and 58 percent of 80 percent of the ASC payment rate net of deductible: 58% (80% $585)	$271
Total	$477

In the first illustration, the hospital charged $1,000 and received a total payment of $702. If the hospital merely increases its charges to $1,300, it will receive $737. As the example shows, for a hospital that is paid based on the blend, the more it charges, the more its total payment (beneficiary plus Medicare program payment) will be. As a result, the current payment system gives an incentive for hospitals to increase charges.

(Note: In order to simplify the examples in this section, the blended payment method is shown as it would apply to an individual procedure. In determining actual payments to hospitals, however, the blended payment calculation is applied in the aggregate to all of the ASC approved procedures a hospital performed during a cost reporting period, not on a procedure-by-procedure basis.)

The same situation exists under the current blended payment methods for hospital outpatient radiology and other diagnostic services. We estimate that the magnitude of the formula-driven overpayment that occurs under the blended payment method to be over $950 million in Medicare program payments to hospitals in 1993—approximately 14.8 percent of total payments for these services. This total includes $350 million for ASC approved surgeries and $600 million for radiology and other diagnostic services, respectively. For surgical procedures, this represents 10.8 percent of total payments to hospitals and 20 percent of Program payments to hospitals for these outpatient services. For radiology, the formula-driven overpayment represents 19 percent of total payments to hospitals and 38.7 percent of Program payments. By FY 2001, we estimate the formula-driven overpayment for surgery, radiology and other diagnostic services to be $6.7 billion.

We believe that these formula-driven overpayments were not intended by the Congress. If Congress chooses to address this issue, it could be enacted either as a separate change or as part of a prospective payment system for outpatient services. It should be pointed out that, if a prospective payment method for outpatient surgery, radiology and other diagnostic procedures is adopted, this change would automatically occur for those services. Indeed, we recommend that the prospective rates be set so that aggregate payments to hospitals for these services are no higher than current law payments net of the total amount of the formula-driven overpayment.

TRIBUTE TO JOHN MOONEY

HON. WILLIAM O. LIPINSKI

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. LIPINSKI. Mr. Speaker, I pay tribute today to an outstanding individual who represents hundreds of thousands of Americans who participated in the battle that was the beginning of the end of Nazi Germany—the invasion of Normandy.

Mr. Mooney, who served in the 2d Armored Cavalry Division, was part of the wave of brave Allied soldiers that stormed the beaches and cliffs overlooking the English Channel on June 6, 1944. Even after the Allies established a beachhead, it took more than 2 months of fierce fighting before the risk of the Germans reversing the invasion had ended.

During the last 3 years, Mr. Mooney and thousands of his comrades have been honored by the Regional Council of Normandy with the Medaille de Jubile, a decoration commemorating the 50th anniversary of the Battle of Normandy and the beginning of the liberation of Europe.

Mr. Speaker, I would like to remind our fellow members and all freedom loving people in America and the world of the debt of gratitude we owe Mr. Mooney and the heroic soldiers, sailors and airmen whose efforts at Normandy marked the beginning of the end of Nazi tyranny.

HONORING DR. MENASCHE-LANIADO

HON. ELIZABETH FURSE

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Ms. FURSE. Mr. Speaker, I rise today to recognize a very special woman who provides dental care for Soviet Union students who are participants in the programs created from the Freedom Support Act.

It is an unfortunate reality that these students arrive in our country with staggering dental problems. Dr. Sandra Menasche-Laniado of Portland, OR, has quietly taken it upon herself to provide the vital care that these students require, asking for no monetary compensation.

As an example of her incredible unselfishness, she currently is treating one young lady whose dental treatment will come to the staggering total of $3,780.

Dr. Menasche-Laniado is truly the essence of one person making a difference. She points the way in demonstrating the virtue of compassion and turning this compassion onto a path of positive, meaningful action. I applaud her work, and I am privileged to have this opportunity to recognize Dr. Menasche-Laniado before this body.

CELEBRATING A CENTURY OF INTEGRITY

HON. NITA M. LOWEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mrs. LOWEY. Mr. Speaker, my distinguished colleagues, I rise today to call your attention to an important centennial anniversary that occurred in New York State last month.

On January 28, the New York State Society of Certified Public Accountants celebrated 100 years of distinguished service to the public.

In fact, the society is the oldest State professional accounting association in the Nation.

The founding members established the society to facilitate and support the establishment of the New York State CPA licensing law, the first such law in the United States.

The New York State Society of Certified Public Accountants represents the CPA profession, which was created to maintain the integrity of our Nation's capital markets.

The society has continuously served its members for 100 years by providing educational and professional information to enable them to better serve the public interest. Its code of conduct provides the framework for the highest ethical behavior and professionalism issues to protect the public interest.

The committees of the society have assisted state, local, and Federal regulators and other government groups in the discharge of their oversight of financial reporting, soundness, and integrity.

Please join me in wishing congratulations to the New York State Society of CPA's on its 100th anniversary.

INTRODUCTION OF THE MEDICARE HOSPICE BENEFIT AMENDMENTS OF 1997

HON. BENJAMIN L. CARDIN

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. CARDIN. Mr. Speaker, I rise today with my colleague, ROB PORTMAN, and more than 50 additional colleagues to introduce the Medicare Hospice Benefit Amendments of 1997. This legislation will make technical changes and clarifications to improve the Medicare hospice benefit. This is a noncontroversial bill that has true bipartisan support and should be included as part of Medicare reform this year.

Hospice care is a vital Medicare benefit. It is a coordinated program of palliative medicine and supportive services provided mainly in the home but also in home-like settings that provides for physical, psychological, social, and spiritual care for dying persons and their families. Services are provided by a medically directed, interdisciplinary team of professionals and volunteers. Hospice recognizes dying as part of the normal process of living and focuses on maintaining the quality of remaining life. Hospice affirms life and neither hastens nor postpones death.

The concept of hospice care emerged in this country in response to the unmet needs of dying patients and their families for whom traditional medical care was no longer effective, appropriate, or desired. Hospice has become an effective alternative to there being ''nothing else to do.'' The Nation's hospice programs currently provide compassionate care to more than 390,000 patients and families each year. In 1994, one out of every three people who died from cancer or AIDS were cared for by hospice. Terminally ill Medicare patients who elect hospice opt out of most other Medicare services related to their terminal illness and instead receive all of their care through the hospice program.

Hospice is not only a compassionate and appropriate form of care for terminally ill individuals, it is also cost effective. A 1994 Lewin study comparing the relative cost of hospice care to conventional care for Medicare beneficiaries with cancer, found that for every dollar Medicare spent on hospice patients, it saved $1.52 in Medicare part A and B expenditures. Based on these findings, the growth and greater utilization of hospice care should be viewed in a positive light and should be encouraged.

The Medicare hospice benefit was adopted by Congress 1982. Since then, more and

more Americans have chosen to receive humane and cost-effective hospice care. In recent years, it has become clear that certain technical changes are necessary in the Medicare hospice benefit not only to protect beneficiaries but to ensure that high quality and cost-effective hospice services continue to be available.

The Medicare Hospice Benefit Amendments of 1997, will make six technical changes to the Medicare hospice benefit.

First, the bill restructures the hospice benefit periods. Under current law, the patient's attending physician and the hospice medical director must certify that the patient electing hospice care in lieu of other Medicare services is terminally ill—defined as having a prognosis of 6 months or less to live if the illness runs its normal course. There are four benefit periods, with recertifications of terminal illness by the hospice physician at the beginning of each. The first two periods last 90 days, the third is 30 days, and the fourth is of unlimited duration.

If a beneficiary revokes a hospice election during a benefit period, the remaining days in that period are forfeited. This existing structure is especially troubling for patients who withdraw from hospice during the fourth hospice period because they then forfeit their ability to elect hospice services in the future. Thus, a patient who goes into remission and is no longer eligible for hospice because his or her life expectancy exceeds 6 months, is not able to return to hospice when his or her condition worsens. Our bill would correct this problem by restructuring the benefit periods so that there would be two 90-day periods, followed by an unlimited number of 60-day periods. This would also result in more frequent reevaluation of patients who outlive their original prognosis.

Second, our bill clarifies that additional Medicare services are available—in addition to those specifically required by the hospice rules—when these services are a necessary component of the plan of care. This amendment is consistent with current HCFA policy. The existing statute is ambiguous because the beneficiary must waive coverage under part B for most services when they are related to the terminal illness, but some items are not clearly listed as part of the hospice benefit. For example, diagnostic tests and radiation therapy are not listed in the definition of hospice care, but occasionally the hospice team may agree with the attending physician that these services are necessary to manage the patient's terminal illness. Our bill would ensure that the hospice would be able to provide the appropriate care and that beneficiaries would not be liable for the costs of that care.

Third, our bill amends the core services requirement to allow hospices to contract for physician services with independent contractor physicians or physician groups. HCFA has interpreted the existing statute as requiring a W–2 employer/employee relationship between the hospice and its medical director and other staff physicians. This raises corporate practice of medicine problems in some States, and it is increasingly difficult for hospices to recruit part-time physician employees as the trend toward physician groups continues.

Fourth, the bill allows waivers of certain staffing requirements for rural hospices to be granted. Some hospices in rural areas have difficulty becoming Medicare-certified because of shortages of certain professionals. Currently, approximately 80 percent of hospices are Medicare-certified or pending certification.

Fifth, our bill amends the so-called waiver of liability provisions to protect the beneficiary if a hospice claim is denied by Medicare because the terminal illness eligibility requirement allegedly was not met. While this bill does not reinstate the waiver of liability presumption under which providers with low error rates were paid before 1996, waiver of liability for hospice reasonable and necessary denials is still available on a case-by-case basis. This means that the hospice may appeal the denials and the beneficiary is not liable for payment. The same process and protection are needed for denials based on 6-month prognosis issues.

Last, our legislation allows HCFA to set documentation requirements for physician certifications. Currently, the statute requires that paperwork documenting the physician certification of a patient's terminal illness be completed within a certain number of days of the patient's admission to hospice. This bill will eliminate the strict statutory requirements and give HCFA the discretion, as it currently has with home health certifications, to require hospice certifications to be on file before a Medicare claim is submitted.

In summary, the Medicare Hospice Benefit Amendments of 1997 is very similar to the bill we introduced last year. The major difference is that we dropped a provision in the 1996 legislation to extend the presumption of the waiver of liability that CBO scored with a budget impact. Therefore, our new bill should be revenue neutral. This Medicare Hospice Benefit Amendments of 1997 is noncontroversial and is needed to ensure that we have a smoothly operating Medicare hospice benefit for our Nation's seniors. I look forward to working with my colleagues to enact this legislation in this Congress.

HONORING THE DEDICATED SERVICE OF BOB FERGUSON

HON. GLENN POSHARD

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. POSHARD. Mr. Speaker, I rise today to recognize the dedication and accomplishments of Mr. Bob Ferguson of Flora, IL. Born and raised in that community, Bob has devoted his entire life to helping his friends and neighbors in various capacities and has become the standard by which such service is measured. Last November Bob was named as the 1996 Citizen of the Year by the Flora Chamber of Commerce, and I would like to extend my congratulations in regard to this honor as well as my thanks for his years of selflessness.

Bob Ferguson understands the meaning of the word commitment. He exemplifies it, as his life has been a series of enduring relationships. After serving his country in the U.S. Navy, Bob married his wife Shirley in 1949 and has raised two daughters and been blessed with six grandchildren. He worked for the U.S. Postal Service for 32 years while also serving as Flora City commissioner for over 12 years. His list of achievements in the community is too large to list in its entirety, but a sampling of its diversity is telling: Assistant Bible school superintendent with the First Christian Church, original organizer and board member of the Flora Bank & Trust, a charter member of the Clay County Historical Society, member of the Flora Elks Lodge, the American Legion, the VFW, Freemasonry, Clay County Shrine Club, and other like organizations, and cochairman of the Clay County Red Cross financial drive. His willingness to help when asked and his ability as a fundraiser and civic leader should inspire everyone who does not think they can make a difference through volunteering. Not only did he participate on the behalf of numerous worthy causes, but he directed his special talents to make these efforts especially fruitful. A person's time and energy are often the most valuable gifts they have to give, and in Bob's case it has resulted in a profound impact on an immeasurable number of lives.

Mr. Speaker, as a public servant, I am extremely moved by the unselfish acts of others. Bob Ferguson is not only a good friend of mine and the entire 19th Congressional District of Illinois, but also an exemplary role model. I hope all of our citizens can follow his lead and look around them to see where they can make a difference. It is an honor to represent Bob in the U.S. Congress.

1–800 ''BUY AMERICAN'' LEGISLATION

HON. JAMES A. TRAFICANT, JR.

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 4, 1997

Mr. TRAFICANT. Mr. Speaker, I rise today to reintroduce legislation to establish a toll-free 1–800 phone number consumers can call to get information on products made in America. Similar legislation I authored was approved unanimously by the House in both the 103d and 104th Congress. Unfortunately, the other body did not act on the bill in either Congress.

My bill directs the Commerce Department to contract out the program to a private company. The toll-free number will provide consumers with information on products made in this country. The bill uses the same definition for an American-made product that the Federal Trade Commission uses in determining uses of ''Made in the USA'' labels. Only those products with a sale price of $250 or more would be included in the program. The bill would subject any companies providing false information to Federal penalties. One of the key components of my bill is that the program would be self-financed through the imposition of a modest annual registration fee on participating companies.

I want to emphasize that my bill will not require the Commerce Department to hire more people or create a new unit. The only expense to the Department would be to prepare language for the Federal Register and to prepare bid documents. Let me reemphasize that the program will be contracted out and run by a private company. All the program would do is provide American consumers with information on what products are made in America.

When making a big purchase, most Americans want to buy American. This program will help them make an informed and patriotic decision. I urge my colleagues to cosponsor this bill. The text of the bill is as follows: