health insurance. Today they can deduct 40 percent of the cost of their insurance. Under current law, they cannot fully deduct that cost until 2007.

So, my proposal is simple. Let's close the loophole that everyone admits was an accident, and use that money to accelerate the full deductibility of health insurance for the self-employed. It's a clear choice between a loophole that nobody wanted to exist and entrepreneurs who—especially those on our farms and ranches—may not exist much longer if we don't get them some help.

While I recognize time is short for passing this bill this year, I urge my colleagues to join me in supporting this legislation and in pursuing this goal next year.

MEDICARE HOME HEALTH FAIR PAYMENT ACT OF 1998—S. 2616

Statements on the bill, S. 2616, introduced on October 9, 1998, did not appear in the RECORD. The material follows:

By Mr. ROTH (for himself, Mr. MOYNIHAN, Mr. CHAFEE, Mr. BREAUX, Mr. JEFFORDS, Mr. DOMENICI, Ms. COLLINS, Mr. BAUCUS, Mr. D'AMATO, Mr. BRYAN, Mr. HATCH, Mr. KERREY, Mr. ROCKEFELLER, Mr. NICKLES, Mr. GRASSLEY, Ms. MOSELEY-BRAUN, and Mr. MURKOWSKI):

S. 2616. A bill to amend title XVIII of the Social Security Act to make revisions in the per beneficiary and per visit payment limits on payment for health services under the medicare program; to the Committee on Finance.

MEDICARE HOME HEALTH FAIR PAYMENT ACT OF 1998

Mr. ROTH. Mr. President, I rise to introduce the Medicare Home Health Fair Payment Act of 1998.

This legislation is the product of a great deal of hard work and analysis. It has bipartisan, bicameral, support. Currently, the bill has 15 cosponsors, and similar legislation was introduced in the House of Representatives.

Staff worked to make sure that the technical aspects of this bill could be implemented. After technical review from the Health Care Financing Administration, it is our understanding that the changes in home health payments could be implemented as intended.

I would like to thank the many Senators who were very helpful and contributed to the debate of addressing the home health interim payment system. In particular, I commend Senator COLLINS, Senator GRASSLEY, Senator BREAUX, Senator COCHRAN, and Senator BOND. All put forward legislative proposals which we examined closely, and which helped us in our development of the legislation now before us.

With this budget neutral proposal, about 82% of all home health agencies in the nation will benefit from improved Medicare payments. Although I have heard concerns that we do not go far enough to help some of the lowest cost agencies, it is an important step in the right direction. In fact, we have received letters of support from the Visiting Nurse Associations of America and the National Association for Homecare.

Let's remember where we were before the Balanced Budget Act of 1997. Home health spending was growing by leaps and bounds, cases of fraud and abuse were common, and the Medicare program was headed towards bankruptcy in 2003.

Last year, Medicare spent $17 billion for 270 million home health care visits so that one out of every ten beneficiaries received care at home from a nurse, a physical or occupational therapist, and/or a nurse aide.

Unlike any other Medicare benefit, the home health benefit has no limits on the number of visits or days of care a beneficiary can receive, beneficiaries pay no deductible, nor do they pay any co-payments.

Prior to BBA, home health agencies were reimbursed on a cost basis for all their costs, as long as they maintained average costs below certain limits. This payment system gave immense incentives for home health agencies to increase the volume of services delivered to patients, and it attracted many new agencies to the program.

From 1989 to 1996, Medicare home health payments grew with an average annual increase of 33 percent, while the number of home health agencies swelled from about 5,700 in 1989 to more than 10,000 in 1997.

In response to this rapid cost growth and concerns about program abuses, the BBA included a number of changes to home health care. Congress and the Administration supported moving toward a Prospective Payment System (PPS). In order for HCFA to move to a PPS, however, a number of computer system changes were necessary with respect to their home health operations. The interim payment system (IPS) was developed to manage reimbursement until the PPS could be implemented.

Significant Medicare payment issues for home health care have emerged from our analysis from the impact of the IPS. There are severe equity issues in payment limit levels both across states and within states. These wide disparities are exacerbated by a major distinction drawn in payment rules between so-called ''new'' versus ''old'' agencies. ''Old'' agencies being those that were in existence prior to 1993, and ''New'' agencies those in existence since then.

The effects of the current home health payment methodology are that similar agencies providing similar services in the same community face very different reimbursement limits, leading to highly arbitrary payment differences.

The payment limit issues will deepen significantly more in 1999 due to a scheduled 15% cut in already tight and severely skewed payment limit levels. Further, the prospective payment system scheduled to go on-line in October, 1999, will be delayed by several months to one year, because of year 2000 computer programming problems, according to the Health Care Financing Administration.

This legislation takes several steps to improve the Medicare home health care IPS and addresses the 15% cut.

First, it increases equity by reducing the extreme variations in payment limits applicable to old agencies within states and across states. This is achieved through a budget-neutral blend for ''old'' agencies.

Second, it increases fairness by reducing the artificial payment limit differences between ''old'' and ''new'' agencies. Such distinctions are contributing to the perception of arbitrariness in the home health care system. And, our proposal does not create additional classes of home health agencies, such as ''new-new'' agencies subject to even deeper, arbitrary payment limits in the future. Restricting new entrants to home health care is an inappropriate barrier to entry in underserved areas—both in rural and inner city areas. In the legislation, greater fairness is achieved by eliminating the 2 percent discount applicable to new agencies, and raising the per visit limits for all agencies from 105 percent to 110 percent of the national median.

Third, the proposal lengthens the transition period for payment changes by providing all agencies a longer transition period in which to adjust to changed payment limits. It creates a sustainable fiscal base for the statutorily mandated prospective payment system (PPS) by delaying the scheduled 15 percent cut and the PPS for one year.

The following is a summary of the Medicare Home Health Fair Payment Act of 1998:

PER BENEFICIARY LIMITS

1. ''Old'' agency: payment is a blended formula equal to 50 percent BBA policy + 50 percent (50 percent national mean + 50 percent regional mean); and

2. ''New'' agency: payment is increased by 2 percent to equal 100 percent of the national median, (which continues to be regionally adjusted for wages).

PER VISIT LIMITS

3. Increase the per visit limits from 105 percent to 110 percent of the median.

DELAY BOTH THE 15 PERCENT ACROSS-THE-BOARD CUTS AND THE PPS

4. Delay of the 15 percent across-the-board cuts in payment limits and the implementation of the prospective payments system now scheduled to take effect on October 1, 1999.

DESCRIPTION OF OFFSET POLICIES

1. Reduce the home health care annual market basket (MB) in the following manner: for fiscal year 2000 it is MB minus 0.5 percentage point; for FY 2001 it is MB minus 0.5 percentage point; for FY 2002 and FY 2003 it is full MB; and in FY 2004 it is MB plus 1.0 percentage point. Savings of $300 million over 5 years.

2. Non-Controversial Revenue Raisers—Revenues of $406 million over 5 years.

a. Math Error Procedures—This provision would clarify the math error procedures that the IRS uses.

b. Rotavirus Vaccine—This provision will add an excise tax of 75 cents on a vaccine against rotavirus gastroenteritis, a highly contagious disease among young children.

c. Modify Net Operating Loss Carryback Rules—Certain liability losses can be carried back over ten years. This provision would clarify the types of losses that qualify for the 10-year carryback.

d. Non-Accrual Based Method—This provision would limit the use of the non-accrual experience method of accounting to amounts received for the performance of certain professional services.

e. Information Reporting—This provision requires reporting on the cancellation of indebtedness by non-bank institutions.

3. Budget Pay-Go surplus for remaining offset.

At the beginning of my statement, I recognized my colleagues for their leadership on this issue. Now, I would like to especially thank the staff involved for their hard work and dedication to the completion of this bill. This represented a herculean task on their behalf. In particular, I would like to recognize the principal staff involved who spent many long hours putting the details of this package together, they are Gioia Brophy and Kathy Means of my staff; Katie Horton and David Podoff from Finance Minority staff; Louisa Buatti and Scott Harrison of the Medicare Payment Advisory Commission; Tom Bradley and Cyndi Dudzinski of the Congressional Budget Office; Jennifer Boulinger and Ira Bernie of the Health Care Financing Administration; John Goetchus of Senate Legislative Counsel; and Richard Price of the Congressional Research Service.

Mr. President, I ask unanimous consent that letters of support from the Visiting Nurse Association of America and the National Association of Homecare be printed in the RECORD.

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

VISITING NURSE ASSOCIATIONS OF AMERICA,
Boston, MA, October 10, 1998.

Hon. WILLIAM V. ROTH, Jr.,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR CHAIRMAN ROTH: The Visiting Nurse Associations of America (VNAA) deeply appreciates your efforts to craft a solution to the problems caused by the Medicare home health interim payment system for our members and other cost effective home health agencies. Urgent action is needed before Congress adjourns to provide relief to these agencies to assure that they can continue to care for their Medicare patients.

We understand that one barrier to action has been the difficulty in finding acceptable funding offsets to the modest Medicare spending required to achieve a workable package. We have been advised that the Finance Committee is currently considering an adjustment to future home health market baskets that would generate approximately $300 million in new Medicare savings to offset in part the cost of the one year delay in the automatic 15% reduction in home health payments now scheduled for October 1, 1999. Specifically, VNAA understands that this proposal would reduce the market basket index in 2000 and 2001 by 0.5 percentage point. In 2002 and 2003 the full market basket index would be used, and in 2004 the market basket would be increased by one percentage point.

VNAA strongly supports the delay in the 15% cut and supports the adjustment to future home health market baskets as a needed partial offset to the cost of that important action.

VNAA hopes that its support for this offset will facilitate quick action by the Senate. If there are any questions about our position, please contact our Washington Representative, Randy Fenninger, at 202–833–0007, Ext. 111.

Thank you for your continued efforts on behalf of cost effective home health agencies and their patients.

Sincerely,

CAROLYN MARKEY,
President and CEO.

NATIONAL ASSOCIATION FOR HOME CARE,
Washington, DC, October 7, 1998.

Hon. WILLIAM V. ROTH, Jr.,
Chair, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR SENATOR ROTH: The National Association for Home Care (NAHC) is the largest home care organization in the nation, representing all types of home health agencies and the patients they serve. We have had continuing concerns over the past year regarding the effects of the home health provisions of the Balanced Budget Act of 1997, particularly by the interim payment system (IPS).

We are pleased that you and other members of the Senate Finance Committee have shown the leadership to develop a package of IPS refinements that will help to ease some of the most pressing problems of the new payment system. We are particularly grateful for your inclusion of a one-year delay of the 15 percent reduction that is currently scheduled for October 1, 1999. While there remain a number of important issues relating to the IPS that we believe must be addressed in the 106th Congress, your proposal will make a meaningful difference in helping agencies to remain open and to serve Medicare beneficiaries throughout the nation.

Many thanks for all of your efforts. We look forward to working with you, members of the House of Representatives, and others in developing additional relief legislation early next year.

Sincerely,

VAL J. HALAMANDARIS,
President.

Mr. MOYNIHAN. Mr. President, I am pleased to join my distinguished Chairman, Senator ROTH, and other colleagues in introducing a bill to improve the home health interim payment system.

Prior to the Balanced Budget Act of 1997 (BBA), home health agencies were reimbursed on a cost basis for all their costs, as long as they maintained average costs below certain limits. That payment system provided incentives for home health agencies to increase the volume of services delivered to patients, and it attracted many new agencies to the program. From 1989 to 1996, Medicare home health payments grew at an average annual rate of 33 percent, while the number of home health agencies increased from about 5,700 in 1989 to more than 10,000 in 1997.

In order to constrain the growth in costs and usage of home care, the BBA included provisions that would establish a Prospective Payment System (PPS) for home health care, a method of paying health care providers whereby rates are established in advance. An interim payment system (IPS) was also established while the Health Care Financing Administration works to develop the PPS for home health care agencies.

The home health care industry is dissatisfied with the IPS. The resulting concern expressed by many Members of Congress prompted us to ask the General Accounting Office (GAO) to examine the question of beneficiary access to home care. While the GAO found that neither agency closures nor the interim payment system significantly affected beneficiary access to care, I remain concerned that the potential closure of many more home health agencies might ultimately affect the care that beneficiaries receive, particularly beneficiaries with chronic illness.

The bill we are introducing today adjusts the interim payment system to achieve equity and fairness in payments to home health agencies. It would reduce extreme variations in payment limits applicable to old agencies within states and across states and would reduce artificial payment level differences between ''old'' and ''new'' agencies. The bill would provide all agencies a longer transition period in which to adjust to changed payment limits.

Clearly, since the bill may not address all the concerns raised by Medicare beneficiaries and by home health agencies, we should revisit this issue next year. A thorough review is needed to determine whether the funding mechanism for home health is sufficient, fair and appropriate, and whether the benefit is meeting the needs of Medicare beneficiaries.

America's home health agencies provide invaluable services that have given many Medicare beneficiaries the ability to stay home while receiving medical care. An adjustment to the interim payment system and delay in further payment reductions will enable home health agencies to survive the transition into the prospective payment system while continuing to provide essential care for beneficiaries.

Mr. GRASSLEY. Mr. President, I am pleased to cosponsor the Medicare Home Health Fair Payment Act of 1998, which is a first step toward addressing the crisis in Medicare home health care. This is not a perfect bill, but it's a good bill, and it is the best we can do at this moment in time. And it's a good example of the Senate listening to the American people. Let's pass it right now.

The Senate Special Committee on Aging, which I chair, highlighted the problems with the home health Interim Payment System (IPS) in a hearing on March 31st of this year. For more than six months since that day, I have been working to find a solution to these problems, because I believe that it's Congress' responsibility. It's true that the IPS legislation was primarily HCFA's product. And HCFA's implementation of the IPS has been questionable in many respects. But even if

HCFA proposed it, there's no denying that Congress passed the IPS. So I have argued all year that it is incumbent on Congress to fix what's wrong with it, this year.

What's wrong with the IPS? In short, it bases payment on an individual home health agency's historical costs from Fiscal Year 1994. That means that if the agency had high costs per patient in that year, it can receive relatively high payment this year. That would be fine if HCFA knew that the agency had sicker patients this year, but the sad truth is that HCFA has no idea. So IPS has been a windfall for some agencies, but crushing for agencies with low historical costs. We have a lot of those in Iowa, where we still know the value of a dollar. Many of those hit hardest are the ''little guys,'' the small businesses that are the lifeblood of the program in rural areas.

For months, I have worked with a bipartisan group of Finance committee members, including especially Senators BREAUX, BAUCUS, and ROCKEFELLER, on fixing IPS. In July we introduced the product of those efforts, the Home Health Access Preservation Act, and that bill clearly influenced the new Finance bill. I thank Chairman ROTH and his fine staff for their willingness to work with us to find a viable approach. In the final months of this session, they have really gone the extra mile.

Now, this bill doesn't give anyone everything that they want. Senators ROTH and MOYNIHAN rightly focused on creating something that could actually pass this year, and so the bill is a product of compromise. One of the key features is that the bill is paid for, so that it will not add another burden onto the already-burdened Medicare Part A trust fund. The offsets used are fair ones, and should not be controversial.

I am familiar with the bill the House is voting on today. Should both bills be passed, with all due respect to my House colleagues, I urge them to recede to the Senate bill in conference. I have worked on this issue a long time, and I don't believe this bill can be improved upon.

Mr. President, this bill will not satisfy everyone. It's a compromise, and in fact, it likely will not fully satisfy anyone. But it's the right thing to do, because it will help to keep some of our good home health providers around for another year, so they can make sure our seniors get home care when they need it.

Mr. BREAUX. Mr. President, I rise today in support of the Medicare Home Health Fair Payment Act of 1998. This is an issue that I have worked on for several months with Senator GRASSLEY and other Members of the Senate and I am pleased that the Senate has addressed this issue before adjourning.

I am the first to admit that there is too much fraud, waste, and abuse in Medicare's home health benefit and there is probably no other state where the problem is more pronounced than Louisiana. Every graph I see on home health shows Louisiana off the charts—Louisiana has the highest per beneficiary spending in the country; we have more visits per patient than any other state in the country; Louisiana represents 5.2% of all Medicare home health visits even though only 2.3% of Medicare beneficiaries live in the state. There are 466 home health agencies in Louisiana—we have more home health agencies than McDonalds in the state. So I know firsthand that there are problems with home health and that states like Louisiana could afford a reduction in the number of agencies. The problem is that the interim payment system crafted by Congress and the Administration last year is causing the wrong agencies to go out of business.

It is clear that the IPS has had serious unintended consequences. In Louisiana and other states, the interim payment system has for the most part rewarded inefficient providers and forced many low-cost, efficient agencies out of the program. For example, you could have one agency with a per beneficiary limit of $12,000 competing with another agency down the street with a per beneficiary limit of $4,000. What we did with IPS is essentially put that $4,000 agency at such a competitive disadvantage that there is no way it can stay in business.

When we finally move home health to prospective payment, it is critical that some low-cost providers be in business to treat patients who need home care. The Grassley-Breaux bill that we introduced several months ago tried to level the playing field by bringing the very high cost providers down while raising the reimbursement for low cost providers. This reflects what will happen under prospective payment when all providers will essentially be paid the same amount for treating the same kind of patient. We also eliminated the distinction between old and new providers in an attempt to further level the playing field. To ensure that high cost patients would still have access to home health, the Grassley-Breaux bill included an outlier policy so that home health agencies would not turn high cost patients away.

The interim payment reform proposal put forward by Senators ROTH and MOYNIHAN is an important first step towards fixing IPS and I applaud the bipartisan approach the Senate used in arriving at this proposal. I think most members would argue that much more needs to be done and I would agree. I am hearing from many home health agencies in Louisiana that this bill will only be of marginal help to the state but that it is important that something get done this year. As is the case with most things we do around here, particularly in the waning hours of this Congress, getting something is better than getting nothing. I am pleased that there is a bipartisan commitment by the Senate Finance Committee to revisit this issue next year and take a much more comprehensive look at the home health benefit. It is imperative that the Congress address this issue again next year since this proposal represents only a temporary fix. But it is an important one. The Senate bill:

(1) Institutes a new blend for old agencies to increase reimbursements to low-cost agencies and reduce payments to very high-cost agencies. This will begin to level the playing field and prepare all providers for prospective payment. While the Senate proposal narrows the discrepancy between old and new agencies, I think much more needs to be done to restore equity to the program.

(2) Slightly increases payments to so-called ''new'' agencies, those in business since 1994. While in Louisiana this will only mean about an extra $52 per patient per year, it is important to recognize that new agencies need some relief.

(3) Increases the per visit cost limits from 105% of the national median to 110% of the national median.

(4) Most importantly, the Senate proposal delays the across-the-board 15% reduction that is currently scheduled for October 1, 1999. HCFA was originally required to institute a prospective payment system for home health agencies by October 1 of next year. Because of the Y2K problem, HCFA is now anticipating that it will not have PPS in place until April 1, 2000. Delaying the automatic 15% reduction in payments to home health agencies will ensure that the agencies aren't punished for HCFA's inability to implement PPS in a timely manner.

The goal of this bill is to fix some of the problems created in the BBA. Again, it is certainly only a first step—there is still much more that needs to be done and I am hopeful that the 106th Congress will revisit this issue to ensure that Medicare beneficiaries continue to have access to this very important benefit.

I urge my colleagues to support this bipartisan measure. It may not be everything everyone wants, but it certainly is better than doing nothing this year and it provides much-needed temporary relief to home health agencies across the country.

Mr. JEFFORD. Mr. President, today, I am very pleased to join in introducing the Medicare Home Health Fair Payment Act, legislation that significantly improves the interim payment system to home health agencies established under the Balanced Budget Act of 1997. Over the past eight months, I have been working as hard as I know how to find a solution for the crisis faced by our home health care agencies in Vermont. Our 13 home health agencies are model agencies that provide high-quality, comprehensive home health care with a low price tag. However, under Medicare's new interim payment system the payments to the agencies are so low that Vermont's seniors may be denied access to needed home health services.

Under the legislation, the reimbursement from Medicare to home health agencies will be increased, and the 15% across-the-board cut scheduled for next year will be delayed by one year. Adoption of this bill will give the Vermont home health agencies needed financial relief until a new prospective payment system is in place.

For the past seven years, the average Medicare expenditure for home health care in Vermont has been the lowest in the nation. However, rather than being rewarded for this cost-effective program, Vermont has been penalized by the implementation of the current interim payment system. In June, 1998, Vermont's home health agencies projected that the statewide impact of the current interim payment system was a loss of over $4.5 million in Medicare revenues for the first year. This represents a loss of over 11% on an annual base of $40 million statewide.

Vermont is a good example of how the health care system can work to provide for high quality care for Medicare beneficiaries. Home health agencies are a critical link in the kind of health system that extends care over a continuum of options and settings. New technology and advances in medical practice hospitals to discharge patients earlier. They give persons suffering with acute or chronic illness the opportunity to receive care and live their lives in familiar surroundings. Time and time again, Vermont's home health agencies have proven their value by providing quality, cost-effective services to these patients. Yet time and again, federal policy seems to ensure that their good deeds should go punished.

The Medicare Home Health Fair Payment Act is the product of a great deal of hard work by the Finance Committee and is carefully designed to ease the burden of home health care agencies in the transitional years prior to the introduction of a new prospective payment system in 2000. The bill includes several strong policy components, which promote equity and fairness among the agencies nationwide. Under the new prospective payment system, Vermont and other cost-effective agencies can look forward to being rewarded rather than penalized for their high-quality, low-cost comprehensive medical care to beneficiaries.

It is my strong hope, that this bill will be adopted by the Senate, supported by the House, and signed into law. I have worked closely with Vermont's 13 home health agencies, Senator LEAHY and the Governor's Office in developing a solution to the payment crisis. The signing of this bill will mark a victory for our State, and it will also reflect a strong nationwide commitment to high-quality, cost-effective home health agencies such as those in Vermont.

Ms. COLLINS. Mr. President, I rise in support of the legislation introduced by the distinguished chairman of the Finance Committee. I would have preferred the approach taken in my own home health bill, which I introduced last April and which has 29 Senate cosponsors, because it would have done more to level the playing field and provide more relief to historically cost-effective agencies. However, I understand that the chairman faced a difficult task of balancing a number of competing issues, and the bill we are considering today is an important first step that will move the process forward and provide a measure of relief to those cost-effective agencies in every State that are currently being penalized by the formula used to calculate the per-beneficiary limit.

America's home health agencies provide invaluable services that have enabled a growing number of our most frail and vulnerable Medicare beneficiaries to avoid hospitals and nursing homes and stay just where they want to be—in their own homes. However, critics have long pointed out that Medicare's historic cost-based payment for home health care has inherent incentives for home care agencies to provide more services, which has driven up costs.

Therefore, there was widespread support for the Balanced Budget Act provision calling for the implementation of a prospective payment system for home care. Until then, home health agencies are being paid according to a new ''interim payment system,'' which unfortunately is critically flawed.

As we are all aware, the Health Care Financing Administration has diverted considerable resources to solving its Y2K problem so that there will be no slowdown of Medicare payments in 2000. As a result, implementation of the prospective payment system for home health agencies will be delayed, and home health agencies will remain on IPS far longer than Congress envisioned when it enacted the Balanced Budget Act. This makes it all the more imperative that we act now to address the problems with a system that effectively rewards the agencies the have provided the most visits and spent the most Medicare dollars, while it penalizes low-cost, more efficient providers.

Home health agencies in the Northeast are among those that have been particularly hard-hit by the formula change. As the Wall Street Journal recently observed, ''If New England had been just a little greedier, its home health industry would be a lot better off now . . . Ironically, . . . [the region] is getting clobbered by the system because of its tradition of nonprofit community service and efficiency.

Moreover, there are wide disparities in payments and no logic to the variance in payment levels. The average patient cap in the East South Central region is almost $2,500 higher than New England's without any evidence that patients in the southern States are sicker or that nurses and other home health personnel in this region cost more.

Moreover, the current per-beneficiary limits range from a low of $760 for one agency to a high of $53,000 at another. As such, the system gives a competitive advantage to high-cost agencies over their lower costs neighbors, since agencies in a particular region may have dramatically different reimbursement levels regardless of any differences among their patient populations. And finally, this system may force low-cost agencies to stop accepting patients with more serious health care needs.

Mr. President, I realize that we cannot address every home health issue that has been raised this year. Some matters will have to carry over to the next Congress, and I fully intend to work with my colleagues next year on these items. Nonetheless, there are things we can do this year, and I believe that it is imperative that Congress act now to begin to address these problems. At least one agency in Maine has closed because the reimbursement levels under this system fell so short of its actual operating costs. Other cost-efficient agencies in my State are laying off staff or declining to accept new patients with more serious health conditions.

Which brings us back to the central and most critical issue—the real losers in this situation are our seniors, since cuts of this magnitude simply cannot be sustained without ultimately affecting patient care.

Mr. President, once again, I commend the chairman of the Finance Committee for his efforts on this difficult issue and urge my colleagues to join me in supporting this legislation.

Mr. BOND. Mr. President, I thank the Senator from Delaware, Mr. ROTH, for attempting to bring some resolution to the home health crisis before the end of this session and making much needed revisions to the Medicare home health interim payment system (IPS). I fully support delaying the automatic 15 percent reduction for one year, raising the cost limits to 110 percent of the median, and raising payments for new agencies. However, I still have serious reservations about a blend approach which reshuffles the deck chairs on the *Titanic*. It is imperative that we restore access to home health care for medically complex patients, and I look forward to working with my colleagues to address this issue in conference.

At this time my distinguished colleague from Mississippi, Mr. COCHRAN, and I would like to engage the able Chair of the Senate Finance Committee, Mr. ROTH, in a discussion about the problems that have resulted from IPS, and further action that the Senate must take to complete the work begun this year in this important area.

Mr. President, there is not a single Member of the Senate or House of Representatives who has not become painfully aware of the serious problems that have arisen within the home health program over the last year. These problems stem from enactment

of a temporary payment system that was recommended to us by the Health Care Financing Administration. The fact is that the so-called interim payment system (IPS) was untested, and, as we have found, made such swift and deep cuts in reimbursements, thereby hampering the ability of home care providers to serve needy patients and affecting access to care for some of the most frail, oldest, and poorest of our seniors and disabled.

The IPS is the worse case of false economy that I've ever seen. If the elderly and disabled cannot get care at home, it's clear where they will go for care. Emergency room costs will rise, patients will go into more expensive institutionalized care, or patients simply won't get any care at all. In addition to increasing Medicare costs, there will be an explosion in Federal and State Medicaid budgets. I believe the Senator from Mississippi would agree that the problems brought about by IPS are significant.

Mr. COCHRAN. Mr. President, the statements made by the Senator from Missouri are, I'm sad to say, quite true. Most recent official figures from 29 state health departments indicate that close to 800 agencies have closed in those states. This number represents parent agencies; other data from the states indicate that the number of agencies and branches that have closed is much higher. We also know that there are many more agencies on the brink of closing if some relief from IPS is not provided soon. If the current rate of closures continues, we could easily see a loss of 2,000 more home health agencies by October 1, 1999.

Agency closing are resulting in significant beneficiary care access problems. In fact, a recent GAO study found that two-thirds of discharge planners and more than a third of the aging organizations surveyed reported having had difficulty obtaining home health care for Medicare patients in the last year, especially those who need multiple weekly visits over an extended period of time. Matters will only get worse as agencies become more and more limited in their ability to provide needed services. In fact, in testimony before the Ways and Means Committee in August, Ms. Gail Wilensky, former head of the Health Care Financing Administration, warned that, if the Congress waits for proof that a crisis is occurring in home care before it acts, it will be too late. She also indicated that more money was taken out of home care than the Congress had expected when IPS was designed and then implemented by HCFA.

Mr. BOND. Mr. President, I might add at this time that despite the fact that HCFA is responsible for this draconian system, HCFA has only offered technical assistance to address this crisis. HCFA must beheld accountable for this insane and inequitable system and face up to the fact that its system is wreaking havoc throughout our country.

Clearly the program cannot continue under this scenario and continue to provide quality services to eligible individuals. Some of my colleagues may wonder how this all came about. Perhaps the Senator from Mississippi can provide some insight into this.

Mr. COCHRAN. Mr. President, I thank my colleague. In addition to HCFA imposing an untested payment system with the home health IPS, the scoring mechanism used by CBO to estimate savings resulting from IPS included a ⅔ behavioral offset. What this means is that CBO presumed that for every $3 saved under IPS, agencies would find some way, through expanding the number of beneficiaries they serve, to make up $2 of every $3 lost under IPS. What has become clear, as was indicated by the Senator from Missouri, CBO's behavioral assumptions about agencies increasing the number of beneficiaries served have not come to pass. Instead, we are seeing a near dismantling of the home care program as the result of IPS.

We have already seen the devastating effects of the interim payment system in my state of Mississippi. While I applaud the Senate for its efforts to reform the interim payment system, we must commit ourselves to continuing this work as soon as the Senate reconvenes. I am particularly concerned that we must address the problems that will be created by the automatic 15% reduction in payment limits which we have agreed to delay one year. It took this distinguished body that long to reach the temporary solutions which we have before us today and we cannot put off deliberations on this additional cut until the last moment. Prudence dictates that we find ways to insure that any additional cuts in reimbursement not adversely affect efficient providers nor burden patients in their access to necessary home care services.

Mr. BOND. Thank you for those insights Senator COCHRAN. I fully agree that this must be a priority of the Senate to address as soon as possible. There are additional issues which also need to be addressed at that time, particularly how to reimburse those agencies which serve our nation's most medically complex patients. We have a moral obligation to ensure that our nation's seniors and disabled are provided the quality and comfortable care they deserve. In addition, we must look at provisions which require that the payment limits are prorated where a patient is served by more than one agency. It is my understanding that the Health Care Financing Administration is not capable of administering this provision, yet it is having impact on patient's access to care. The problem centers around the inability of a home health agency to properly manage its business when it does not know the ultimate payment limitation which it must budget. The home health agency has no way of knowing whether a patient has received services from another home health agency during the year and cannot possibly figure out whether its breaking even or going broke. While we do not want home health agencies to abuse the system through schemes that allow them to circumvent the limits by transferring patients, we also do not want to penalize patients and providers from the appropriate management of home care services. Another issue is the elimination of the periodic interim payment methodology scheduled for October, 1999. That termination date was chosen to coincide with implementation of prospective payment system, which we now know, will not be in operation at that stage. This Congress should recognize the need to continue that system until such time as a Prospective Payment System is in place.

Mr. COCHRAN. Mr. President, I too am very concerned about the delay in the development and implementation of a PPS system. It is the only clear solution to deal with those complex patients who are having increasing difficulty in gaining access to home care services. If we cannot have PPS soon, we must find a way to better reimburse agencies which care for these high cost patients. Home health agencies in Mississippi report to me that this is one of the most important problems that must be addressed. At the same time, putting together a PPS program will do no good if we destroy the foundation of our home health services delivery system. As the result of IPS, I am told that home health agencies across the country will find some time in the middle of next year that they have likely been over paid by the Medicare program even though they delivered appropriate services to patients at a reasonable cost. This Congress must find a way to deal with that pending crisis in order to protect those home health agencies that met patient's needs yet still incurred costs beyond the arbitrary limits which were developed under IPS.

Mr. ROTH. Senator BOND and Senator COCHRAN, I thank you for your leadership within the Senate of these crucial issues affecting Medicare beneficiaries across the country. Through your assistance we hope to ensure that home health care is readily available where the needs arise. We will continue to explore fully those issues which you have raised. We will also draw on the resources of Medpac, HCFA, the GAO, and representatives from home care patients and providers to determine whether more work is required. Home health care is a crucial part of our health care system and the elderly and disabled protected by the Medicare program deserve the attention of this Congress to insure that we not disrupt this important benefit without a full and accurate understanding of the consequences. Once again, I thank Senator BOND and Senator COCHRAN for the guidance that they have offered to this body in addressing these important issues.

Mr. CONRAD. Mr. President, I want to comment on the home health proposal that is before us and ask the Chairman of the Finance Committee to clarify his intentions with regard to addressing this issue in the next Congress.

The current home health interim payment system isn't working. Under the current system, those agencies that abused the system and milked Medicare for every possible reimbursement dollar are rewarded with generous cost limits. However, North Dakota agencies that did not abuse the system, that worked hard to keep their costs down, are penalized with unrealistically low limits. Not only is this terribly unfair, it creates a terrible incentive for efficient, low-cost agencies to go out of business and transfer their employees and their customers to agencies that have ripped off the system.

This system clearly penalizes North Dakota home health agencies and the beneficiaries who rely on their services. The median per beneficiary cost limit for North Dakota home health agencies is the second lowest in the country—a mere $2150 per year. In fact, the agency in North Dakota with the highest limit has a cap that is below the lowest limit in the state of Mississippi. There is no rational basis for this sort of inequity.

Unfortunately, the proposal before us today takes only the smallest of steps toward correcting this inequity and leaves in place too many of the current incentives that favor high cost, wasteful home health agencies. I do not see how I can, in good conscience, go back to North Dakota home health agencies and tell them that we can only lift their payments rates 2 or 3 percent when agencies in other parts of the country will continue to have payment limits 3 and 4 times as high as theirs. It is not fair. It is not good policy. It is not good enough. For that reason, I will feel constrained to object to this legislation unless I can be assured by the Chairman of the Finance Committee that there will be an opportunity to do better next year.

Mr. ROTH. Mr. President, I thank the gentleman from North Dakota for his comments. He is right; this change is only a small step. It does not ''fix'' the interim payment system. However, in the time remaining this year, this is the best we can do. It takes an important step toward making the system more fair, and it reduces the perverse incentives in the current system. In addition, it recognizes that the Prospective Payment System for home health will be delayed, so it delays for one year the 15% cut in payments that is currently scheduled to go into effect on October 1, 1999.

I want to assure my colleague from North Dakota, however, that I fully intend to revisit the home health issue next year. At that time, I pledge to work with him and other members of the Finance Committee to see if we can come up with a system that better addresses the needs of North Dakota home health agencies.

Mr. CONRAD. I thank the Chairman. With that assurance, I will drop my objection and let this legislation move forward.

ADDITIONAL COSPONSORS

S. 2130

At the request of Mr. GRAMS, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 2130, a bill to amend the Internal Revenue Code of 1986 to provide additional retirement savings opportunities for small employers, including self-employed individuals.

SENATE JOINT RESOLUTION 56

At the request of Mr. GRASSLEY, the names of the Senator from Oklahoma (Mr. NICKLES) and the Senator from Alabama (Mr. SESSIONS) were added as cosponsors of Senate Joint Resolution 56, a joint resolution expressing the sense of Congress in support of the existing Federal legal process for determining the safety and efficacy of drugs, including marijuana and other Schedule I drugs, for medicinal use.

SENATE CONCURRENT RESOLUTION 108

At the request of Mr. DORGAN, the name of the Senator from Minnesota (Mr. WELLSTONE) was added as a cosponsor of Senate Concurrent Resolution 108, a concurrent resolution recognizing the 50th anniversary of the National Heart, Lung, and Blood Institute, and for other purposes.

ADDITIONAL STATEMENTS

TRIBUTE TO INDIANA STAFF

• Mr. COATS. Mr. President, I rise today to pay tribute to a group of people that have been of tremendous service to me during my tenure as a United States Senator. That group is my Indiana staff.

As I have so often said, whatever success I have achieved during my service as a Senator is greatly attributable to the tireless work of my staff. Their hours are long, and they toil in relative obscurity. However, they do so for the same reason that we as Senator make the sacrifice. They work so hard because they believe in this great nation we serve, and the ideals that are woven into the very fiber of our existence as Americans.

So much of our work here in the Senate focuses on legislative activity. For that is the stuff of headlines and news stories. However, it is hardly a reflection of one of the most fundamental responsibilities of a United States Senator, and that is providing caring and responsive service to the citizens of our state, the people who's trust we are charged with protecting and serving. And, Mr. President, it is those people serving in my State and regional offices that work so hard to insure that the needs and requests of my Indiana constituents are met with friendly and effective service. They are the front line, they are my eyes and ears in Indiana, and without their hard work, it would be impossible for me to serve effectively.

As the distinguished senior Senator from Indiana pointed out yesterday, we have a rather unique operation back in Indiana. The senior Senator and I share a combined staff. They have served the state well. I would like to take a moment now to acknowledge my Indiana staff. Kathy Blane, Susan Brouillette, Sarah Dorste, Mark Doude, James Garrett, Amy Gaston, Michelle Mayer, Kevin Paicely, Lane Ralph, Karen Seacat, Libby Sims, Cory Shaffer, Angela Weston, Mike Duckworth, Barbara Keerl, David Graham, Pat McClain, Phil Shaull, Amy Hany, Tim Sanders, and Barb Franz. I believe I have included everyone. If I have not, let them know my appreciation.

As I have said, the distinguished senior Senator and I have shared staff, and so many will continue to work for the citizens of Indiana. Though some will go on to other endeavors, that same sense of responsibility and public service that has motivated them to date, I am sure will drive them to continue to play a positive role in the lives of Hoosiers for years to come.

I thank them and salute them.•

TRIBUTE TO JUDGE JAN SMITH

• Mr. REID. Mr. President, I rise today to pay tribute to an outstanding Nevadan, my friend and former colleague, Judge Jan Smith. At the age of seventy-one, after years of service as Justice of the Peace for the Jean-Good Springs community, Judge Smith will retire from the bench next year. I want to take this opportunity pay tribute to Jan for her efforts to improve the lives of so many Americans, because her accomplishments have helped us all.

I have been fortunate enough to be a first hand witness to some of Jan's incredible achievements. I have watched her rise from legal aide and working mother in the early nineteen sixties to become one of Nevada's most influential judicial officers.

After toiling away as a legal secretary for a District Attorney and a county judge, Jan became deeply involved with a variety of grass roots causes. She was one of the first women in the state to be an advocate on behalf of the environment. In the city of Henderson, she canvassed neighborhoods and city hall to prevent industry from inflicting permanent damage to the environment. As a mother of six, she was insightful enough to take action so that her children could grow up with an ample supply of clean air and water.

Judge Smith was also a champion for the underprivileged. She worked tirelessly to create opportunities for the poor and disadvantage in Nevada. Like many of her contemporaries, she