MEDICARE BENEFICIARY ACCESS TO QUALITY HEALTH CARE ACT OF 1999

Mr. BAUCUS. Mr. President, I am speaking in support of the Medicare Beneficiary Access to Quality Health Care Act of 1999.

Congress faces historic choices in the next few weeks: managed care reform, campaign finance legislation, whether to increase the minimum wage, Comprehensive Test Ban Treaty. But the problem is, Congress is long on disagreement and short on time. In all my years of Congress, I have scarcely seen a more partisan and divisive atmosphere than that which prevails today.

One area where Congress appeared ready to act this year is in addressing changes to the Balanced Budget Act, otherwise known as BBA, of 1997. I am disappointed that we have not yet done so. Rural States such as Montana have long battled to preserve access to quality health care. I daresay that the State so ably served by the Senator from Maine, Ms. COLLINS, is in somewhat the same condition.

By and large, and against the odds, it is a battle we have generally won. Through initiatives such as the Medical Assistance Facility and the Rural Hospital Flexibility Grant Program, Montana and other relatively thinly populated States have providers who have worked diligently to give Medicare beneficiaries quality health care, but now these providers face a new challenge—the impact of BBA Medicare cuts.

From home health to nursing homes, hospital care to hospice, Montana facilities stand to take great losses as a result of the BBA. Many already have. One hospital writes:

Dear Senator BAUCUS:

The BBA of 1997 is wreaking havoc on the operations of hospitals in Montana. Our numbers are testimony to this. The reduction in reimbursements of $500,000 to $650,000 per year is something our facility cannot absorb.

Another tells me:

Senator BAUCUS: An early analysis of the negative impact to [my] hospital projects a decrease in reimbursements amounting to an estimated $171,200. My hospital is already losing money from operations and these anticipated decreases in reimbursements will cause a further immediate operating loss. If enacted and implemented, I predict that we will have no choice but to reduce or phase out completely certain services and programs. . . .

Home health agencies report to me that in a recent survey, 80 percent of Montana home health care agencies showed a decline in visits averaging 40 percent. Let me state that again. Of the home health care agencies in my State, 80 percent report a decline in visits averaging 40 percent. These are some of the most efficient home health care agencies in the Nation. It simply is not fair that they are punished for being good at managing costs.

As for skilled nursing care in Montana, I saw the effects firsthand in a visit to Sidney Health Center in the northeast corner of my State. A couple of months ago, I had a workday at Sidney. About every month, every 6 weeks, I show up at someplace in my home State with my sack lunch. I am there to work all day long. I wait tables. I work in sawmills. I work in mines—some different job. This time it was working at a hospital. Half of it is a skilled nursing home; the other half an acute care center.

At the skilled nursing center, I changed sheets. I took vitals. I worked charts. They even had me take out a few stitches. After a while, I felt as if I was a real-life doctor doing my rounds with my stethoscope casually draped around my neck. One patient actually thought I was in medical training; that is, until I treated that patient. They also had me read to about 20 old folks for about a half hour. I must confess that all but five immediately fell asleep.

At the end of the day, I had to turn my stethoscope in for a session with the administrators. The financial folks showed me trends in Medicare reimbursement over the last couple of years. They believe as I do, that the BBA cuts have gone too far.

So what do we do about it? Over the next few weeks, the Senate Finance Committee is likely to consider legislation to restore some of the funding cuts for BBA. Anticipating this debate, I introduced comprehensive rural health legislation earlier this year. The bill now has over 30 bipartisan Senate cosponsors.

Last week, I joined Senator DASCHLE and the distinguished ranking member of the Finance Committee, as well as Senator ROCKEFELLER, in support of a comprehensive Balanced Budget Act fix, a remedy to try to undo some of the problems we caused. The Medicare Beneficiary Access to Quality Health Care Act addresses problems the BBA has caused in nursing home care, in home health care, among hospitals and also physical therapy, as well as some other areas. In particular, I draw my colleagues' attention to section 101 of the bill.

Medicare currently pays hospital outpatient departments for their reasonable costs. To encourage efficiency, however, the BBA called for a system of fixed, limited payments for outpatient departments. This is called the outpatient prospective payment system, known as PPS. Thus far, it appears this PPS will have a very negative impact on small rural hospitals. HCFA estimates—the Health Care Financing Administration—that under this law, Medicare outpatient payments would be cut by over 10 percent for small rural hospitals. I don't have the chart here, but hopefully it is coming later. If you look at the chart, you will see some of the projected impacts on hospitals in my State.

Prospective payment is the system of the future, and Congress is right to use it where it works. But in some cases, prospective payment just doesn't work. Consider what happened with inpatient prospective payment about 15 years ago. In 1983, Congress felt, much as it does now, that Medicare reimbursements needed to be held in check. It implemented prospective payment for inpatient services. Enacting that law, it also recognized that for some small, rural facilities, there should be exceptions to prospective payment.

The basic reason is simple, because prospective payment is based upon the assumption that the efficient hospitals will do well and survive, and the nearby inefficient hospitals not doing well will fail, but that is OK because people can always go to the surviving efficient hospital. And the assumption, obviously, is invalid for sparsely populated parts of America because if there is a hospital in a sparsely populated part of America that fails under undue pressure because of reimbursement, there is no other hospital or health care facility for somebody in rural America. That is the essential failing in the assumption behind PPS.

Congress called these facilities ''sole community hospitals,'' and 42 of the 55 hospitals in my State enjoy that status—that is, the security of being named a sole community provider or medical assistance facility.

Section 101 of the bill we introduced last week would provide similar security for outpatient services, and it should be enacted right now.

Just last week, the health care research firm, HCIA, and the consulting firm, Ernst and Young, released a study showing that hospital profit margins could fall from their current levels of about 4 percent to below zero by the year 2002. We must act now to ensure that this does not happen.

I might say, however, time is running out. We are already in the midst of a 3-week stopgap measure to keep the Government running. If we don't sit down and iron out our differences soon, we risk going home not having acted on the BBA and not correcting this problem, which I think is irresponsible.

Despite the partisan atmosphere that has prevailed here over the last several months, Congress does have a record of success in dealing with important health care issues in a bipartisan way.

A few years ago, we passed the Health Insurance Portability Act to prevent people from losing health insurance when they change jobs.

In 1997, we worked together—Members of all stripes—in passing the Children's Health Insurance Plan, legislation to provide children of working families with health insurance. Just last week, children in my State started enrollment in that program.

With some common sense on both sides of the aisle and with fast action on the issue, Congress can come together to solve some of the problems caused by the so-called BBA of 1997. We ought to do so, and we ought to do it right now.

Mr. President, you might be interested in what some of the conditions of

the BBA 1997 are in the State of the Presiding Officer. In Maine, the hospital in Bangor would lose 24 percent of payments it would otherwise receive. Booth Bay Harbor would find about a 38-percent reduction. That is somewhat typical of hospitals of that size and in that situation around the country.

So I hope that at the appropriate time we can work with dispatch and expeditiously solve this problem before we adjourn.

Mr. LEVIN. Mr. President, I rise today in support of the Medicare Beneficiary Access to Care Act.

I have traveled around my State of Michigan and I have heard from all types of health care providers. I consistently hear one message: all health care providers, big and small, are reeling from the cuts mandated under the 1997 Balanced Budget Act (BBA).

When Congress passed the BBA, it was estimated that it would save $112 billion in Medicare expenditures. The Congressional Budget Office has reestimated those savings at $206 billion. It is clear that the BBA has gone further than we intended.

This bill addresses some of the problems the health care community is facing. The bill provides some measure of relief to providers by committing $20 billion dollars towards addressing some of the BBA problems.

Here are some of the bill's provisions:

Medicare currently pays hospital outpatient departments for their reasonable costs, subject to some limits and fee schedules. To create incentives for efficient care, the BBA included a prospective payment system (PPS) for hospital outpatient departments. HCFA expects to implement this system in July 2000. When implemented, it is expected to reduce hospital outpatient revenues by 5.7 percent on average. Michigan hospitals have told me that this payment system will reduce annual hospital payments for out patient services by $43 million for Michigan hospitals.

This bill would protect all hospitals from extraordinary losses during a transition period. Each hospital would compare its payments under the PPS to a proxy for what the hospital would have been paid under cost-based reimbursement. In the first year, no hospital could lose more than 5% under the new system. This percentage would increase to 10% in the second year and 15% in the third year.

Prior to the BBA, a hospital's inpatient payments increased by 7.7% if the hospital had one intern or resident for every 10 beds. This percentage was cut to 7.0% in 1998, and phased down to be set permanently at 5.5% by 2001. This bill freezes Indirect Medical Education (IME) payments at the current level of 6.5% for 8 years.

Due to concern that Medicare+Choice managed care plans were not passing along payments for Graduate Medical Education (GME) to teaching hospitals, the BBA carved out payments for GME and IME from Medicare + Choice rates and directed them to those hospitals. However, the carve out was phased in over several years. This bill contains a provision that would speed up the carve-out, ensuring that teaching hospitals get adequate compensation for the patients they serve.

Teaching hospitals are critically important to Michigan. There are 58 teaching hospitals in Michigan, which constitutes one of the nation's largest GME programs.

The BBA reduced disproportionate share hospital (DSH) payments by 1% in 1998, 2% in 1999, 3% in 2000, 4% in 2001, and 5% in 2002. This bill would freeze the cut in disproportionate share payments at 2% for 2000 through 2002.

The BBA created a prospective payment system (PPS) for skilled nursing facilities. There has been a concern that the PPS may not adequately account for the costs of high acuity patients. This bill includes a number of provisions to alleviate the problems facing skilled nursing facilities. Importantly, this bill repeals the arbitrary $1500 therapy cap that was mandated under the BBA.

The BBA mandated a 15% cut to home health payments. Last year Congress delayed this cut to October 2000. Our bill would further delay this 15% cut for two years. In addition, our bill creates an outlier policy to protect agencies who serve high cost beneficiaries.

The BBA phased out cost based Medicaid reimbursement for rural health clinics and federally qualified health centers but did not replace it with anything to assure that these clinics would be adequately funded. Our bill creates a new system for clinic payments.

In summary, these provisions are vitally important to the health care community of Michigan, both providers and beneficiaries. We cannot afford to allow our health care system, the best in the world, to decline.

DEPARTMENT OF TRANSPORTATION AND RELATED AGENCIES APPROPRIATIONS ACT, 2000—CONFERENCE REPORT

Mr. INHOFE. Madam President, I submit a report of the committee of conference on the bill (H.R. 2084) making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 2000, and for other purposes.

The PRESIDING OFFICER. The report will be stated.

The legislative clerk read as follows:

The committee conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2084) have agreed to recommend and do recommend to their respective Houses this report, signed by all of the conferees.

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of the conference report.

(The conference report is printed in the House proceedings of the RECORD of September 30, 1999.)

Mr. SHELBY. Mr. President, I am pleased that today the Senate has the opportunity to consider the conference agreement for the Fiscal Year 2000 Transportation Appropriations bill, and expect that we will reinforce the Senate's strong support for this legislation, which was passed just 18 days ago by a vote of 95 to 0.

The Transportation Appropriations bill provides more than $50 billion for transportation infrastructure funding, and for safe travel and transportation in the air and on our nation's highways, railroads, coasts and rivers. I am pleased that we have reached an accommodation between the House and the Senate Conferees on the Transportation appropriations bill. The House didn't win on every issue, the Senate didn't win on every issue, the Administration didn't get everything that they wanted—there was a fair amount of give and take on the part of all interested parties and I am confident that the result is a balanced package that is responsive to the priorities of the Congress and of the administration.

The 302(b) allocation was tight and constrained our ability to do some things that I would have liked to do—but we have stayed within the allocation agreed to by the House and the Senate and we have a bill that the Administration will sign. I believe this bill represents a balanced approach and a model for how appropriations bills should be constructed. It stays within the allocation, it stays pretty close to the budget request with the exception of denying new user fee taxes and making some firewall shifts that the authorizing committee objected to, it adheres to the commitment made in TEA–21 on dedicated funding for Highways and Transit, it provides adequate—but constrained—levels for FAA, it maintains a credible Coast Guard capital base and operational tempo, and it continues to focus on making further strides in increasing the safety of all our transportation systems.

At the same time, Chairman WOLF, Ranking Member SABO, the senior Senator from New Jersey and I have gone to great lengths to craft a bill that accommodates the requests of members and funds their priorities. Scarcely a day passes where one member or another does not call, write, or collar me on the floor to advocate for a project, a program, or a particular transportation priority for their state. I received over 1,500 separate Senate requests in letter form over the last six months. This bill attempts to respond to as many of those requests as possible.

As many of you know, the current fiscal constraints were especially felt in the transit account, where demand for mass transit systems is growing in every state, but funding is fixed by the TEA–21 firewall. I won't belabor that point other than to say we did the best we could under very difficult circumstances.