A committed civic and business leader, Mr. Weldon is currently a member of various boards including Empire State Funeral Directors Association, Metropolitan Funeral Directors Association, Harlem Junior Tennis League, and Vice President of LaGuardia Memorial House. He also serves as the Secretary of the Board of the Business Resource and Investment Service Center (BRISC) of the Upper Manhattan Empowerment Zone.

Active in the Harlem Business Alliance since 1987, he later served two terms as President. It was during those terms, that he led the organization into the forefront of economic development in Harlem and throughout New York City.

In 1995, I appointed George Weldon to the Uptown Partnership where he currently serves as its Chairman. The Partnership was convened to bring together the diverse business communities in the Upper Manhattan Empowerment Zone. He also serves on the Mayor's Harlem Task Force for Conflict Resolution.

A native of Harlem, Mr. Weldon served in the U.S. Army and is an Honorable Discharged veteran of World War II and the Korean Conflict. Upon leaving the Army, he attended the American Academy of Mortuary Science College where he graduated as a Licensed Funeral Director.

George Weldon has received numerous awards and citations for his service and commitment to the community including the Education Alumni Group of City College of New York (Business Educator of the Year), the Metropolitan Civic League (Martin Luther King, Jr. Award), and the New York Urban League (Building Brick Award).

Mr. Weldon is married and is the father of two children, both of whom have followed in his footsteps as Funeral Directors. He is also the grandfather of five.

In his own words: ''Let's not only leave our children a legacy of love, but a legacy of economic empowerment.''

THE INTRODUCTION OF ''THE MEDICARE, MEDICAID AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 2000''

HON. EDWARD J. MARKEY

OF MASSACHUSETTS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 27, 2000

Mr. MARKEY. Mr. Speaker, I am pleased to join with my friend and colleague, the Gentleman from Massachusetts, Mr. FRANK, the entire Massachusetts delegation in the House, and many of my other colleagues in the House in introducing the ''Medicare, Medicaid, SCHIP Balanced Budget Refinement Act of 2000.''

Mr. Speaker, in this era of unprecedented surplus, we must ask the question, ''Who's surplus is it?'' The answer is, ''it's the seniors' surplus.'' The legislation we are introducing today is closely modeled after legislation (S. 3077) recently introduced in the Senate, and will provide $40 to $50 billion over five years in additional Medicare and Medicaid payments to health care providers adversely affected by the cuts in the 1997 law, including hospitals, home health agencies, managed care plans, and nursing homes.

In 1997, seniors in our country were told that the price tag for Balanced Budget Act was going to be $115 billion. Even then, the Gentleman from Massachusetts (Mr. FRANK) and I thought that price was too high, and that was one of the principal reasons we voted against the bill. But today, we find ourselves in a situation where the actual cost of the BBA is turning out to be over $200 billion. In addition to the cost of the BBA doubling, Medicare spending is down sharply, increasing by just 1.5 percent in FY98, decreasing by 1.0 percent in FY99, and increasing just 1.5 percent in FY2000—well below the predicted growth rates for the program.

Mr. Speaker, we owe our seniors a refund. That's not too much to ask for the men and women who built this country. The 1997 Medicare cuts have harmed seniors, and I believe we should give this senior surplus back to the seniors to pay for their health care programs.

Congress is working on a package of Medicare givebacks this year to deal with the most critical aspects of the BBA cuts, a package that will cost about $21 billion. However, I am hopeful that as we move forward in the few remaining weeks of this session, that we will increase the price tag for this package. $21 billion is not going to be enough to get the job done.

Mr. Speaker, the following is a summary of the legislation, outlining specific areas of relief, such as community and teaching hospitals, skilled nursing facilities, home health care facilities, and Medicare HMOs, which I submit into the RECORD.

THE MEDICARE, MEDICAID AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 2000

We believe strong that Congress, in light of the projected budget surplus for the next five years, should provide substantial relief to health care providers hurt by the 1997 Balanced Budget Act. Today, we are introducing the House companion bill to S. 3077, the Balanced Budget Refinement Act of 2000.

THE FOLLOWING IS A SUMMARY OF THE KEY PROVISIONS OF THE LEGISLATION:

Hospitals: Significant portions of the BBA spending reductions have impacted hospitals. According to the Medicare Payment Advisory Commission (MedPAC), ''Hospitals' financial status deteriorated significantly in 1998 and 1999,'' the years following enactment of BBA. BBRA–2000 would address the most pressing problems facing hospitals by:

Fully restoring, for fiscal years '01 and '02, inpatient market basket payments to keep up with increases in hospital costs, an improvement that will help all hospitals.

Preventing implementation of further reductions in (IME) payment rates for vital teaching hospitals—which are on the cutting edge of medical research and provide essential care to a large proportion of indigent patients. Support for medical training and research at independent children's hospitals is also included in the Democratic proposal.

Targeting additional relief to rural hospitals (Critical Access Hospitals, Medicare Dependent Hospitals, and Sole Community Hospitals) and making it easier for them to qualify for disproportionate share payments under Medicare.

Providing additional support for hospitals with a disproportionate share of indigent patients, including elimination of scheduled reductions in Medicare and Medicaid disproportionate share (DSH) payments, and extending Medicaid to legal immigrant children and pregnant women, as well as providing State Children's health Insurance Program (SCHIP) coverage to these children.

Establishing a grant program to assist hospitals in their transition to a more data intensive care-delivery model.

Providing Puerto Rico hospitals with a more favorable payment rate (specifically, the inpatient operating blend rate) as MedPAC data suggests is warranted.

Home Health. The BBA hit home health agencies particularly hard. Home health spending dropped 45 percent between 1997 and 1999, while the number of home health agencies declined by more than 2000 over that period. MedPAC has cautioned against implementing next year the scheduled 15 percent reduction in payments. BBRA–2000 would:

Repeal the scheduled 15 percent cut in the home health payments, remove medical supplies in the home health prospective payment system (PPS), provide a 10-percent upward adjustment in rural home health payments to address the special needs of rural home health agencies in the transition to PPS. Security costs for high crime areas are also covered in this legislation.

Provides $500 million to care for ''outlier'', or the sickest and most costly, patients.

Clarifies the ''homebound'' definition allowing Medicare beneficiaries to attend adult day care, religious services or important family events while continuing to receive home health benefits.

Allows home health agencies to list telemedical services on their cost reports and orders HCFA to study whether these services should be reimbursable under Medicare.

Provide full update payments (inflation) for medical equipment, oxygen, and other suppliers.

Skilled Nursing Facilities (SNFs). The BBA was expected to reduce payments to skilled nursing facilities by about $9.5 billion. The actual reduction in payments to SNFs over the period is estimated to be significantly larger. BBRA–2000 would:

Allow nursing home payments to keep up with increases in costs through a full market basket update for SNFs for FY 2001 and FY 2002, and market basket plus two percent for additional payments.

Further delay caps on the amount of physical/speech therapy and occupational therapy a patient can receive while the Secretary completes a scheduled study on this issue.

Rural. Rural providers typically serve a larger proportion of Medicare beneficiaries and are more adversely affected by reductions in Medicare payments. In addition to the rural relief measures noted above (under ''hospitals''), BBRA–2000 addresses the unique situation faced in rural areas through a number of measures, including: a permanent ''hold-harmless'' exemption for small rural hospitals from the Medicare Outpatient PPS; assistance for rural home health agencies; a capital loan fund to improve infrastructure of small rural facilities; assistance to develop technology related to new prospective payment systems; bonus payments for providers who serve independent hospitals; ensuring rural facilities can continue to offer quality lab services to beneficiaries; and specific provisions to assist Rural Health Clinics.

Hospice. Payments to hospices have not kept up with the cost of providing care because of the cost of prescription drugs, the therapies now in end-of-life care, as well as decreasing lengths of stay. Hospice base rates have not been increased since 1989. BBRA–2000 would provide significant additional funding for hospice services to account for their increasing costs, including full market basket updates for fiscal years '01 and '02 and a 10-percent upward adjustment in the underlying hospice rates.

Medicare+Choice. This legislation would ensure that appropriate payments are made

to Medicare+Choice (M+C) plans. Expenditures by Medicare for its fee-for-service providers included in BBRA–2000 indirectly benefit M+C plans to a significant extent. Moreover, the legislation includes an increase in the M+C growth percentage for fiscal years '01 and '02, permitting plans to move to the 50:50 blended payment one year earlier, and allowing plans which have decided to withdraw to reconsider by November 2000.

Physicians. Congress understands the pressures that physicians face to deliver high-quality care while still complying with payment and other regulatory obligations. BBRA–2000 provides for comprehensive studies of issues important to physicians, including: the practice expense component of the Resource-Based Relative Value Scale (RBRVS) physician payment system, post-payment audits, and regulatory burdens. BBRA–2000 would provide relief to physicians in training, whose debt can often be crushing, by lowering the threshold for loan deferment from $72,000 to $48,000.

Beneficiary Improvements. House Democrats continue to believe that passage of a universal, affordable, voluntary, and meaningful Medicare prescription drug benefit is the highest priority for beneficiaries. In addition, BBRA–2000 would directly assist beneficiaries in the following ways:

Coinsurance: BBRA–2000 would lower beneficiary coinsurance to achieve a true 20 percent beneficiary copayment for all hospital outpatient services within 20 years.

Preventive Benefits: The bill would provide for significant advances in preventive medicine for Medicare beneficiaries, including waiver of deductibles and cost-sharing, glaucoma screening, counseling for smoking cessation, and nutrition therapy.

Immunosuppressive Drugs: The bill would remove current restrictions on payment for immunosuppressive drugs for organ transplant patients.

ALS: The bill would waive the 24-month waiting period for Medicare disability coverage for individuals diagnosed with amyotrophic lateral sclerosis (ALS).

M+C Transition: For beneficiaries who have lost Medicare+Choice plans in their area, BBRA-2000 includes provisions that would strengthen fee-for-service Medicare and assist beneficiaries in the period immediately following loss of service.

Return-to-home: The bill would allow beneficiaries to return to the same nursing home or other appropriate site-of-care after a hospital stay.

Part B penalty: The bill would limit the penalty for late enrollment in Medicare Part B.

Vision Services: The bill would allow beneficiaries to access vision rehabilitation services provided by Orientation and Mobility Specialists, Low Vision Therapists, and Rehabilitation Teachers.

Other Provisions. BBRA–2000 would address other high priority issues, including: improved payment for dialysis in fee-for-service and M+C to assure access to quality care for end stage renal disease (ESRD) patients; increased market basket updates for ambulance providers in fiscal years '01 and '02; an immediate opt-in to the new ambulance fee schedule for affected providers; and enhanced training opportunities for geriatricians and clinical psychologists. BBRA–2000 also The Act in addition includes important modifications to the Community Nursing Organization (CNO) demonstration project, and additional funding for the Ricky Ray Hemophilia program.

Medicaid and SCHIP. The growing number of uninsured individuals and declining enrollment in the Medicaid program are issues that also must be addressed. To improve access to health care for the uninsured and ensure that services available through the Medicaid and SCHIP programs are reaching those eligible for assistance, BBRA–2000 includes the following provisions:

Improve eligibility and enrollment processes in SCHIP and Medicaid.

Extend and improve the Transitional Medical Assistance program for people who leave welfare for work.

Improve access to Medicare cost-sharing assistance for low-income beneficiaries.

Give states grants to develop home and community based services for beneficiaries who would otherwise be in nursing homes.

Create a new prospective payment system (PPS) for Community Health Centers to ensure they remain a strong, viable component of our health care safety net.

Extend Medicaid coverage of breast and cervical cancer treatment to women diagnosed through the federally-funded early detection program.

Permit nurse practitioners and clinical nurse specialists to bill independently under State Medicaid plans, regardless of whether or not a physician or other health care provider is supervising.