

EC-9071. A communication from the Secretary of Transportation, transmitting, pursuant to law, the report of the Office of Inspector General for the period October 1, 1999, through March 31, 2000; to the Committee on Governmental Affairs.

EC-9072. A communication from the Office of Personnel Management, transmitting a draft of proposed legislation relative to the physicians comparability allowance program; to the Committee on Governmental Affairs.

EC-9073. A communication from the Department of the Interior, transmitting a draft of proposed legislation relative to the use and distribution of the Western Shoshone Judgment Funds; to the Committee on Indian Affairs.

EC-9074. A communication from the Corporate Policy and Research Department, Pension Benefit Guaranty Corporation transmitting, pursuant to law, the report of a rule entitled "Benefits Payable in Terminated Single-Employer Plans; Allocation of Assets in Single-Employer Plans; Interest Assumptions for Valuing and paying Benefits"; received May 18, 2000; to the Committee on Health, Education, Labor, and Pensions.

EC-9075. A communication from the Patent and Trademark Office, Department of Commerce transmitting, pursuant to law, the report of a rule entitled "Changes to Permit Payment of Patent and Trademark Office Fees by Credit Card" (RIN0651-AB07), received May 18, 2000; to the Committee on the Judiciary.

EC-9076. A communication from the Board of Governors of the Federal Reserve System transmitting, pursuant to law, the report of a rule entitled "Regulation P-Privacy of Consumer Financial Information" (Docket No. R-1058), received May 18, 2000; to the Committee on Banking, Housing, and Urban Affairs.

EC-9077. A communication from the Office of Thrift Supervision, department of the Treasury transmitting, pursuant to law, the report of a rule entitled "Privacy of Consumer Financial Information" (RIN1550-AB36), received May 18, 2000; to the Committee on Banking, Housing, and Urban Affairs.

EC-9078. A communication from the Federal Railroad Administration, Department of Transportation, transmitting a report entitled "Implementation of Positive Train Control Systems"; to the Committee on Commerce, Science, and Transportation.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Ms. SNOWE:

S. 2600. A bill to amend title XVIII of the Social Security Act to make enhancements to the critical access hospital program under the medicare program; to the Committee on Finance.

By Mr. ASHCROFT:

S. 2601. A bill to amend the Internal Revenue Code of 1986 to exclude from the gross income of an employee any employer provided home computer and Internet access; to the Committee on Finance.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. SNOWE:

S. 2600. A bill to amend title XVIII of the Social Security Act to make en-

hancements to the critical access hospital program under the Medicare Program; to the Committee on Finance.

CRITICAL ACCESS HOSPITAL ENHANCEMENT ACT

• Ms. SNOWE. Mr. President, I rise today to introduce the Critical Access Hospital Enhancement Act of 2000. This bill provides some much-needed program flexibility and refinements to the Medicare Critical Access Hospital Program.

Congress created the Critical Access Hospital Program three years ago when we passed the Balanced Budget Act of 1997 (P.L. 105-33). Under current law, a Critical Access Hospital must be located at a distance of over 35 miles from the nearest hospital; have emergency room and inpatient services provided by physicians, physician assistants and nurse practitioners; have fifteen or fewer inpatient beds; and inpatient stays must be limited to an average of 96 hours (four days).

The Critical Access Hospital program enables eligible rural hospitals to receive higher reimbursement rates for acute medical care. Through special allowances for staffing and reimbursements, designation as a Critical Access Hospital means that a community may be able to maintain local health care access which would otherwise be lost.

Many rural patients are Medicare and Medicaid participants and reduced reimbursements hit hospitals and medical centers hard: for example, two-thirds of the patients at Blue Hill Memorial Hospital in my home state of Maine are enrolled in Medicare or Medicaid. Designation as a Critical Access Hospital is especially important to these small, rural hospitals because it provides higher reimbursement rates.

To date, there are 165 hospitals across the country that have been designated as Critical Access Hospitals, and three in Maine: Blue Hill Memorial in Blue Hill, St. Andrews Hospital in Boothbay Harbor, and C.A. Dean Memorial Hospital in Greenville. Without the Critical Access Hospital program many small, rural hospitals—many of which are often the only point of care for miles—will be lost. My bill seeks to strengthen this program; it is my hope that with passage of the legislation I introduce today, more of our nation's small, rural hospitals will be able to participate in this valuable program.

This bill will bring increased flexibility and programmatic refinements to the Critical Access Hospital Program through the restoration of bad debt payments, extending cost-based reimbursement to ambulance and home health services associated with Critical Access Hospitals, and modifying the provisions related to swing bed and laboratory services. In addition, I propose including a seasonality adjustment for hospitals that are based in communities that experience large seasonal population fluctuations.

Rural residents are often poorer and more likely to lack private health insurance when compared with their urban neighbors. As a result, rural hos-

pitals disproportionately incur bad debt expenses. The BBA reduced bad debt payments for hospitals and the Health Care Financing Administration has interpreted this provision to apply to Critical Access Hospitals. My bill restores bad debt payments as a way to improve participation rates in the Critical Access Hospital program.

Emergency medical care is a crucial component in the Critical Access Hospital health care delivery system. Congress clearly stated that all outpatient departmental services furnished by Critical Access Hospitals should be reimbursed on the basis of reasonable costs, but HCFA has carved out ambulance services. My bill extends cost-based reimbursement to ambulance services associated with Critical Access Hospitals as it follows Congress's original legislative intent.

Critical Access Hospitals are often the sole sponsor of home health services in remote areas. If a Critical Access Hospital is the only home health provider in a rural community, then it would be useful to reimburse those services on the basis of reasonable costs. This bill will extend cost-based reimbursement to home health services associated with Critical Access Hospitals and will help maintain access to post-acute medical care for Medicare beneficiaries.

Critical Access Hospitals are currently required to comply with extensive minimum data set standards under the skilled nursing facility (SNF) prospective payment system (PPS). This bill will provide cost based reimbursement to swing bed services furnished by Critical Access Hospitals to help alleviate some of the administrative expenses associated with SNF PPS.

Laboratory services furnished by Critical Access Hospitals have historically been reimbursed on the basis of reasonable costs. In an attempt to clarify the statute and eliminate the collection of beneficiary coinsurance, the Balanced Budget Refinement Act (P.L. 106-113) that we passed last November inadvertently referenced the fee schedule. Consequently, HCFA has interpreted the provision to mean laboratory services now will be reimbursed at the fee schedule rate. Correcting this provision is critical to ensuring that Medicare beneficiaries have access to important laboratory tests, and my bill does just that.

Seasonal fluctuations can occur in places like coastal Maine where tourism swells the population in an area or in a small town near a ski resort. This seasonal population increase makes many otherwise tiny hospitals ineligible for the Critical Access Hospital Program. We must ensure that hospitals are available year round for a community's permanent population. It seems to me that if a hospital generally serves a community with a population of 2,000 but is seasonally faced with substantially much larger population, it should not de facto be made