program;

18 (4) the medicare program's approach to reim-
19 bursement for those patients with intense pain
20 should be modified to ensure access to technologies
21 and therapies for cancer pain patients well in ad-
22 vance of qualifying for hospice care; and

23 (5) each head of an agency that is responsible
24 for the operation a federal health care program
25 should—

1 (A) review coverage under the program for
2 effective pain prevention and management serv-
3 ices, including outpatient prescription medica-
4 tions; and

5 (B) submit to the Senate a report on such
6 review by not later than December 31, 2003.

7 **SEC. 304. SENSE OF THE SENATE REGARDING IMPROVING**
8 **THE COVERAGE OF HOSPICE CARE.**

9 (a) FINDINGS.—The Senate finds the following:

10 (1) While 23 percent of the medicare bene-
11 ficiaries who died in 2000 received hospice care, 60
12 percent of medicare beneficiaries who died in 2000
13 of cancer received hospice care.

14 (2) By the time medicare hospice patients are
15 exposed to a variety of pain management tools, it is
16 often too late and the cancer has progressed beyond
17 the point of lucid patient decision-making.

18 (3) The medicare hospice reimbursement struc-
19 ture contains built-in disincentives to providing pal-
20 liative therapies that have high early costs, even
21 when these therapies may become cost-effective after
22 a certain period of time. Small hospices in particular
23 are often unable to cover the costs of these treat-
24 ments to palliate symptoms.

1 (4) Median lengths of stay in a hospice care
2 program decreased from 26 days in 1992 to 19 days
3 in 1998.

4 (5) In 2001, $\frac{1}{2}$ the patients in hospice care
5 programs were there for 3 weeks or less.

6 (6) A recent study of hospice patients found
7 that 33 percent of patients die within 7 days of re-
8 ceiving hospice care.

9 (7) Because of the requirement under the medi-
10 care program that patients receive no curative ther-
11 apy while receiving hospice care, the medicare hos-
12 pice reimbursement structure contains built-in dis-
13 incentives to entering hospice care programs and re-
14 ceiving palliative therapies that could extend life and
15 improve the quality of life for terminal patients.

16 (8) Recent studies published by Harvard Uni-
17 versity and Medicare Payment Advisory Commission
18 have suggested that medicare might have the ability
19 to provide improved coverage for cancer pain pa-
20 tients and realize a cost savings by modifying exist-
21 ing policy to create and utilize an outlier payment
22 system.

23 (9) At the present time, the medicare program
24 will reimburse physicians for consulting with pa-
25 tients about end-of-life care. In practice, however, it

1 is often a registered nurse or social worker who pro-
2 vides patients with end-of life-care. These services
3 are complex, sensitive and time consuming.

4 (10) Registered nurses and medical social work-
5 ers with an expertise in palliative or hospice care are
6 qualified to perform end-of-life services and are able
7 to make home visits when necessary. Their services
8 should be reimbursed under the medicare program.

9 (11) A payment source is needed for patients
10 who require palliative care and who are terminally ill
11 but do not meet the medicare hospice criteria or who
12 still want to receive aggressive treatment.

13 (b) SENSE OF THE SENATE.—It is the sense of the
14 Senate that the Administrator of the Centers for Medicare
15 & Medicaid Services should—

16 (1) restructure the hospice benefit under the
17 medicare program for high cost outliers;

18 (2) increase medicare hospice care reimburse-
19 ment for short stays;

20 (3) provide for reimbursement under the medi-
21 care program for nurses and social workers with ex-
22 pertise in hospice care for consultations and home
23 visits provided to terminally ill patients who, for a
24 variety of reasons, may not have elected access the
25 hospice benefit;

1 (4) create a payment source for palliative care
2 for terminally ill patients who do not elect hospice
3 care or do not meet the medicare hospice benefit cri-
4 teria;

5 (5) improve the medicare hospice benefit
6 through approaches such as—

7 (A) increasing the reimbursement on the
8 day of admission and the day of death, to offset
9 the cost of late referrals;

10 (B) increasing the reimbursement rate for
11 the last 7 days a patient spends on the benefit;
12 and

13 (C) using a case-mix reimbursement rate
14 rather than the flat-rate, four-category per
15 diem benefit.

16 **SEC. 305. SENSE OF THE SENATE REGARDING THE COV-**
17 **ERAGE OF ALL TREATMENTS FOR CANCER**
18 **PATIENTS.**

19 (a) FINDINGS.—The Senate finds the following:

20 (1) While cancer treatments are often treated
21 within the setting of a health care facility, many of
22 the latest treatment advances afford patients the op-
23 portunity to treat themselves at home.

24 (2) The medicare program often does not pro-
25 vide for reimbursement for the most efficient and ef-

1 fective treatments based on the fact that the treat-
2 ments are self-injectable or taken orally.

3 (b) SENSE OF THE SENATE.—It is the sense of the
4 Senate that—

5 (1) medicare patients should have access to the
6 best treatment available;

7 (2) the lack of reimbursement for certain treat-
8 ments can serve as a disincentive for researchers to
9 investigate more efficient and effective treatments
10 for elderly cancer patients; and

11 (3) in the event that a comprehensive out-
12 patient prescription drug benefit under the medicare
13 program is not enacted into law during the 107th
14 Congress, the Senate should consider a targeted out-
15 patient prescription medication benefit under the
16 medicare program for cancer patients.