

not a consensus around this issue. Senator SNOWE and I got 54 votes—a majority in the Senate—to join us in a funding plan for a prescription drug program. I am of the view that we cannot afford not to cover prescription drugs because so many of these prescription drugs today help to lower blood pressure and cholesterol and keep folks well.

What Senator SNOWE and I are proposing is a market-oriented approach. It is based on the model that is used for Federal employees. It is market driven. It has choices. We would not see the kind of price-control approach that is being advocated by some. I am very opposed to that kind of price-control orientation because what will happen is, if you just try to control prices for Medicare drugs, the costs will all be shifted to somebody else.

Senator SNOWE and I do not want to see a divorced mom at the age of 27, with a modest income and two kids, have to pick up all the extra costs. So we are going with a market-oriented approach. I hope that in the days ahead, as a result of bills such as this, and others that I know are being sent to our colleagues—and the campaign we have launched here on the floor so that seniors will, as this poster says, send in copies of their prescription drug bills—we can show the people of this country that we are not going to wait until the next election or the election after that; we are going to find a way to come together now to do the job we were elected to do, which is to work in a bipartisan way.

Unfortunately, that did not happen this week on the Comprehensive Test Ban Treaty. I wish it had. I am anxious to work with the Presiding Officer and my colleagues on the other side of aisle. We can do it on prescription drugs. We can do it on an issue that is foremost in the minds of millions of our families and our seniors.

We have 20 percent of the Nation's older people spending more than \$1,000 a year out of pocket on their prescription medicine.

I described this afternoon an elderly woman with a monthly income of \$1,179, who every month spends more than \$500 on prescriptions. Let's show seniors such as that elderly woman who wrote from the Willamette Valley in my home State of Oregon that we can act now. She was skeptical. She has heard all the oratory and all the partisan rhetoric on this issue, and she is understandably skeptical.

Senator SNOWE and I are trying to mobilize a bipartisan coalition in this Senate to act in this session so that older people can get decent prescription drug coverage under Medicare. We should not wait until the next election. We were elected to act now and to act in a bipartisan way.

I hope, as a result of this short statement today, that additional older peo-

ple, as this poster says, will send us copies of the prescription drug bills with which they are faced.

Senator SNOWE and I intend to be back on this floor again and again and again through this session of Congress until we get action. We will be talking about it next week, and we are going to talk about it the following week and the week after that. It is not right to wait on an issue such as this that is so pressing to vulnerable older people such as those who have written me the letters I have described today.

I am very grateful to my colleague, the other Senator from Maine, who, by the way, has a long record of being an advocate for consumer issues as well. And she knows how much I enjoy working with her. I thank her for this courtesy this afternoon.

Mr. President, I yield the floor.

Ms. COLLINS addressed the Chair.

The PRESIDING OFFICER. The Senator from Maine.

Ms. COLLINS. First, I thank the Senator for his kind comments and for bringing to the Senate's attention a very important issue.

I ask unanimous consent that the Senator from Kansas and I be allowed to proceed in morning business in a colloquy for as much time as we may consume.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Ms. COLLINS. Thank you, Mr. President.

HOME HEALTH SERVICES

Ms. COLLINS. Mr. President, Senate Republicans are committed to enacting legislation to preserve, strengthen, and save Medicare for current and future generations. In addition to addressing the long-term issues facing Medicare, it is absolutely critical that this Congress also take action this year to remedy some of the unintended consequences of the Balanced Budget Act of 1997, which have been exacerbated by a host of ill-conceived new regulatory requirements imposed by the Clinton administration.

These problems are the subject of the issue my colleague from Kansas and I wish to address today, for these problems are jeopardizing access to critical home health services for millions of our Nation's most vulnerable and frail senior citizens.

America's home health agencies provide invaluable services that have enabled a growing number of our vulnerable senior citizens to avoid hospitals, to avoid nursing homes, and receive the care they need and want in the security and privacy of their own homes—right where they want to be.

In 1996, however, home health was the fastest growing component of the Medicare budget, which understandably prompted Congress and the Clin-

ton administration to initiate changes that were intended to make the program more cost effective and efficient. There was strong bipartisan support for the provisions that called for the implementation of a prospective payment system for home care. Unfortunately, until this system is implemented, home health care agencies are being paid under a critically flawed interim payment system known as IPS, that penalizes those home health agencies that historically have been the most cost effective.

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

Ms. COLLINS. I am happy to yield to my colleague.

Mr. ROBERTS. For all of those who are listening and watching this debate, I thank the distinguished Senator from Maine for her—I wrote it down—untiring, persevering, never-give-up leadership with regard to this effort to resolve our problems with HCFA. What an acronym. We have all heard of Peter and the dike. This is Susan at the dam, the HCFA dam. In fact, we could probably turn that around in regard to what is happening.

I want to ask a question. Do you mean this new interim payment system—and we will go through this in some detail. I want folks to remember interim payment system, IPS. That is the acronym. Everything has to be an acronym in Washington. I don't call it IPS. I call it the "IPS mess". It not only rewards but actually penalizes the home health care agencies for their past, not bad behavior but good behavior: is that right?

Ms. COLLINS. Unfortunately, that is exactly right. Unbelievable though it may seem, the formula that is being used actually penalizes those agencies in our two States that have done a good job of holding down costs. It rewards those home health agencies that have provided the most visits, that have spent the most Medicare dollars. It is totally backwards. In fact, home health agencies in our two regions of the country, the Northeast and the Midwest, are among those that have been particularly hard hit by this inexplicable formula, the IPS, that the Senator just mentioned.

The Wall Street Journal observed last year—this could be said of agencies in the Midwest as well—that if New England had just been a little greedier, its home health agencies would be a whole lot better off now. Ironically, the regions, yours and mine, are getting clobbered by the system because they have had a tradition of non-profit community service and efficiency.

Even more troubling—and I commend the Senator from Kansas for his leadership on this issue; I know this troubles him as well—is the fact the flawed system is restricting access to care for the

very senior citizens who need the care the most. Those are our seniors who are the sicker patients, who have complex chronic care needs, such as diabetic wound care patients whom I visited in northern Maine during a home health care visit, or IV therapy patients who require multiple visits. Indeed, according to a recent survey by the Medicare Payment Advisory Commission, almost 40 percent of home health agencies have said there are patients who they no longer serve due to the flawed interim payment system and the regulatory overkill on the part of the Clinton administration.

I show the distinguished Senator from Kansas and the distinguished Presiding Officer, who is also committed to this issue, and my other colleagues, a chart that demonstrates the dramatic impact the IPS, this flawed payment system, has had in my own State of Maine.

As you can see, the number of Medicare beneficiaries who have been served by home health care agencies has dropped dramatically. It has dropped by 13 percent, from 49,458 to 42,858; 6,600 senior and disabled citizens in my State have lost their access to home health care services in 1 year. This is so troubling to me. The number of visits has plummeted by more than 420,000, and reimbursements to our home health agencies have dropped by an astounding \$20 million in a year. Keep in mind that Maine has some of the least costly home health care agencies in the country. They have been very prudent in their use of resources. They were low cost to begin with. So when this formula went into effect, it put such a squeeze on them, they had no choice but to close offices, lay off staff, and stop serving some of the most vulnerable, ill senior citizens in my State.

The point is, cuts of this magnitude, that we have seen in the State of Maine and throughout the country, cannot be sustained without hurting senior citizens.

Mr. ROBERTS. Mr. President, I will ask the Senator from Maine, if she will yield, another question.

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. I heard similar complaints—I have them written down—on the interim payment system, the IPS system, from the same agencies in my State. In fact, since January of 1998, 56 Medicare-certified agencies in Kansas have closed their doors, largely as a result of the changes in the IPS. These are not the fly-by-night home health care agencies we hear about that sometimes are in the press. Many of these agencies have been in existence for 20 years. I have visited these agencies. There was a survey conducted by the Kansas Home Care Association that shows agencies have laid off an average of 42 percent of their staff. They are subsidizing their Medicare payments to

the tune of \$213,000. In 1997, many agencies decreased the Medicare patient visits by 63 percent. Your chart shows 6,600 people. I have asked Kansas to come up with the numbers of people who are affected. They are trying to do that. It could be in the hundreds; it could be in the thousands.

But one person, just one person is a valued individual. That is everybody's mom, dad, grandmother, or granddad. So from the standpoint of numbers, it is astounding what the distinguished Senator has put up on the chart with regard to this so-called IPS system. We are going through the same kind of problem. I am going to ask you, how much longer is this IPS mess going to be in effect? It was supposed to be a transition program to the prospective payment system, but they said, well, we can't do it that fast. I understand that because it does take a lot of work, but how much longer will we have to put up with this?

Ms. COLLINS. Unfortunately, I say to my friend, the Senator from Kansas, the answer is far longer than any of us in Congress ever anticipated. The problems with the IPS system, which the Senator has described so eloquently for his State, and we have seen in my State, are all the more pressing because the Clinton administration has missed the deadline for implementing the prospective payment system. As a consequence, home health care agencies throughout our Nation are going to be struggling under this unfair and flawed payment system far longer than Congress ever envisioned or intended when it passed the Balanced Budget Act.

Mr. ROBERTS. Mr. President, I ask the Senator to yield for another question, if she will.

Ms. COLLINS. I am happy to.

Mr. ROBERTS. The home health care agencies are worried about IPS in Kansas. I know the same is true of all around the country. They also complain that their financial problems have been exacerbated—that is a fancy word that means a whole lot worse—by a host of new regulatory requirements imposed by HCFA—my favorite agency in Washington—including the implementation of something called OASIS—I have the report—that they are requiring nurses to fill out. Oasis, if you look in the dictionary, is a desert island somewhere or in the middle of the desert; you come to an oasis and you get relief. Oasis is not relief. You don't spell relief by spelling oasis: a new outcome and assessment information data set; new requirements for surety bonds, sequential billing, overpayment recoupment, and a new 15-minute increment reporting requirement that is a doozy. What about all these reporting requirements in addition to the IPS problem? What about OASIS?

Ms. COLLINS. The Senator is absolutely correct. We not only have a

flawed payment system, but home health agencies are struggling under a mountain of burden of unnecessary and onerous regulations imposed by HCFA, imposed by the Clinton administration. In fact, my colleague may be interested to know that earlier this year I chaired a hearing of the Permanent Subcommittee on Investigations on home health care. We heard firsthand about the financial distress and cash-flow problems that home health agencies across the country are experiencing. In fact, the Senator has talked about the number that have closed in Kansas.

The Senator may already know, but for the benefit of my colleagues who may not be as well informed as the Senator from Kansas, more than 2,300 home health agencies across the country have been forced to close their doors as a result of the regulatory burden and the flawed payment system.

We heard witnesses talk about their frustrations. In fact, the CEO of the Visiting Nurses Service in Saco, ME, termed the Clinton administration's regulatory policy as being one of "implement and suspend." She and others pointed to numerous examples of hastily enacted, ill-conceived requirements along the lines of what the Senator pointed out—surety bonds, sequential billing, the OASIS system, a host of unnecessary regulatory requirements. What has happened is, no sooner does HCFA impose this burden on these home health agencies and they invest the costs necessary to comply, then HCFA changes its mind and suspends the regulatory requirements and says never mind.

Mr. ROBERTS. Will the Senator yield for another question or just an observation?

Ms. COLLINS. Yes.

Mr. ROBERTS. Now, wait a minute, HCFA imposed the cost burden of this mandate on home health care agencies. Then they had seconds thoughts. Why?

Ms. COLLINS. I think the Senator will allow me to respond. This is a typical example of the administration rushing in without thinking through the regulatory burden that is imposed and, in response to an outcry from Members of Congress, such as ourselves, and from senior citizens and home health agencies, it then decided maybe it made a mistake. But, in the meantime, our home health agencies have gone through the time, trouble and expense of implementing these requirements.

Mr. ROBERTS. But they suspended them?

Ms. COLLINS. That's correct.

Mr. ROBERTS. They didn't say you have no requirement to keep up the reporting paperwork; they just suspended them. So that shoe will drop again.

Ms. COLLINS. The Senator makes a good point. In some cases, they may suspend it and then they may turn around and impose the burden again. It

is hard to know. The agency seems to be in so much turmoil and so insensitive to the home health care agencies.

Mr. ROBERTS. If there is a home health care agency and they go through the requirements and get, hopefully, up to speed—although you don't know how with the lack of personnel and you are not being paid for it, et cetera—they could then be suspended, but they have already gone through those costs to comply. But then you don't know. Aren't they sort of in a "HCFA purgatory" here?

Ms. COLLINS. The Senator is exactly correct. Let me give you a specific example. In 1998, HCFA instituted a new policy for sequential billing. Under this policy, home health agencies are required to submit claims in a sequential order to Medicare. Now, this required a substantial investment in computer software, a lot of process changes on behalf of the home health agencies and the fiscal intermediaries. Moreover, the way the system was set up, if there were subsequent claims for a particular patient, they could not be paid until all previous claims relating to this patient were settled. This caused enormous cash flow problems for home health agencies. They experienced delays as long as 120 days before they could get the payment they were due.

One witness at my hearing testified that her agency was still owed about \$20,000 for fiscal '98, and other agencies reported they had to obtain bridge loans, or tap into their credit lines, solely because of this ill-conceived policy.

Now, due to the objections raised by the Senator from Kansas, myself, other Members, and the home health care industry, HCFA finally decided to suspend the policy this past July. But, in the meantime, we have had over a year of turmoil because of this policy, and home health agencies had already spent time, energy, training, and effort to comply with a misguided policy that now is, as you put it, in "HCFA purgatory."

Mr. ROBERTS. Mr. President, I ask the Senator if she will yield for another question?

Ms. COLLINS. I am happy to yield.

Mr. ROBERTS. We have also heard a number of complaints from my constituents about this business called OASIS. For those who don't know, again, OASIS is a system of records containing all this data on the physical, mental, and functional status of Medicare and Medicaid patients receiving care from home health care agencies. So HCFA then implemented OASIS, as I understand it, as a tool to help the agency improve the quality of care and form the basis for a new home health prospective payment system. There is certainly nothing wrong with that. But the problem, as the Senator has pointed out, is that the collection of data is burdensome and expensive

for agencies; it invades the personal privacy of patients, and it must be collected for non-Medicare patients—that is the part I don't understand—as well as those served by Medicare.

Why on earth would they require that? I don't understand this. You talk about an unfunded mandate. This has to be at least in the top 10.

The Kansas House of Representatives actually passed a resolution earlier this year that asked Congress to rescind HCFA rules requiring OASIS. I have it right here. It is not often that an entire legislature of a State passes a resolution telling some alphabet soup agency back here, wait a minute, this doesn't make any sense; you are causing an awful lot of regulatory overkill and causing home health care agencies to go out of business. Let's see. The State of Kansas is very concerned about the health and well-being of the senior and disabled citizens. We have 1, 2, 3, 4, 5, 6 "whereases," translated: Whoa, HCFA, don't do this. It is an unfunded mandate.

This was passed by the House of Representatives of the State of Kansas and it was resolved "that the Secretary of State be directed to provide an enrolled copy of this resolution to the President of the United States, Secretary of Health and Human Services, President of the United States Senate, Speaker of the House of Representatives, Minority leaders of the United States Senate and the United States House of Representatives," saying please don't enforce these OASIS regs the way they are being enforced. It is signed by the distinguished speaker of the House in Kansas and the President of the Senate.

I ask unanimous consent that the resolution be printed in the RECORD.

There being no objection, the material resolution was ordered to be printed in the RECORD, as follows:

HOUSE CONCURRENT RESOLUTION NO. 5041

Whereas, New rules made by HCFA require OASIS assessment and follow-up reports for all patients of Medicare-certified home health agencies and health departments whether or not the personal or attendant care for such patients is paid from Medicare; and

Whereas, The new HCFA report requires an 18-page initial assessment, which must be completed by a registered nurse, with a 13 page follow-up assessment being required every 60 days; and

Whereas, The requirement for computer software for the preparation and transmission of such assessments and follow-up reports is another unfunded mandate of the federal government; and

Whereas, The HCFA requirement requires costly unfunded reporting of those who receive services which are not paid by Medicare—which reporting duplicates existing assessment and reporting requirements of the Kansas Department on Aging; and

Whereas, In the environment of the small, home health care services existing in Kansas, it is not feasible to create separate organizations to provide services for non-Medicare customers. The end result of the HCFA

rules is that Medicare-certified agencies will no longer be able to provide in-home services to non-Medicare customers. Consequently, with lower levels of preventive home services being available to older Kansans there will be an increase in hospital admissions, thus increasing Medicare costs, and an increase in nursing home admissions, thus increasing Medicaid costs; and

Whereas, OASIS appears to be solely a research project of HCFA, totally unfunded by federal sources, and accomplished with loss of funds by reporting agencies and loss of services for Kansas seniors: Now, therefore,

Be it resolved by the House of Representatives of the State of Kansas, the Senate concurring therein: That we memorialize the Congress of the United States to require the Health Care Financing Administration OASIS reporting and data reporting requirements to apply only to Medicare patients and not to all patients of Medicare-certified home health agencies; and

Be it further resolved: That the Secretary of State be directed to provide an enrolled copy of this resolution to the President of the United States, Secretary of Health and Human Services, President of the United States Senate, Speaker of the United States House of Representatives, minority leaders of the United States Senate and the United States House of Representatives, and to each member of the Kansas Congressional delegation.

Mr. ROBERTS. I am sure that this burden is being felt by agencies nationwide, not only in Kansas. I am not sure the legislatures of each State have been passing resolutions to say we need relief from OASIS, but I ask the Senator if she has any idea how long it takes for nurses to collect this information?

Ms. COLLINS. Most agencies are reporting that it takes a nurse between 1 and a half and 2 hours per patient. Now, I point out, that is 2 hours that could be used on direct patient care, on tending to the problems that caused the home health visits to be necessary in the first place. Instead, as the Senator has so ably described, it is being spent on unnecessary paperwork.

Mr. ROBERTS. Mr. President, I have 2 or 3 more questions. I have a copy of OASIS. This is not relief. I understand the time requirements. I want you to look at this. This OASIS document includes an 18-page initial assessment that must be completed by a registered nurse, and a 13-page follow-up assessment that is required every 60 days. This is perpetual reporting, a perpetual reporting machine, well-boiled by HCFA. And this is on top of assessments already required by States. 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 in this assessment?

I think I know the answer. I have read through this OASIS—the third degree, or whatever you want to call it. Will the Senator speak to the nature of the questions in the assessment?

Ms. COLLINS. Well, the Senator has put his finger on yet another problem. As I understand it—and the Senator is

the expert on the OASIS system—OASIS collects information on the patients' medical history. We can understand that part, but also on the patient's living arrangements, sensory status, medications, and emotional state.

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

Ms. COLLINS. I am glad to.

Mr. ROBERTS. Emotional status?

Ms. COLLINS. That is correct.

Mr. ROBERTS. I see that page, as I have gone over this.

I tell the distinguished Presiding Officer, nurses in Colorado must ask the questions of these patients about their feelings—it sounds like a Barbara Streisand song—such as if they have ever felt depressed, had trouble sleeping, or even if they have ever attempted suicide. The thought occurs to me that Members of this distinguished body from time to time feel depressed and have trouble sleeping. I hope that would not be the case with regard to suicide.

I am being too sarcastic.

Do we really think we need to ask a nurse to bother a physical therapy patient for this information so that he or she can send the answers over to some computer someplace in Baltimore that will then use this information to develop a prospective payment system, and we can't find out when it is going to be proposed? Who in Baltimore reads these? I asked that in regard to HCFA, in regard to all of their requirements back when it was Health, Education, and Welfare in regard to Kansas City. I wanted to go to Kansas City and say: Who reads this stuff? What do they do with it? Maybe the Senator and I could go to Baltimore and figure that out. Why on Earth would we ask a nurse to bother a physical therapy patient for this information so they can send the answers? It hasn't anything to do with physical therapy patients. Why is that?

Ms. COLLINS. I completely agree with my colleague. These are the questions, when asked of the senior citizens whom I talked to, they find very intrusive. The nurses who are treating them are offended that they have to pry into matters that have no connection to the reason for the home health visit.

Moreover, as I pointed out earlier to my friend and colleague, this is time that is being spent on unnecessary paperwork, on intrusive questions that alienate and destroy the relationship between the nurse and the patients that could better be used for actually caring for the patient.

Agencies are not reimbursed for this time. Moreover, in a State such as Maine, which is very rural, our home health providers have to spend a lot of time traveling from patient to patient. This is time that is lost from the system.

Another issue, which the Senator has also raised, which is inexplicable to

me, is why is HCFA collecting this data for non-Medicare patients? I don't understand that. Am I correct? The Senator from Kansas is much more knowledgeable about the OASIS system than I am. Am I correct that it actually applies to non-Medicare patients as well?

Mr. ROBERTS. I would be happy to respond to the distinguished Senator.

Unfortunately, she is correct. Any Medicare-approved health care agency must comply with all Medicare conditions of participation. That is MCP—probably another acronym, and I will not venture to say what that sounds like—including the collection of OASIS. This means patients who do not participate in Medicare are still subject to Medicare assessment.

In June, HCFA amended this regulation to say that these agencies don't have to—here again, this is what we have a lot of trouble with—transmit the data on non-Medicare patients for the time being, but they still must spend the time taking these assessments. Hello.

Ms. COLLINS. Yet another sample of what the Senator has described as policies being implemented, then pulled back, agencies not knowing whether they are coming or going, and being subjected to the confusing and conflicting and extensive requirements that are detracting from the ability of these agencies to provide essential care to our seniors.

I want to give the Senator from Kansas yet another example of this regulatory overkill by HCFA. I don't know whether the Senator from Kansas is familiar with this, but it is the new 15-minute incremental reporting requirement. HCFA is requiring nurses to act more like accountants or lawyers billing for every 15 minutes of their time. They are going to have to carry stopwatches to comply with this. Implementation is not only going to be very difficult for the staff to administer, but also, once again, it changes the very relationship between the patient and the nurse. It is very disruptive to a patient's care.

Mr. ROBERTS. Will the Senator yield for one additional observation and a question?

Ms. COLLINS. I am glad to yield.

Mr. ROBERTS. I want to go back to my statement earlier when I said in that June HCFA responded in regard to the outcry on the part of the home health care agencies in regards to the regulation on the conditions of participation with OASIS. As I indicated before, the agency still must spend the time taking the assessment. So I asked staff. I said: Wait a minute. Why is it, if they suspended it, you still have to take the assessment? I don't know where they are storing all of this paperwork. Maybe they burn it at Christmas time. That may be a good idea. But, at any rate, write the mail; don't

send it. And I asked staff: Why are we still doing this if, in fact, you don't send it in? It is a privacy issue. Look at the questions that are involved. These are privacy issues, and they haven't figured that out yet. So if, in fact, there are privacy issues, it would seem to me we had better settle those first or we are going to have lawsuits, big time. Why issue the regulation and then say to people: Well, we have a bunch of privacy issues that we haven't thought through, but keep on filling them out, and when we figure out the privacy issue, why, then we will get back to you.

I am extremely sympathetic to the concerns raised by my constituents that these new policies will harm seniors.

But let's give HCFA a break. I have been pretty critical and a little sarcastic, and I have to admit that I have a bias.

I have been working on this ever since I have had the privilege of being in public service. Even back when I was an administrative assistant to Congressman Keith Sebelius, we used to have these HCFA directives coming out to the rural health care delivery system. I can remember one right off the bat on behalf of cost containment.

Give HCFA a break. They are in charge of cost containment. We are all good at passing laws and then passing a lot of regulations, and saying, OK, you have to really put up with these, and it is up to HCFA to put out the regulations. And when we find they don't work, the people come to us and complain about it.

I can remember one rather incredible thing when they said we are not going to pay anybody any Medicare reimbursement unless the patient admissions are reviewed by hospitals on a 24-hour basis by three doctors. We thought about that a little and said: We think we are for this—because we didn't have any doctors. I figured, well, what the heck. If we go ahead and accept this regulation, maybe they could provide the three.

Then there was the other great example of the sole provider and community hospital—talking about Goodland, KS, America, out on the prairie at the top of the world, a great place to live, a great farming community miles from nowhere. We asked again—it was HHS at that particular time—can you give us this decree, or this ruling to make this hospital eligible for a little more in payments? They said: Well, no, because everybody out there—I am not making this up—has four-wheel drives, and it is pretty flat in Kansas. What? As opposed to Colorado, I say to the distinguished Presiding Officer, who serves as an outstanding Senator. Four-wheel drive, and it is flat, and because they have lizards, windstorms. Our weather out there is a little tough for some bird in, like Virginia, down here to make that assessment.

So I have a little bias here, but I want to give HCFA a break.

I want to ask the Senator, are these policy changes necessary to achieve the Medicare savings goals? Medicare is a top concern; strengthen and preserve it. We have all worked very hard to do that. Are these policies necessary to achieve the savings that we want to achieve to strengthen and preserve Medicare?

Ms. COLLINS. The Senator has raised an excellent question. There is a very good answer. That is no. In fact, the regulatory overkill of the Clinton administration has already exceeded the savings projected by the balanced budget amendment. Medicare for home health fell nearly 15 percent last year, and CBO now projects the reductions in home health care will exceed \$46 billion over the next 5 years. That is almost three times greater than the \$16 billion estimate that the Congressional Budget Office originally estimated.

It is yet another indication that these cuts are far too deep, and that they are hurting far too many people completely unnecessarily. They have been far too severe and much more far reaching than Congress ever intended when it was trying to bring a measure of fiscal restraint to the Medicare Program.

Mr. ROBERTS. I ask the distinguished Senator from Maine, didn't we fix the problems last year when we passed the omnibus appropriations bill? I think we both made speeches at that particular time. What is the status?

Ms. COLLINS. The Senator worked closely with me and others last year in providing a small measure of relief in the omnibus appropriations bill. I am pleased that together we were able to take some initial steps to remedy this issue. However, I think it is evident from the overwhelming evidence that the proposal did not go nearly far enough in relieving the financial distress of these home health agencies. The ones that are paying the price are the good agencies, the cost-effective agencies that are serving our seniors. That is the tragedy.

Mr. ROBERTS. If I could ask the Senator one final question, I know I have been hard on HCFA. Each Member has some very special experiences, and these are experiences that come to our attention when a constituent is having a big-time problem or a hospital or home health care agency. All of the folks that work down at HHS certainly don't fall under the category that I have been talking about. So what about our responsibility? What about our leadership? What should we do to fix the problem? How can we provide more relief to the beleaguered home health care agency?

Ms. COLLINS. I know the Senator from Kansas has been such a leader and cares so much about this issue and has joined with me in introducing legisla-

tion, along with our colleague from Missouri, Senator BOND, and 31 of our colleagues. Both sides of the aisle have joined in legislation that we have introduced called the Medicare Home Health Equity Act.

This solves the problem. For one thing, it eliminates another 15-percent cut that is scheduled to go into effect in October of next year. I am sure my friend, the Senator from Kansas, agrees with me if that goes into effect, it will sound the death knell for the remaining home health agencies. That means the ones that have been struggling to hang on will be forced to close their doors or refuse even more services to our senior citizens. This is totally unnecessary because we have already achieved the savings, the targets set by the Balanced Budget Act.

The legislation includes a number of other provisions that affect a lot of the regulatory issues we have discussed today. I think it is absolutely critical we pass this legislation or similar provisions before we go home. I have visited senior citizens in my State who, if they lose their home health services, are going to be forced into nursing homes or hospitals. The irony is that is going to be at far greater cost.

Mr. ROBB. It will increase the costs.

Ms. COLLINS. The Senator is right. This is penny wise and pound foolish—not to mention the human toll that is being taken on our vulnerable senior citizens and our disabled citizens.

I know the Senator shares my commitment. This is of highest priority. We must solve this problem before we adjourn.

Mr. ROBERTS. If the Senator will yield one more time, I thank the Senator for all of her leadership and all of her hard work in this effort. I believe it is absolutely mandatory for Congress to bring much needed relief to the home health care industry in the time-frame she has emphasized, as well as to the small rural hospitals and teaching hospitals that also are feeling the pinch of all the legislative and regulatory changes made in the last few years.

The Senator is exactly right. We will have to move quickly. We must do it this year. There has been talk if we can't agree on a single proposal, we might have to put it off until next year. Time is of the essence in regard to our hospitals, especially the small rural providers. They operate on a shoestring budget. The same is true for the home health care agencies.

I will continue to work with the distinguished Senator to pass legislation before Congress adjourns for the year. We cannot go home before we straighten this out and provide some help.

I thank the Senator for her leadership. I think we have had a very good colloquy.

Ms. COLLINS. I thank the Senator from Kansas. I appreciate his support

and his compassion in making sure we are keeping our promise to our senior citizens. With his help and with our continuing partnership, I am convinced we can do the job and solve this problem before we adjourn.

I yield the floor.

GUNS IN SCHOOLS

Mr. GORTON. Mr. President, when is it okay for a gun to be at school? I find it hard to think of an instance when it is. In fact, a few years ago Congress was so concerned about guns at school that it passed a law that required school districts to implement a zero tolerance policy for guns or lose their Federal funding. Schools must expel a student who brings a gun to school for a year.

Three weeks ago a young man at Lakeside High School, a public school of 520 students in the Nine Mile Falls School District in eastern Washington, brought a handgun to school. Thankfully, school authorities were notified quickly and nobody was hurt. Students and parents were understandably upset that such an incident would happen at all, and assumed that the situation would be dealt with in accordance with the district's "zero-tolerance" policy for such matters.

What happened was very different. I began receiving calls from students and parents who were concerned that this young man will now be allowed back at school after just 45 days. They were both confused and upset when they found out that Federal law supersedes local policies for addressing such incidents. So upset, in fact, that students at Lakeside High School have begun organizing a walkout. I have a flyer that has been circulated by students promoting a planned walkout on October 18. The students plan to drive to the district office and protest the return of the student. I ask unanimous consent the students' flyer be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Do we really want this kid with a gun coming back to our school?!

NO!!!

Let's stand for our
RIGHTS!

Join US

On October 18, 1999, LHD Students Are Having A WALK OUT! Between 1st and 2nd Block—Meet In The Student parking lot and drive down to the district office.

WE HAVE A RIGHT, TOO!

Like other school districts across the country, the students, parents and educators at Lakeside High School have just run head-first into the double standard inherent in the discipline