

Mr. Speaker, I ask my colleagues to join me in wishing a happy retirement to Mrs. Lora Lucks and in recognizing her for her outstanding achievements in education and her enduring commitment to the community.

TRIBUTE TO MARATHON ASHLAND
PETROLEUM

HON. DAVID D. PHELPS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 16, 1999

Mr. PHELPS. Mr. Speaker, it is my great honor to rise today to congratulate Marathon Ashland Petroleum on the recognition of their Illinois Refining Division as an OSHA Voluntary Protection Program Star participant. The Voluntary Protection Program promotes partnerships between the Occupational Safety and Health Administration, labor and management and recognizes those facilities that exemplify effective safety and health program management.

Having personally visited Marathon's Robinson, IL, refinery, located in my congressional district, I can attest to the superior quality of its operation and the dedication and talent of its employees. Although I am not surprised to learn that OSHA has recognized Marathon's efforts on behalf of health and safety, I could not be more pleased.

Under the Voluntary Protection Program, management commits to operate an effective program, and employees commit to participate in the program and work with management to ensure a safe and healthful workplace. OSHA regularly evaluates the site and the program's operation to ensure that safety and health objectives are being met, and participants receive the Star designation when they have complied with all program requirements.

Mr. Speaker, I believe the Voluntary Protection represents the best in voluntary partnerships formed to achieve an important mutual goal. I am proud to offer my heartfelt congratulations to Marathon Ashland Petroleum's Illinois Refining Division on reaching the milestone of an OSHA Star designation. Their efforts on behalf of health and safety are deserving of such recognition, and I wish them continued success in the future.

INTRODUCTION OF THE MEDICARE
HOME HEALTH ACCESS RESTORATION
ACT OF 1999

HON. WILLIAM J. COYNE

OF PENNSYLVANIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 16, 1999

Mr. COYNE. Mr. Speaker, today I am introductory the Medicare Home Health Access Restoration Act of 1999. I am introducing this legislation because of the dramatic changes the Interim Payment System (IPS) has made in the way home health care is provided in my home state of Pennsylvania and elsewhere. I am concerned that those changes are making it more difficult for the sickest and most vulnerable Medicare recipients to get the home health services to which they are entitled.

Medicare provides home health services to homebound patients who need skilled nursing

care. Many of these patients are recovering from surgery or receiving therapy after a serious illness like a stroke. Home care recipients often suffer from chronic illnesses that require monitoring, like severe diabetes and some mental illnesses. Home health care recipients tend to be the oldest, sickest, and poorest of Medicare beneficiaries. They are disproportionately low-income and over 85. They report being in fair or poor health. Three-fourths of them cannot perform at least one basic activity of daily living, like bathing, cooking, or getting out of bed. Almost half of home care recipients cannot perform 3 or more activities of daily living.

In Pennsylvania, where home care costs and visit frequency have always been lower than the national average, home care visits have declined by over 25 percent since IPS became effective. That means the average home care recipient sees a nurse 11 times less under IPS than she did before, perhaps getting one visit a week instead of two. Over 90 percent of my state's home health agencies reported that they will lose money in the first year of IPS and 6,100 home care workers have been laid off. These changes are causing agencies to provide less care, spend less time caring for patients, and avoid the patients who most need help.

Like most other people who are concerned about the home care benefit, I support the shift to the prospective payment system, which will allow us to pay more accurately for the services beneficiaries receive. But it could be quite a while before PPS is implemented, particularly since the Health Care Financing Administration has temporarily suspended collection of the necessary data. The Interim Payment System is what we have now, and we could have it for a long time. It is affecting patient care now, and I do not believe we can just live with it" for the months or years until the PPS is ready.

The low IPS caps on payments for home health services mean that agencies often can't afford to provide Medicare beneficiaries with the services they need and to which they are entitled. Because the caps are based on individual agency 1994 spending, the problem is particularly serious for historically low-cost agencies. The low-cost agencies were given the lowest caps. Since they have already trimmed the fat from their operations, they are being forced to lay off nurses and cut services. The caps also create wide regional variation, and Medicare beneficiaries in historically efficient areas receiving much smaller benefits.

Because the caps are based on an "average" patient, it is particularly difficult for the sickest patients to access care. The IPS does not acknowledge that some agencies specialize in very sick patients and that some individual patients require so much care that few agencies can afford to serve them. The current system creates an incentive for agencies to avoid admitting the sickest patients or to discharge them early.

The legislation I am introducing today would make several important changes in the IPS. (1) It would gradually move toward a more equitable and reasonable payment level by increasing the payments for efficient agencies, increasing the number of times a home care nurse is allowed to visit a sick patient, and repealing the scheduled 15% cut in payments. (2) It would provide exceptions to the caps for

the costliest patients and agencies that specialize in treating them. (3) It would protect beneficiaries from being inappropriately discharged because of the caps.

Medicare's sickest and most vulnerable patients cannot wait much longer for Congress to act. Each day that the current system is in effect, home care agencies close or lay off workers, beneficiaries in states with low caps receive less service than they need, and high-needs patients struggle to find agencies that will serve them. These reductions in the quality and quantity of home care services put patients right back where no one wants them to be—in expensive hospital and nursing home beds.

SUMMARY OF MEDICARE HOME HEALTH ACCESS
RESTORATION ACT

Purpose: To restore access to home health services for Medicare recipients whose necessary care has been curtailed or eliminated due to provisions in the 1997 Balanced Budget Act.

MAJOR PROVISIONS

Adjusts per-beneficiary limits to provide fair reimbursement to efficient agencies. The bill would increase the per beneficiary limit for agencies with limits under the national average to 90% of the national average in 1999, 95% in 2000, and 100% in 2001. The bill would also cap payments to providers at 250% of the national average in 1999, 225% in 2000, and 200% in 2001.

Provides exceptions to caps for agencies that specialize in a particular type of hard-to-serve patients AND for individual "outlier" patients. Agencies that can demonstrate to the Secretary that they specialize in treating a much more expensive population will be exempted from the 250% payment cap. All agencies could apply for quarterly "outlier" payments if they treated more costly than average patients. HCFA will also be required to report back to Congress regarding their implementation of the exceptions policy, to ensure that the provisions are implemented in a timely manner and that the relief is reaching agencies.

Increases the per-visit limit to 110% of the median.

Permanently repeals the 15% cut in IPS home health payments. The bill eliminates the 15% cut from the Interim Payment System.

Protects beneficiaries from inappropriate discharge. The bill provides Medicare beneficiaries with a notice of discharge similar to the one provided to Medicare+Choice hospital patients. It requires HCFA to provide information to physicians about how the IPS affects their patients.

Requires a GAO study on the value of home care to the Medicare program. The bill asks the Comptroller General to document the impact that providing home care (or not providing home care) has on other government spending, including Medicare inpatient services and Medicaid nursing home reimbursement.

50TH ANNIVERSARY OF AMERICAN
LEGION POST 273, MADEIRA
BEACH, FLORIDA

HON. C.W. BILL YOUNG

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 16, 1999

Mr. YOUNG of Florida. Mr. Speaker, I rise today to recognize the 50th anniversary of American Legion Post 273, in Madeira Beach,