approve a crucial $5 million increase in the Bank's Administrative budget that will enable the Bank to modernize its computer systems and to maintain its commitment to have Hongkong to help American businesses sell overseas. This modernization is absolutely necessary at this time to ensure that the Bank is Y2K compliant. New systems and personnel will also help the bank reduce turn-around time on decisions for both small and large U.S. exporters.

The gentleman's amendment would prohibit the Bank, as well as the Overseas Private Investment Corporation and the Trade Development Agency, from entering into any new obligations. This extremely dangerous amendment plays right into the hands of our European and Asian competitors, who will not cease to subsidize and finance the deals that their companies make simply because we will have chosen to do so; rather, this amendment will make it even more difficult for American exporters to compete in the combative worldwide marketplace, cutting U.S. jobs in the process.

This amendment may save a few dollars, but I assure my colleagues that the costs in lost exports and lost jobs far outweigh any savings we may incur. I urge my colleagues to fight to preserve American jobs and vote against this amendment.

IN SUPPORT FOR THE PATIENTS’ BILL OF RIGHTS

HON. EARL POMEROY
OF NORTH DAKOTA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 3, 1999

Mr. POMEROY. Mr. Speaker, today I am signing the discharge petition for the purpose of forcing floor consideration of the Patient's Bill of Rights. I have held back from this action before this time out of my expectation the House Speaker would have brought this issue—if not this bill—forward before the August recess. I am disappointed the majority leadership has broken its promise to have House action on this matter this week. The Senate has acted. The American people want Congress to act. Because the indefinite House delay is irresponsible and very unfortunate I am signing the discharge petition. I hope all minority members who have yet to sign will join me in this action. I further hope that we will be joined by a sufficient number of Republicans who understand that it is time to act, in order to finally force House action on this issue.

EXPLANATION OF OMNIBUS LONG-TERM HEALTH CARE ACT OF 1999

HON. FORNEY PETE STARK
OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 3, 1999

Mr. STARK. Mr. Speaker, Representative Markey and I have introduced the Omnibus Long-Term Health Care Act of 1999. We are joined by Representatives McGovern, McDermott, Moakley, Oliver, Capuano, and Gordon.

The following is a detailed outline of the provisions of this legislation. We invite members of the House to join us in cosponsoring this legislation. We invite my colleagues to suggest refinements and additions to the legislation to make it more comprehensive, workable, and effective legislation to help the millions of Americans facing the problems of obtaining quality long-term health care.

TITLE I: LONG-TERM CARE/GIVER TAX CREDIT

Title I of the bill provides a $1000 tax credit similar to the one described by the President in his State of the Union address. Our proposal has several notable differences. First, our tax credit is completely refundable, and there is no distinction between care for an adult or a child. If the credit is not refundable, it will fail to help those families in greatest need of help.

To be honest, $1000 is not that much money for long-term care, but it does provide a family with modest relief that they can use as they see fit. That is why we have structured the bill to ensure as much need the support will receive the refund.

Another important distinction between our proposal and the President's is the treatment of children with long term care needs. The President's proposal would limit the tax credit to $500 for children with long term care needs. We do not agree with this policy. The long-term care needs of a disabled child are just as expensive and emotionally and troubling as they are for an adult.

Our legislation also has a broader definition of individuals with long-term care needs. The President's proposal includes individuals who require assistance in to perform activities of daily living (bathing, dressing, eating, continence, toileting, and transferring in and out of a bed or chair). This is a good start but does not include people with severe mental health disabilities or developmental disabilities who cannot live independently.

Finally, our legislation limits the amount of the refund for the wealthy, not the poor. In our bill, reductions in the refund begin at the upper income levels, not the lower income levels. The full refund is available up to income of $110,000 for a joint return, $75,000 for an individual return, and $55,000 for a married individual filing a separate return. Above these levels, the refund is decreased by $50 by every $1,000 over the threshold level.

TITLE II: LONG-TERM CARE MEDICARE IMPROVEMENTS

Title II of the legislation addresses a range of reforms and improvements to Medicare benefits. The goal of this title is to provide adequate long-term coverage to patients with chronic health care needs. We believe that we can adjust Medicare benefits so that people can continue to live in their homes and communities, and enjoy the contact with their families and friends. These proposals are cost effective as they rely on services in facilities other than hospitals and skilled nursing facilities, and allow people to continue to live in familiar surroundings with their family.

LONG-TERM BENEFITS

The first section extends Medicare Home Health Aid-Type services to chronically dependent individuals. This section establishes a new "long-term" home health benefit to maintain people with chronic conditions at home rather than in more expensive settings. Many people can no longer take care of themselves because physical or mental disabilities impair their ability to perform basic activities of daily living (ADLS), including eating, bathing, dressing, toileting, transferring in and out of a bed or chair, and continence. These are activities that we all take for granted. The inability to do any of these independently is distressing for the patient and a clear indication of the extent of the impairment.

This provision allows individuals who suffer from a chronic physical or mental condition that impedes two or more ADLS to receive in-home care. To help contain costs, the provision would require competitive bidding of these services.

ADULT DAY CARE

The second section of this title's reforms is a provision for Medicare Substitute Adult Day Care Services. This provision would incorporate setting services to the current Medicare home health benefit. The provision allows beneficiaries to substitute any portion of their Medicare home health services for care in an adult day care center (ADC). Adult day care centers provide effective alternatives to complete confinement at home. Many States have used Medicaid funding to take advantage of ADCs for their patients.

For many, the ADC setting is superior to traditional home health care. The ADC can provide skilled therapy like the home health provider. In addition, the ADC also provides rehabilitation activities and meals for the patients. Similarly, the ADCs provide a social setting within a therapeutic environment to serve patients with a variety of needs.

To achieve cost-savings, the ADC would be paid a flat rate of 95% of the rate that would have been paid for the service had it been delivered in the patient's home. The care would include the home health benefit and transportation, meals and supervised activities. As an added budget neutrality measure, the title allows the Secretary of Health and Human Services to reduce the payment rate for ADCs if growth in those services is greater than current projections under the traditional home health program.

This program is not an expansion of the home health benefit. It would not make any new people eligible for the Medicare home health benefit. Nor would it expand the definition of what qualifies for reimbursement by Medicare for home health services. This legislation recognizes that ADCs can provide the same services, at lower costs, than traditional home health. Further, the legislation recognizes the benefits of social interaction, activities, meals, and a therapeutic environment in which trained professionals can treat, monitor, and support patients.

The legislation also includes important quality assurance and anti-fraud protections. In order to participate in the Medicare home care program, ADCs must meet the same standards set for home health agencies. The only exception is that the ADCs would not be required to be "primarily" involved in the provision of skilled nursing services and therapy services. The exception recognizes that ADCs provide services to an array of patients and that skilled nursing services and therapy services are not their primary activity.
Here is an example of how the system would work. A physician prescribes home care for the patient. Next, the patient and his or her family decide how to arrange for the services. They could choose to receive all services through home care, or choose a mix of adult day care and home care services. Therefore, if the patient required three physical therapy visits and two home health aide visits, the patient could receive the physical therapy at the ADC while retaining the home health aide visits. When the patient goes to the ADC, he or she will receive the physical therapy and other benefits the ADC provides. All of these services would be incorporated into the payment rate of 95% of the home setting rate for the physical therapy service. This plan offers a savings for Medicare and an improved benefit to the patient.

3. HOME HEALTH CARE MANAGERS

The third section of this title makes a number of improvements in the quality of services provided through home care. First it establishes a group who will oversee the provision of home health care. This section of the legislation will ensure that those in need of long-term health care will receive necessary and cost effective care.

The Balanced Budget Act of 1997 (BBA) implemented a number of policies designed to slow the growth of a health benefit that was doubling in cost every three or four years. Prior to the BBA, the incentive to home health agencies was to over-use services to boost profits. In the BBA's prospective payment system (PPS), the incentive will be the opposite, and there are real concerns about potential under-utilization of services. The Medicare Home Health Care Manager legislation would ensure that an independent case manager evaluates the patient's needs and service level. The case manager will be financially independent of the home health agency and would be paid through a Medicare fee schedule, independent of the amount or type of care the patients receive. The legislation would also provide the Health Care Financing Administration (HCFA) with the flexibility to make more effective use of reimbursement home health case managers on a competitively bid basis.

This type of case manager program is endorsed by the Medicare Payment Advisory Commission (MedPAC), a Commission appointed by Congress to provide expert advice on Medicare and Medicaid policy. In their March 1998 report to Congress they recommended that such a case manager be adopted for the home health benefit. Their report states:

Such an assessment would help to minimize the provision of services of marginal clinical value, while ensuring that patients receive appropriate care. Requiring case management of long-term home health users who could improve outcomes for individuals with long-term home health needs and at the same time slow the growth of Medicare home health expenditures. (Emphasis added)

In addition, there are real-life examples of case management that have saved money and improving care. For example, Maryland's Medicaid program has a high cost user initiative which in FY 96 saved the state $3.30 for each $1 spent—a savings of 230%. The Health In-
Currently, 1.6 million elderly live in skilled nursing facilities. These people are among the sickest and most vulnerable segment of the population. A major portion of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) brought sweeping reforms to the nursing home industry. That legislation did much to improve and ensure the quality of health care provided in skilled nursing facilities. Fortunately, the majority of skilled nursing facilities responded well to these changes and continue to offer quality care for their patients. Unfortunately, a sizable minority of skilled nursing facilities continues to place profits ahead of quality care. Because of the continued failure of these providers, we must give the states and health care regulators the legal tools to bring these providers into line or remove them from the system.

This title provides several important modifications and additions to the OBRA-87 legislation. First, all skilled nursing facilities will be required to conspicuously post in each ward of the facility a list of the names and credentials of the on-staff employees directly responsible for resident care and the current ratios of residents to staff. This simple requirement will allow families and the nursing home ombudsman program to determine whether the facility provides adequate staff to attend to the residents’ needs. In addition, the legislation would direct the Secretary of Health and Human Services to issue guidelines for adequate staffing for skilled nursing facilities.

The second provision of this title gives states alternative punitive measures to use with repeatedly noncompliant nursing facilities. One of the distressing trends identified in the GAO report is a phenomenon they describe as a “yo-yo” effect. A nursing facility will correct the problem and avoid the fines or penalties. Once found to be in compliance, the facility will slip back and provide substandard services until cited again by regulators.

Our proposed legislation offers two fixes. First, the legislation would allow states to require the expense of resurveying and re-inspecting the skilled nursing facility where there has been a substantial violation of the regulations. Second, the legislation would prohibit the facility from including the costs of the resurveying and reinspection in its reasonable costs figures. In other words, they cannot pass the bill of rectification onto Medicare or Medicaid. This proposal is a clear financial disincentive for homes to practice a yo-yo management and adds an important regulatory tool for the states.

The third major initiative in our legislation is the requirement of criminal background checks. Skilled nursing facilities would be required to conduct a criminal background check of all employees and would be prohibited from hiring any person who has been convicted of patient or residence abuse. This portion of the legislation makes clear that we do not want felons who have a history of abusing others working with one of the most vulnerable groups of people in the nation.

Finally, the legislation requires skilled nursing facility reporting to the state when an employee has harmed a patient or resident. The legislation calls for revising the current Nursing Aide Registry. Under our legislation, the new name of the data base will be the Nursing Facility Employee Registry and will list any nursing facility employee who has been convicted or had a finding of abuse or neglect of a patient.

EXTENSIONS OF REMARKS

August 3, 1999

Title seven also protects the future retirement income of caregivers who leave their employment to offer long-term care. This title does two things. First, it ensures that caregivers will continue to receive their Social Security credits while they are caregivers. Second, while the caregiver is unemployed he or she will be credited with the arithmetic average of his or her previous three years of employment as a contribution to income.

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 2000

SPÉECH OF

HON. LORETTA SANCHEZ
OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Monday, August 2, 1999

The House in Committee of the Whole on the State of the Union had under consideration the bill (H.R. 2006) making appropriations for foreign operations, export financing, and related programs for the fiscal year ending September 30, 2000, and for other purposes:

Ms. SANCHEZ. Mr. Chairman, today the House considered the Foreign Operations Appropriations Bill for fiscal year 2000. One issue of great concern to me was the absence of funding for the Community Adjustment and Investment Program (CAIP) in this appropriations bill. The CAIP is a way of helping communities that are negatively impacted by NAFTA.

With NAFTA came hard times for many areas around the country. Businesses moved operations to Mexico, leaving thousands of Americans without jobs and many communities in economic distress.

The CAIP program allows NAFTA affected communities to receive funding for job training and investment capital for job creation. Providing workers with the skills to acquire new jobs, and providing the communities with the funding to establish new enterprises, will help to bolster the economies of many NAFTA-impacted areas. President Clinton understood this when he requested that the CAIP receive $17 million in his fiscal year 2000 budget.

NAFTA was supposed to increase economic prosperity for everyone involved in this agreement. The least we can do in Congress is to make sure that those American workers who were negatively impacted by NAFTA have a chance to succeed as well. The CAIP is a program which helps to achieve that goal.

I am hopeful that my colleagues will realize the importance of CAIP and ensure that it will receive funding when this bill goes to conference.