event of a real oil-supply crisis, diminishing the ''psychological value'' of using the SPR again if Iraq makes good on implied threats to cut oil output, and undercut Saudi Arabia's cooperation with the U.S.

GREENSPAN'S CLOUT

And he took the unusual step of invoking Mr. Greenspan, whose prestige has increasingly been used to influence economic-policy issues far beyond his purview of monetary policy. The letter begins: ''Chairman Greenspan and I believe that using the Strategic Petroleum Reserve at this time, as proposed by DOE, would be a major and substantial policy mistake.''

I ask Members to consider the mechanical function of what has to take place. There are some people in this body who just assume you pull it out of SPR and, bang, it is there for the heating oil requirements of the Northeast Corridor, or it is there to relieve our pricing. It isn't. It is not a refined product. It has to be refined. It has to go to refineries. The refineries are operating at nearly full capacity, and when you pull it out of your reserve, it is like taking it out of your savings account. What do you do for an encore when the savings account is gone? We are certainly not going to replace SPR during this timeframe when oil prices are at an all-time high. We increase the vulnerability of the United States; we increase the potential for further increases in the price of oil.

There is one other point I want to make. The idea of a government-operated heating oil reserve, we don't really know what it means. But if I am in the business of storing heating oil, if I am a jobber in the Northeast and I know the government is going to store, I am not going to build up my reserve. Why should I? The government is going to take care of that. What does that do to the incentive of the private sector to build up reserves?

We have to think this thing through. I hope that the press will question the Vice President a little bit on the mechanics of what the net gain is. What does it do to our national security? Does it make us more vulnerable to OPEC? I also request the media to check on whether we have the authority or not—because the administration is begging us to pass EPCA, which gives us the authority, allegedly, to reauthorize the Strategic Petroleum Reserve. We have a lot of bits and pieces that we haven't taken care of.

It will be interesting to see what kind of explanation the American public is given because so often it is very easy to spin the story that the answer is SPR. Do you know what the administration is doing? They are buying more time, hopefully, to get through this election because that is the bottom line. We are heading for a train wreck on energy.

I will throw a little bit more water in my remaining 2 minutes, not on SPR but on the realization of what is coming in the second show. The second show is natural gas; $5.35 per thousand cubic feet, October, next month. It was $2.16 6 months ago. Inventories are 15 percent below last winter's level. We will not have any new supply this winter. Fifty percent of American homes rely on natural gas and nearly 18 percent of the Nation's electric power.

There we have it. The administration doesn't have a plan. We have introduced legislation to get this matter back on course, the bottom line, as Senator LOTT and a number of us have joined together in coming down with what we think is a responsible energy plan that would increase the domestic supply. It would increase certain tax benefits that would ensure that we have the incentive in order to relieve the supplies associated with the realization that the next crash is coming on natural gas.

I wanted to identify the specific mechanics associated with the issue of opening up the Strategic Petroleum Reserve and remind my colleagues that gas is right behind us in the crisis area, and the American taxpayer will bear the brunt of this. I hope the administration will rise to the occasion with some real relief.

I yield the floor.

The PRESIDING OFFICER (Mr. ROBERTS). The distinguished Senator from Pennsylvania is recognized.

(The remarks of Mr. SPECTER pertaining to the introduction of S. 3086 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

The PRESIDING OFFICER (Mr. BUNNING). The Senator from Texas.

Mr. GRAMM. Mr. President, it is my understanding that Senator BIDEN has time reserved to speak. He is not here. I ask unanimous consent that the Senator from Maine and the Senator from Kansas be recognized for 20 minutes; that if Senator BIDEN is here at that point, he then be recognized; and that I be recognized for 20 minutes when Senator BIDEN has completed his remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SPECTER. Mr. President, I have been advised that Senator BIDEN's schedule will not permit his arrival at this time, so I suggest holding his time in abeyance. I have no objection to the request by the Senator from Texas.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. I thank the Chair, and I thank the Senator from Texas for arranging the time this morning.

HOME HEALTH CARE SERVICES

Ms. COLLINS. Mr. President, Senate Republicans are committed to enacting legislation to preserve, strengthen, and save Medicare for current and future generations. It is also critical that Congress take action this year to address some of the unintended consequences of the Balanced Budget Act of 1997 which has been exacerbated by a host of ill-conceived regulatory requirements imposed by the Clinton administration. The combination of regulatory overkill and budget cuts is jeopardizing access to critical home health care services for millions of our Nation's seniors.

If one thinks about it, health care has really come full circle. Patients are spending less time in the hospital, more and more procedures are being done on an outpatient basis, and recovery and care for patients with chronic diseases and conditions increasingly takes place at home. Moreover, the number of older Americans who are chronically ill or disabled in some way continues to grow each year.

As a consequence, home health care has been an increasingly important part of our health care system, and I know the Senator from Kansas has been a very strong supporter of ensuring that these vital services are provided for our senior citizens. The kind of highly skilled and often technically complex services our Nation's home health care agencies provide have enabled millions of our most frail and vulnerable older citizens to avoid hospitals and nursing homes and receive care right where they want to be—in the comfort and security of their own homes.

In 1996, however, home health care was the fastest growing component of Medicare spending. This understandably prompted consideration of some changes as part of the Balanced Budget Act that were intended to slow the growth in spending to make the program more cost-effective and efficient.

Mr. ROBERTS. Mr. President, will the distinguished Senator from Maine yield for a question?

Ms. COLLINS. I will be happy to yield.

Mr. ROBERTS. First off, I thank the Senator so much for taking this time to draw attention to a very serious problem. I know the Senator from Maine is experiencing the same thing I am experiencing in Kansas and all Senators are experiencing when they go back home. Every hospital board—beleagured hospital boards—every hospital administrator, all of the rural health care delivery system—it is not only applicable to rural areas but all over—have been questioning me and our colleagues about when are we going to do something with regard to the Medicare reimbursement.

The Senator has indicated—I underlined it in the Senator's remarks:

It is also critical that Congress take action this year to address some of the unintended consequences of the Balanced Budget Act of 1997. . . .

We should have done it this spring. The Senator from Maine and I talked about it. We should have done it last year. We did certainly provide that assistance. I wish we could have done that earlier. We are going to do that.

Then the Senator also said:

. . . [and also some problems] which have been exacerbated by a host of ill-conceived regulatory requirements imposed by the Clinton administration—

And the folks at HCFA.

That is a marvelous acronym, HCFA. I will tell you what, if that is not a four-letter word in the minds and eyes of people who have to provide health care services throughout our country, I do not know what is. Asking HCFA for help, if you are a hospital board or a hospital administrator, is like asking the Boston strangler for a neck massage. It just does not work.

My question is this: as I recall, there was strong bipartisan support for these provisions, but haven't they produced cuts in home health care spending far beyond what Congress ever intended? It is my understanding—and I want people to understand this—home health care spending dropped $9.7 billion in fiscal year 1999, just about half of the 1997 amount; is that correct?

Ms. COLLINS. The Senator, as always, is entirely correct. I know how concerned he has been that inadequate reimbursements under Medicare, plus regulatory overkill by HCFA, are really jeopardizing the provision of care in our rural hospitals and our home health care agencies.

In fact, we know the Balanced Budget Act is already producing—or expected to produce—four times the savings that we intended when the 1997 Balanced Budget Act was passed. Moreover—and I know the Senator from Kansas shares my deep concern about this—looming on the horizon, believe it or not, is an additional 15-percent cutback in home health care reimbursements. That will put our already struggling home health agencies at risk. I know the Senator from Kansas shares my belief that it would, if allowed to go into effect, seriously jeopardize access to care for millions of our Nation's seniors.

The effects of these home health care cuts have been particularly devastating to the State of Maine. In Maine, I would inform my colleague from Kansas, nearly 7,500 Maine seniors have lost access to home health care due to the cutbacks and the regulatory overkill by HCFA.

Those 7,500 seniors did not get well. That is not why they lost their access to home health care. In fact, what has happened is some of them have been forced prematurely into nursing homes or they are at risk of increased hospitalization, which ironically costs the Medicare trust fund more money than if they were still receiving home health care. Some of them—and this is most tragic of all—are going without care altogether.

Cuts of this magnitude, particularly for the home health agencies in your section of the country and mine, which were historically low cost to begin with, cannot be sustained without ultimately adversely affecting patient care.

Mr. ROBERTS. Mr. President, will the Senator yield?

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. The same complaints are made in Kansas. The same complaints are made throughout the country. The home health care agencies in my State—in fact, since January of about 2 years ago, 68 Medicare-certified agencies in Kansas have closed their doors, more than a 25-percent drop, more than a quarter drop.

These were not the ''fly-by-night'' agencies that some in the Federal Government and others in regards to various inspections—and you have talked about that we have heard about so much—many of these agencies had been in existence for 20 years.

The latest numbers from HCFA show that the total home health care visits are down by over 45 percent—almost half. The losers of this situation are not just numbers. It is just not accounting in regards to, say, HCFA. These are our Nation's seniors; in particular, those who are really sick. We are talking about the Medicare patients who are suffering through complex and chronic care needs who are already experiencing a lot of difficulty in the home care services they need.

So the same thing is true in Kansas as the Senator has pointed out in Maine. I, obviously, think it is true in every State.

Ms. COLLINS. The Senator has, as always, summarized the situation exactly right. The real losers are the sickest seniors because what is happening is, because they are more expensive to treat, our home health agencies are turning away some of the more expensive patients because they simply cannot afford to provide them care.

I met recently with a group of very dedicated and highly skilled, compassionate home health nurses from the Visiting Nurse Service in Saco, ME. That is southern Maine's largest independent, not-for-profit home health agency. It performs more than 250,000 home visits per year.

During my discussions with these nurses, I heard absolutely hard-breaking stories of how recent cutbacks and regulatory restrictions have affected both the quality and the availability of home health services.

Let me tell my colleague of just one example the nurses related to me. Consider this case. It involves an elderly Maine woman who suffered from advanced Alzheimer's disease, pneumonia, and hypertension, among many other illnesses. She was bedbound, verbally nonresponsive, and had a series of serious health issues, including serious infections.

This woman had been receiving home health care for approximately 2 years, and that had allowed her condition to stabilize through the care and coordination of a skilled nurse. Unfortunately, the care provided to this patient abruptly came to an end when HCFA'S intermediary sent out a notice denying further home health care for this woman.

That is an example of the kinds of regulatory problems that the Senator was talking about.

Let's look at what happened in this case.

The fact is, it produced a tragedy. Less than 3 months later, this woman died. She died as a result of a wound on her foot that went untreated. Undoubtedly, the home health nurse would have caught that problem before it got out of control.

That is just one of the heart-wrenching stories that I have heard not only during that visit but in discussions with patients and health care providers throughout my State.

Mr. ROBERTS. Will the Senator yield?

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. The home health care agencies in my State, as I have indicated, also complain about their exacerbating financial problems. That is a very fancy word to say it has been made a whole lot worse by a host of the new regulatory requirements imposed by HCFA, including the implementation of another marvelous acronym called OASIS. The thought occurs to me, if there is an ''oasis'' that is proposed by HCFA—we all remember the ''Survivor'' show that was so popular—there would be no survivors in regards to this OASIS, I can tell you.

OASIS stands for the new outcome and assessment information data set—new outcome and assessment information data set—new requirements for surety bonds, new requirements for sequential billing, new requirements for overpayment recoupment, new requirements on a 15-minute reporting requirement. And all of this adds up.

I just concluded a 40-county tour in my State. I will go on another 65-county tour. At every stop was a hospital administrator. They said: I don't know who reads this stuff. I think they must weigh it somewhere in Kansas City—which is the regional center.

I am not trying to deprive from the purpose and the intent and responsibility that HHS and HCFA and OASIS have here, but it just seems to me that just about the time you have one requirement promulgated—there is another fancy word—then it is changed, and it is changed overnight. This is the kind of thing that a small rural hospital, or any hospital, just cannot put up with, with that very tight margin. We are down to the morrow of the bone.

Naturally, we are going to put in some money in regards to Medicare reimbursement, but this regulatory overkill is something that just has to stop.

Ms. COLLINS. The Senator is entirely correct. I could not agree with his point more.

What I heard from the home health nurses is not only do all these excessive regulatory requirements and paperwork cost a lot of money to the agency, but they detract from the time that otherwise would be spent caring for patients. Instead of focusing on patients, they have to complete paperwork. Indeed, at that visit in Saco, ME, that I mentioned, the nurses—to illustrate the OASIS paperwork which the distinguished Senator from Kansas has

just talked about—put it up all over the room. It covered the walls of the entire room. That was just one OASIS questionnaire.

Last year, I chaired a subcommittee hearing of the Permanent Subcommittee on Investigations. We heard about the problems that excessive regulation was imposing. We heard about the cash-flow problems that agencies across the country are experiencing.

One nurse from Maine, who runs a home health agency, terms HCFA's approach as being one of ''implement and suspend.'' In other words, HCFA requires these agencies to go through all these regulatory hoops to fill out all this paperwork and then says: Never mind. This really isn't what we meant.

Meanwhile, tremendous cost and energy has gone into complying with these burdensome regulations.

Mr. ROBERTS. Will the Senator yield again, please?

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. This OASIS business, in regard to all the complaints we have heard, as I have indicated—I think I ought to go into that a little bit more than explaining what the acronym is. OASIS is a system of records containing data on the physical, mental, and functional status of Medicare and Medicaid patients receiving care from home health agencies.

HCFA tried to implement OASIS as a tool to help the agency improve the quality of care and form the basis for a new home health care prospective payment system. The problem is—and my colleague chaired the subcommittee and asked all the very pertinent questions—the collection of data is so burdensome and expensive for agencies, it invades the personal privacy of the patients. It must be collected for non-Medicare patients as well as those served by Medicare.

Just yesterday, I learned that the whole OASIS information system in Kansas is not working; the computer system has failed. Agencies across the State are having a lot of difficulty in transmitting any kind of data. This burden is being felt by agencies all over the country. The question I have for the Senator is, Does she have any idea how long it takes? She has already spoken about this to some degree. Can we put a timeframe on it? Can we get more specific as to how long it takes for nurses to collect this information for HCFA? What does it cost in terms of nurse time?

Ms. COLLINS. I inform the Senator from Kansas that the testimony at my hearing indicated that it generally takes a nurse as long as 2 hours to complete these forms with one patient. The patients do not welcome this intrusive questionnaire in any way.

Mr. ROBERTS. I certainly agree with that. Will the Senator yield for another question?

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. The OASIS document includes an 18-page initial assessment that must be completed by a registered nurse and a 13-page followup assessment that is required every 60 days. This reminds me of a situation quite a few years ago, when the Department came out with a requirement that all Medicare patients would have to be reviewed by a doctor every 24 hours. At the time I said I was for that, stunning all of the health care folks in my district. I was in the House of Representatives then. I said: Surely, if they are going to require a 24-hour reporting requirement by a doctor, they will furnish us the doctor. There was sort of a method to the madness.

At any rate, as I have indicated, there is an 18-page initial assessment that must be completed by a registered nurse. A 13-page followup assessment is required every 60 days. This is on top of assessments already required by the State. That is very important. It isn't as if there is no regulatory function to safeguard the interests of the patients and the taxpayer. The paperwork burden is immense. I am curious about what is included in this assessment. Is the Senator aware of the nature of the questions?

Ms. COLLINS. Mr. President, this is one of the problems. The Senator from Kansas has put his finger right on it. OASIS collects information not only about the patient's medical condition or history, but about living arrangements, medications, sensory status—I am not even sure what that means—and emotional status as well. That raises a host of problems.

Mr. ROBERTS. Emotional status? I see that patients must answer questions about their feelings. Have they ever been depressed? Have they ever had trouble sleeping? Have they ever attempted suicide? In some cases, that might be necessary, but do we really think we need a nurse to bother a physical therapy patient for this information so that he or she can send the answers over computer to someplace in Baltimore—hopefully Kansas City, but probably in Baltimore?

Does the Senator from Maine have any idea how patients have reacted to this survey? Talk about emotional distress, if somebody were to ask me in a hospital what I felt or how would I feel, do I feel depressed, I think they would learn pretty doggone quick.

Ms. COLLINS. That has been the experience of the nurses in Maine, that the patients believe this is unnecessarily intrusive. We are not talking about patients, in these cases, who are receiving home health because of emotional problems. Obviously, those questions might be appropriate in some cases, but they are clearly not in these cases.

What the nurses explained to me is that the patients say: What does this have to do with what you are treating me for? The nurses expressed concern that this ''exercise of Olympian endurance'' inevitably elicits a negative response from their patients. That is a problem because that patient-nurse relationship is very important. It is a relationship that respects the confidentiality and the privacy of patients, or it should.

Unfortunately, the OASIS information mandated by HCFA immediately erects a barrier that is often difficult to overcome. There is one example I want to share with my colleague from Kansas, one 76-year-old Medicare patient about whom I was told was being treated for a wound to his left shoulder. The wound care and teaching provided by the home health nurse took approximately 30 minutes. Completing the OASIS form took an hour and a half. The patient understandably asked: What does all this have to do with my shoulder? A very common response.

Mr. ROBERTS. Will the Senator yield for another question?

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. I agree with my colleague. That is too much to ask. That is ridiculous. I also point out that the time filling out the forms would be much better used actually caring for the patients. There is an hour and a half that the nurse could have been doing that.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. ROBERTS. Mr. President, I ask unanimous consent for an additional 10 minutes.

Mr. WELLSTONE. Mr. President, I will not object, but with the indulgence of my colleagues, I ask unanimous consent to then be allowed to speak for 15 minutes of the Democrats' time?

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. ROBERTS. I thank my colleague from Minnesota. I will try to keep my remarks certainly more brief and more pertinent.

The point I was trying to make—I know that the same is true with regard to Texas—the Senator from Texas is here—and also Minnesota and Maine—is the time to travel great distances, many miles. Our health care providers spend an awful lot of time traveling from one patient's home to another. What happens is that the first patient may be located many miles away from the next patient. It requires the home health care nurse to work virtually nonstop to meet the deadlines required for the submission of the data to HCFA, which interferes with the personal care and the travel time. This is like 24-hour duty that is exacerbated by all of the data requirements.

Ms. COLLINS. Will the Senator yield on that point?

Mr. ROBERTS. Yes.

Ms. COLLINS. The Senator has spent a lot of time understanding OASIS. One of the complaints I have heard is that OASIS even requires, in some cases, the collection of data for non-Medicare patients; is that correct?

Mr. ROBERTS. I tell my distinguished friend that unfortunately that is correct. Any Medicare-approved home health agency must comply with all Medicare conditions of participation, including the collection of

OASIS. This means that patients who do not participate in Medicare are still subject to the Medicare assessment. That is exactly correct.

Last year, HCFA amended this regulation to say that these agencies don't have to transmit the data on non-Medicare patients for the time being. However, the agency still must spend the time making the assessment. So it is sort of a Catch-22. I am certainly sympathetic to the concerns raised by my constituents that these new regulations and spending cuts will harm, again, the senior. But aren't these policy changes necessary to achieve the Medicare saving goals established by the Balanced Budget Act, I ask my colleague?

Ms. COLLINS. As the Senator's rhetorical question implies, these are not necessary. The fact is that it now appears the savings goals set for home health have not only been met but far exceeded.

According to CBO, spending for home health care fell by 35 percent in 1999, and CBO cites the larger-than-anticipated drop in the use of home health services as the primary reason that total Medicare spending actually dropped, overall Medicare spending, by 1 percent last year. The CBO now projects that the post Balanced Budget Act reductions in home health care will be approximately $69 billion. That is over four times the $16 billion Congress expected to save. It is a clear indication that the cutbacks have been far deeper and far more wide reaching than Congress ever intended.

Mr. ROBERTS. Will my distinguished colleague yield for another question?

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. My colleague referred to—and I referred to it in my opening comments—the additional 15-percent cut across the board in these payments to go into effect on October 1, 2001. With regard to what she has just related to the Senate, given the savings that have already been achieved, the question is obvious, is this additional cut necessary?

I tell my colleagues and all those interested in this particular issue that last year we had to come up with an emergency bill. Nobody likes to do that.

We would prefer it to go through authorization and appropriations. Nobody likes to be faced with an emergency bill. This year is the same way. We are wrestling with that in terms of the budget caps we should live with. We are trying to figure that out. Here we are willing to provide more emergency money and we turn around and go through another 15-percent cut. It seems to me that is not conducive to what we are about with regard to consistency. What effect would that have with regard to home health care agencies?

Ms. COLLINS. A further 15-percent cut would be devastating. It would sound the death knell for those low-cost, nonprofit agencies in our States, which are currently struggling to hang on. It would further reduce our seniors' access to critical home care services. As we have discussed, we don't need to do it. We already have more than achieved the savings goals that were put forth in 1997.

Mr. ROBERTS. If the Senator will yield for an additional question, what are we going to do to help remedy this serious problem? I know the Senator has legislation, but would she summarize what she thinks is the answer to that.

Ms. COLLINS. The Senator from Kansas has been a strong supporter along with my colleagues, Senators BOND and ASHCROFT from Missouri, as well as many colleagues, in cosponsoring legislation introduced to eliminate the automatic 15-percent reduction in Medicare payments that would otherwise occur. It would provide a measure of financial relief for those home health agencies that already are cost-efficient and doing a good job. That is what we need to do—to pass that legislation before we adjourn.

Mr. ROBERTS. If I may ask one additional question, what kind of support do we have in the Senate? I think the magic number is 55. I would like for the Senator to tell our colleagues.

Ms. COLLINS. I am pleased to confirm to the Senator from Kansas that my legislation has strong support not only from the Senator from Kansas but many of our colleagues. It has 55 Senate cosponsors, including 32 Republicans and 23 Democrats, showing that this is a nationwide problem. It also has strong backing of many consumer and patient groups, including the American Diabetes Association, American Nurses Association, National Council on Aging, and the American Hospital Association. All of these groups have come together because they know that an additional 15-percent cutback would be absolutely devastating to American seniors and people with disabilities.

So if we allow this to go into effect, any of our other efforts to strengthen Medicare and home health, to help improve that benefit will really be meaningless.

Mr. ROBERTS. I have one final question. First, I thank the Senator from Maine for all her leadership and her hard work in this effort, for tapping not so gently on the shoulders of the leadership and, in a bipartisan way, attracting all sorts of support for this bill. I believe it is possible for Congress to bring this much needed relief to the home health care industry, as well as to the small rural hospitals and the teaching hospitals that are feeling the pinch of all these regulatory and legislative changes made in the last few years—with every good intent.

But this is the law of unintended consequences personified. We must work quickly. Time is of the essence for many of our home health agencies and hospitals, especially the small rural providers. I don't want to have to go out again on a 105-county listening tour in Kansas and have people come and say; Senator ROBERTS, thank you so much for your past help on a whole litany of things we have gone through regarding the home health care delivery system, only to find out that their doors may close.

I will continue to work with my colleague from Maine to pass legislation before Congress adjourns this year. We have a good team and we have good support. We cannot go home without providing help. I thank the distinguished Senator for her leadership in heading up a home health care posse for fairness and justice.

Ms. COLLINS. I thank the Senator from Kansas for his kind comments and his strong support and leadership. He clearly understands the issues involved. Time is of the essence. I appreciate the opportunity to discuss this issue this morning.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Ms. LANDRIEU. Mr. President, I ask unanimous consent that after my 5 minutes of remarks Senator WELLSTONE and Senator HARKIN be recognized.

Mr. GRAMM. Mr. President, does that reserve my 20 minutes?

The PRESIDING OFFICER. The Senator's 20 minutes is not affected by this request.

Ms. LANDRIEU. Is it the understanding of the Senator from Texas that after I speak Senator HARKIN and Senator WELLSTONE will speak immediately after me? I am under the impression that we have about 20 or 30 minutes on our side.

The PRESIDING OFFICER. The total is 25 minutes.

Mr. GRAMM. As I understand the schedule of the Senate, I think there would be no problem, as long as it didn't exceed 30 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. LANDRIEU. Mr. President, I thank the Senator from Texas. I will be very brief, and then Senator WELLSTONE will need about 10 minutes.

I thank my colleagues from Maine and Kansas for taking time to speak on the floor about such an important issue as health care. As we wrap up this session, I am very hopeful, in a bipartisan way, we can address specifically many of the questions that were raised in terms of the tough situation facing our home health care agencies and hospitals, our rural health clinics. It is something this Congress must address in the last few weeks. I thank them for their leadership.

CONSERVATION AND REINVESTMENT ACT

Ms. LANDRIEU. Mr. President, I come to the floor to say a brief word about an extraordinary and very positive statement that the President of the United States made in the last 45