

entering a new life. And it's the most wonderful place to be." Upon his own death, to which he professed to look forward, Father Hug's words echo. We know that he is at peace after a long and heroic struggle, and he is happy.

Our entire community expresses heartfelt gratitude for the life and beneficence of Father Edward Hug. No man could have given others more. We extend our prayers to his family, his brothers Father Fritz and Father Relmond Hug, also men of the church, and Eldred Hug, his devoted sisters Virginia Kunisch and Marlene Alter, and the entire Hug family. Godspeed.

INCREASING ACCESS TO MEDICARE SERVICES

HON. RICHARD J. DURBIN

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Mr. DURBIN. Mr. Speaker, I am introducing legislation today, along with Congressman JOHN ENSIGN, to create a demonstration program to waive, for selected diagnoses, the Medicare rule requiring a 3-day hospital stay before Medicare will cover services in a skilled nursing facility. There is growing evidence that, for selected diagnosis-related groups or [DRG's], a waiver could save money by allowing care in a less expensive setting.

The legislation would require the Secretary of Health and Human Services to cover services in skilled nursing facilities for at least five DRG's that involve medical conditions that do not need inpatient care and that are not likely or are least likely to result in any net increase in Medicare expenditures. Over the course of time, the Secretary would be able to add to the list of DRG's for which the 3-day stay rule is waived.

The Secretary would monitor this demonstration program to determine the impact of the program on overall Medicare expenditures. If this experiment is successful, it will increase access to Medicare-covered services without an increase in costs.

I expect that, if the DRG's are carefully selected based on evidence of which medical conditions could be treated less expensively in skilled nursing facilities, there will be no increase in total Medicare expenditures and there might even be budget savings. However, in case that expectation is not met, the legislation includes explicit language to ensure budget neutrality.

If this demonstration program, as a whole, causes an increase in overall Medicare spending, payments to skilled nursing facilities will be reduced by a corresponding amount in the following year to make up for the losses. This provides a fail-safe mechanism, supported by the skilled nursing facility industry itself, to ensure that the measure does not cause new Federal outlays. Moreover, the Secretary would be authorized to remove DRG's from the waived list that result in an increase in overall Medicare spending.

If, as I hope, this demonstration program is successful and overall Medicare costs do not rise as a result of the 3-day stay waivers, the legislation directs the Secretary to actively consider adding other DRG's to the waiver list that could be added without increasing total Medicare costs.

While I do not expect Congress to move forward on this measure in the waning days of this legislative year, I believe this idea deserves careful consideration. I am introducing it now in the hope that we can lay the groundwork for this type of budget-neutral reform in the next Congress.

H.R. 4244

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. WAIVER OF 3-DAY PRIOR HOSPITALIZATION REQUIREMENT FOR COVERAGE OF SKILLED NURSING FACILITY SERVICES FOR CERTAIN DRGS.

(a) IN GENERAL.—By not later than October 1, 1997, the Secretary of Health and Human Services shall provide for coverage, under section 1812(f) of the Social Security Act, of extended care services for individuals with a condition that is classifiable within a diagnosis-related group selected under subsection (b).

(b) SELECTION OF DIAGNOSIS-RELATED GROUPS.—For purposes of subsection (a) and subject to subsections (c) and (d), the Secretary—

(1) beginning with fiscal year 1998, shall select at least 5 diagnosis-related groups (as established for purposes of section 1886(d)(4)(A) of the Social Security Act that—

(A) relate to conditions that do not require treatment through receipt of inpatient hospital services, and

(B) are not likely (or are least likely) to result in any net increased expenditures under title XVIII of such Act; and

(2) for subsequent fiscal years may select additional diagnosis-related groups that meet the requirements of subparagraphs (A) and (B) of paragraph (1).

(c) RECOVERY OF EXCESS EXPENDITURES.—If the Secretary determines that the application of this section in a fiscal year has resulted in any increase in aggregate expenditures under such title for the fiscal year above the amount of such expenditures that would have occurred in the fiscal year if this section did not apply (taking into account any reductions in expenditures resulting from the elimination of or a reduction in the length of hospitalization), the Secretary—

(1) shall, notwithstanding any other provision of law, provide for a reduction in the amounts otherwise payable under part A of such title for post-hospital extended care services in the following fiscal year by such proportion as will reduce aggregate Federal expenditures in such fiscal year under such part by the aggregate amount of such increase in the previous fiscal year, and

(2) may rescind the selection of any diagnosis-related group if the application of this section with respect to such group has resulted in such an increase in expenditures under such title.

(d) CONSIDERATION OF ADDITIONAL SELECTIONS.—The Secretary shall actively consider the selection of additional groups under subsection (b)(2) if the Secretary determines that the application of this section has resulted in a net reduction in expenditures under such title.

REAUTHORIZATION OF THE PUBLIC HEALTH SERVICE ACT

HON. BILL RICHARDSON

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Friday, September 27, 1996

Mr. RICHARDSON. Mr. Speaker, I rise in strong support of our community health centers and this reauthorization bill.

I have introduced this piece of legislation in the House as H.R. 3180. Although time constraints prevented the House Commerce Committee from moving this bill through the committee this year, I am extremely pleased that the House will have the opportunity to vote on this important reauthorization.

This bill will consolidate community health centers, migrant health centers, health care for the homeless and health care in public housing projects under one authority as requested by the administration and as supported by the health centers.

Health center programs have been highly successful in delivering primary health care to the Nation's most needy inner city and remote rural over the last 30 days.

These centers have improved health, have high-confidence ratings from the people they serve, and have produced Federal savings by lessening the use of more expensive Federal provided health care.

In New Mexico, Federal health centers serve over 150,000 patients each year. My State has 56 clinics in 27 of our 33 counties. In most areas these clinics are the sole providers of health care in the county. These clinics are usually also the only providers with a sliding fee scale, which means they provide both geographic and economic access to health care for many uninsured or geographically isolated New Mexicans.

Community health programs are a vital part of health delivery to underserved communities across the country and a model of a Federal program that works.

However, over the last 30 years the health care industry in our country has undergone significant changes. This is why I believe we must—through reauthorization—give the health center programs the flexibility and streamlined efficiency to survive in today's health care marketplace.

This authority would support the continued development and operation of local, community-based systems of health care to address the needs of medically underserved communities and vulnerable populations.

At the same time, my legislation frees these centers from unnecessary and burdensome requirements. This bill will: First, make the grant process more flexible, simpler, streamlined, and less burdensome for communities receiving health center awards; second, reduce the Federal administrative costs associated with administering the programs; and third, assure continued Federal support—in these times of tight budgets—for health centers by consolidating the funding previously requested under separate authorities.

In addition, this legislation addresses the rapid expansion of managed care and gives our health centers the ability to complete in today's health care marketplace. This bill will create grants for health centers to plan and develop networks with health maintenance organizations or form their own networks with other physicians and hospitals.

Further this legislation will reauthorize the Rural Health Outreach, Network Development, and Telemedicine Grant Program to focus on the development of coordinated, integrated health care delivery systems in rural areas using advanced technologies.

I believe this bill is the most comprehensive approach to reauthorizing public health centers. This legislation has the support of the public health centers and would allow our public health centers to continue providing top