patient ''case-mix''—or level of patients with similar conditions (from minor to severe). Therefore, it is hard to believe that high costs must be protected by the current IPS agency-specific formula when VNAs and other cost-efficient agencies provide high quality care to diverse populations at less than national average costs.

Mr. Speaker, I urge my colleagues to join me in restoring home health care equity by cosponsoring this important legislation.

PERSONAL EXPLANATION

HON. GERALD D. KLECZKA

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 26, 1998

Mr. KLECZKA. Mr. Speaker, on Wednesday, March 25, 1998, I was granted an Official Leave of Absence to attend a family funeral.

As an elected Representative of Wisconsin's Fourth Congressional District, I have responsibility to my constituents to inform them of the votes from yesterday and to apprise them of how I would have voted.

The following indicates how I would have voted on Rollcall Votes Nos. 68, 70 and 71.

Rollcall No.	Bill No.	Position
68	H.R. 2589 (McCollum Amdt.)	No
70	H.R. 2578 (Pombo Amdt.)	Yes
71	H.R. 2578	Yes

The outcome would have been no different on any of these votes if I had been present.

RESTORE FAIRNESS TO MEDICARE'S HOME HEALTH CARE SYSTEM

HON. CHRISTOPHER H. SMITH

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 26, 1998

Mr. SMITH of New Jersey. Mr. Speaker, today I am joining with my good friend and colleague, Rep. MIKE PAPPAS, in introducing legislation to restore fairness and equity to the Health Care Finance Administration's (HCFA's) new Medicare reimbursement program for home health care.

This new Medicare reimbursement program, known as the ''Interim Payment System'' (IPS), is based on an incomplete and inequitable funding formula which directly jeopardizes home health care agencies and the elderly they serve in my state.

The value of home health care is obvious. All of us intuitively know that enabling our seniors to receive quality, skilled nursing care in their own homes is preferable to other, more costly, sometimes isolated, settings. Senior citizens receive the peace of mind from familiar settings and their loved ones close at hand. And the cost savings to Medicare from proper use of home health care are considerable.

The legislation we have introduced today corrects several flaws contained in the IPS formula and assures fair and reasonable Medicare reimbursement for quality home health care. This bill is a good complement to another legislative effort (H.R. 3108) I am supporting with fellow New Jersey Representative JIM SAXTON. The Pappas-Smith bill is more targeted and limited in scope, focusing on equity issues between home health care agencies, while H.R. 3108 is broader in application and primarily deals with providing more resources to all home health agencies.

One thing that both bills address, however, is the need to reform the IPS. If left unchanged, the IPS will cut Medicare reimbursement for home health care in New Jersey by $25 million in fiscal year 1998 alone. Several agencies in New Jersey could lose $2 million or more in anticipated reimbursement for homebound Medicare patients.

One of the most unfair aspects of the IPS is that it seeks to treat efficient and inefficient home health agencies alike, despite the fact that average utilization rates in New Jersey's agencies—43 visits per beneficiary served in 1996—are far lower than the national average of 74 visits that year.

Because the IPS reimbursement rates for each home health care agency are linked to earlier utilization rates and costs, agencies that were efficient and honest all along still find themselves struggling to squeeze another 12 to 15 percent reduction in aggregate reimbursement rates from already lean operations—a very tall order indeed. Meanwhile, agencies in other parts of the country with abnormally high home health costs and utilization rates are permitted to use base year utilization rates that were badly inflated in the first place. Thus, they will continue to receive high reimbursement rates because they had inflated costs in the past. The IPS, therefore, effectively punishes efficient operations and does not comprehensively address the problem in areas with inordinately high home health utilization statistics.

For example, home health agencies serving senior citizens in NJ will only receive enough funding to provide as few as 30 to 35 visits per patient. Meanwhile, agencies in other parts of the country—such as Tennessee and Louisiana—may continue providing their patients with almost triple that number of visits at twice the cost per visit. Disparities of this magnitude are inherently unreasonable and unfair, and must be corrected.

There is no reason whatsoever why the senior citizens of New Jersey should receive less quality care than senior citizens of any other state. While I understand that special circumstances in other states and counties will always generate some variation in home health car usage, the disparities that are enshrined in the IPS are simply absurd. Are Louisianans and Tennesseans that much sicker or that much more frail that they need to receive 100 or more visits per person? And how can the costs of treating these patients in other states be significantly higher than New Jersey? The wage rates and cost of living indexes in many of these high utilization states are among the lowest in the entire nation. Senator JOHN BREAUX stated that in Louisiana, there are more home health car agencies than there are McDonalds restaurants. Clearly, something is amiss.

In response, our bill—which we have strived to craft in a budget neutral manner—restores fairness and equity to the Interim Payment System in the following ways:

First, our bill will protect efficient home health agencies from drastic cuts in Medicare home health reimbursement through the IPS. Under our legislation, we provide relief from the Interim Payment System for those home health care agencies whose average cost per patient served, as swell as their average number of visits per patient, are below the national average. In this manner, agencies that have been doing a good job in keeping their cost structures under control will not be punished for their own best efforts.

The second provision contained in our bill restores the per visit cost limits for home health agencies to their September 1997 levels. The reason for this change is based on an assessment that unless this change is made, it will be virtually impossible for home health agencies to reduce their average number of visits per patient, and still live within their cost limits.

The provision is a matter of basic math: if an agency is to reduce its average number of visits per patient—as HCFA demands—it must do more with each visit. However, if an agency fits more activities and services into each visit, then by definition its costs per visit are going to rise significantly. So while the number of visits per patient will fall, its costs per patient will rise to some extent, because more services are being performed in an attempt to make the most out of each home health visit.

Under our bill, home health agencies will reduce their visits per patient and still operate within realistic per visit cost limits. HCFA's per visit cost targets, upon close examination, are unrealistic and will not allow home health agencies to accomplish the goal of more efficient home care.

Lastly, our legislation will give the Secretary of Health and Human Services the flexibility to make special exceptions for home health agencies treating unusually expensive patients. Among the problems with the IPS is that as initially implemented, the IPS gives providers a perverse incentive to avoid treating critically ill, chronic, or more expensive patients. Unlike a fully implemented prospective payment system (PPS), the Interim Payment System (IPS) makes no attempt to distinguish between agencies that are simply inefficient and agencies that are treating a disproportionately sicker patient population. Our legislation creates a mechanism for financially pressed home health care agencies to address and care for unusually expensive patients.

Mr. Speaker, this legislation is balanced and carefully crafted to make improvements to the Medicare Interim Payment System. It is designed to be budget neutral. It will enable our senior citizens to continue to receive high quality, medically necessary home health care services. It also will appropriately target federal efforts to reduce waste and fraud in the Medicare program. I urge all of my colleagues to consider this legislation and support our efforts to protect the homebound Medicare patients who are now at risk.

HONORING THE JEWISH HERALD-VOICE

HON. KEN BENTSEN

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 26, 1998

Mr. BENTSEN. Mr. Speaker, I rise to congratulate the Jewish Herald-Voice as it celebrates 90 years of uninterrupted weekly publication on April 1, 1998. Established in 1908,