The Florida State Legislature also gave Dr. Schiebler a grand send off to his retirement before concluding the session.

In a House Resolution passed by the 118 Members present, H.R. 9135 outlined his many accomplishments. In one section, the resolution reads, ''Whereas, the recipient of awards too numerous to set forth in their entirety, Dr. Schiebler has the distinction of being the only individual to receive both the Abraham Jacobi Award and the Doctor Benjamin Rush Award during any one year, has had an Eminent Scholar's Chair in Pediatric Cardiology named for him at the University of Florida, and has had the Gerold L. Schiebler Lectureship established in his honor. . . . That the Florida House of Representatives pauses in its deliberations to honor the distinguished Gerold L. Schiebler, M.D. . . .''

The Florida Senate Resolution ''commending Gerold L. Schiebler, M.D., for his contributions to the health and welfare of children in this state'' was equally complimentary.

A portion of the Senate Resolution reads, ''. . . Gerold L. Schiebler's efforts have resulted in the creation of Children's Medical Services, infant metabolic screening, infant hearing screening, regional neonatal and perinatal intensive care centers, poison control centers, insurance coverage for babies at birth, and numerous other programs. . . . That the Florida Senate commends Gerold L. Schiebler for his dedication and accomplishments in providing better health care for the children of this state.''

And, just last month, out of respect and appreciation to Dr. Schiebler, his peers honored him at the Annual Alumni meeting by choosing him to become one of the first three individuals designated as an Honorary Alumnus of the University of Florida College of Medicine.

In the Florida Senate, I had the pleasure of working with Dr. Schiebler on dental school appropriations, tort reform and children's issues. In that time, I learned that his relationships with legislators was as much about his commitment to helping people as it was about his commitment to his legislative goals. If you needed advice or help about a medical problem for yourself or your family or if you had a constituent who could not get care, you would call Dr. Schiebler. You could send a child without health insurance up to Gainesville and leave a message on his answering machine on Sunday night. You knew he would open the health center's doors on Monday morning. In many cases, he saved people's lives.

Since entering Congress, we have continued to work together on the Patients Bill of Rights, healthcare reform and the Graduate Medical Education Program. We most recently secured federal funding for the creation of the Brain Institute at the University of Florida. The multi-million dollar building now houses magnet systems and the largest breadth of multidisciplinary talent focused on the nervous system.

On a more personal note, he has been very supportive of me and my family. Dr. Schiebler was a great help when my husband John was diagnosed with polycystic kidney disease. We took John up to Shands when John started to go through the dialysis procedures. He was there when John had a transplant. I remember sleeping in my car one night while John was in the ER and the next day Dr. Schiebler asked, ''Why didn't you call me?'' He was helpful to me and continues to be.

It's very hard to completely sum up all of Dr. Schiebler's accomplishments and contributions because he's done so much for so many people, but I will make an attempt. Dr. Schiebler is an advocate for children. He is an advocate for Shands Hospital and the University of Florida Health Science Center. He is an advocate for the American Medical Association. He is an advocate for me. He is an advocate for his family. He credits his wife, Audrey, for shaping and inspiring his every accomplishment, including the couple's six children—Mark, Marcella, Kristen, Wanda, Bettina and Michele—and their 17 grandchildren.

Perhaps his character is best described by his colleague, Dr. Rosenbloom: ''He never, never did anything for Gerry Schiebler. He always acted for the kids for whom he felt responsible, for his family or for his academic family. Never self-serving, he is the most unselfish, caring person of power you will ever meet.''

I couldn't agree more.

Thank you Dr. Schiebler for your many years of service to me, to the University of Florida Health Science Center, to Shands Hospital and to the people of Florida. You will be missed!

MEDICARE PARTIAL HOSPITALIZATION SERVICES RESTORATION AND INTEGRITY ACT OF 2000

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 11, 2000

Mr. STARK. Mr. Speaker, today, I am introducing legislation to restore a benefit in Medicare that has been destroyed. A benefit that is needed by about 100,000 Medicare beneficiaries who need outpatient mental health services to maintain their functional capacity and live lives that are as normal as possible. It is a benefit that was put into Medicare in 1990, but has now been almost completely eliminated by administrative actions of the Health Care Financing Administration (HCFA) that I believe have been and continue to be illegal. I have conveyed my concerns to HCFA several times, but without effect.

The history of this benefit is truly sad. In a report issued in January 2000, the GAO concluded that ''HCFA's implementation of the partial hospitalization benefit was not adequate.'' The GAO report details the mismanagement of this benefit by HCFA from the beginning, and I believe that the mismanagement continues to this day. That is why I am introducing legislation today to stop the mismanagement and restore this benefit as the Congress intended it to be.

Before 1990, Medicare covered partial hospitalization services provided by hospitals. Recognizing a broader need for outpatient mental health services, the Congress expanded the benefit in OBRA 1990 to include services provided by Community Mental Health Centers (CMHCs) as defined in Section 1913 of the Public Health Service Act.

The Congress was quite clear in its intent for this benefit, and the precise language of the statute reflects that intent. Section 1861(ff)(2)(I), as amended by Section 4162 of OBRA 1990, specifies the partial hospitalization benefit as services that are:

''Reasonable and necessary for the diagnosis or active treatment of the individual's condition reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).''

The Congress did not know the specific eligibility requirements needed for this benefit, nor did it know the specific services that should be provided for each patient, depending on the functional status of the individual. Therefore, the Congress mandated that the Secretary promulgate regulations establishing eligibility guidelines and covered services—taking into account accepted norms of medical practice. The Congress expected—and required—the Secretary to promulgate regulations so that the public would have an opportunity to comment and participate in defining and establishing the standards for this benefit.

In March 1992, HCFA issued a manual instruction (IM 205.8)—not a regulation—that included the following language:

''In general, to be covered, the services must be reasonable and necessary for the diagnosis or active treatment of a patient's condition. The services must not be for the purpose of diagnostic study or they must be reasonably expected to improve or maintain the patient's condition and to prevent relapse or hospitalization.

It is not necessary that a course of therapy have, as its goal, restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long term, chronic conditions, control of systems and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. ''Improvement'' in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met.

Some patients may undergo a course of treatment which increases their level of functioning but then reach a point where further significant increase is not expected. Continued coverage may be possible even though the condition has stabilized or treatment is primarily for the purpose of maintaining the present level of functioning. Coverage is denied only where evidence shows that the criteria discussed above are not met, e.g., that stability can be maintained without further treatment or with less intensive treatment.''

Although this definition of the partial hospitalization benefit was not issued through regulations as required by the law, at least it was consistent with the intent of the law in substance, and the mental health community did not complain.

On February 11, 1994, the Secretary published an Interim Final Rule implementing the partial hospitalization benefit. The language of the Interim Final Rule mirrored the language of the statute:

''(a) Partial hospitalization services are services that—

(1) Are reasonable and necessary for the diagnosis or active treatment of the individual's condition;

(2) Are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; and

(3) Include the following:'' (list of services).

This Interim Final Rule did not do what the Congress expected—it did not provide clear eligibility and coverage guidelines, taking into account accepted norms of medical practice. However, it did at least implement the partial hospitalization benefit through regulations, as required by the statute. Following publication of this Interim Final Rule, the 1992 manual issuance continued in force providing more specific instructions and guidelines.

Because HCFA did not involve the mental health community in establishing eligibility and coverage guidelines, HCFA's rules were inadequately defined and unclear. The GAO reported that:

''HCFA initially gave its contractors little guidance on, or explanation of, the program beyond the implementing language of OBRA '90. As a result, contractors struggled to understand the parameters of the partial hospitalization benefit in the first years it was in effect. Our discussions with contractors and HCFA regional offices show that contractors raised concerns over such issues as:

- whether partial hospitalization could cover organic conditions such as Alzheimer's, which are unlikely to improve;
- whether the benefit was available to only those patients with previous psychiatric treatment, or even further limited to only those who had previously been psychiatric inpatients;
- which specific services could be billed to Medicare as partial hospitalization services;
- how frequently services had to be delivered for Medicare to consider a beneficiary's treatment program as partial hospitalization; and
- the level of physician involvement required for services provided to the patient.''

Without clear eligibility and coverage guidelines, HCFA invited fraud and abuse into the program. Expenditures for the benefit mushroomed, and HCFA's contractors began to notice claims for large amounts. For example, GAO reported that a CMHC in Washington came to the attention of its fiscal intermediary because of claims in excess of $10,000 per beneficiary per month. That CMHC operated residential board and care facilities with live-in aides who assisted residents with everyday needs, such as cooking, cleaning, and transportation. The CMHC was billing Medicare up to $100 per hour, per patient, for these services. Another example GAO reported was in Montana, where CMHCs interpreted the partial hospitalization benefit to mean that all CMHC services were covered, and were submitting claims for day care services provided by the CMHC. Other examples reported by GAO include:

- Day care and geriatric care programs were being billed to Medicare as partial hospitalization.
- Arts and craft activities were being billed as occupational therapy or patient education.
- Family counseling services were being billed when there was not evidence of family member participation.
- Long-term psychiatric patients with controlled symptoms were being monitored in partial hospitalization programs for years.

GAO reported that in 1994, one HCFA regional office expressed its concerns about lack of understanding of the partial hospitalization benefit and perhaps misrepresentation of the benefit, but HCFA did not follow up on the concern. By 1995, another HCFA regional office became alarmed about the rapid increase in applications received from new CMHCs, particularly when telephone calls and site visits to CMHCs already participating in the program reached disconnected telephone numbers, private residences, and nonmedical businesses. Still, HCFA did not issue regulations defining the requirements for the facilities and has not issued such regulations to this day. In a statement at a Congressional Town Hall meeting on CMHCs in Houston in March 1999, a representative of the CMHCs stated: ''I am not aware of any other Medicare provider that is certified and regulated in the absence of regulations, based upon shifting standards set out in internal transmittals. The provider community for some time has advocated for formal rulemaking to develop clear and measurable certification standards with industry, clinician and patient input.''

Costs of the partial hospitalizaion benefit mushroomed. In 1993, costs of the benefit were about $60 million; in 1994, about $105 million; and in 1995, $145 million.

Finally, HCFA acted. In July 1996, HCFA issued another manual instruction (Transmittal A–96–2) that severely narrowed the coverage criteria for the partial hospitalization benefit as follows:

''Partial hospitalization may occur in lieu of either:

- Admission to an inpatient hospital; or
- A continued inpatient hospitalization.

Treatment may continue until the patient has improved sufficiently to be maintained in the outpatient or office setting on a less intense and less frequent basis. This is an individual determination.''

In my view, neither the process nor the substance of this new mandate is consistent with the law. HCFA issued this new limitation on the benefit through a manual instruction, not a regulation, in clear violation of the law. Medicare law requires in not one, but two places that the Secretary publish regulations defining this benefit. First, as I mentioned previously, section 1861(ff) requires that the Secretary publish regulations defining the partial hospitalization benefit, and section 1871 requires the Secretary to publish regulations for all Medicare policy. Indeed, section 1871(a)(2), which was enacted in 1965 in the original Medicare statute, provides:

''(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).''

I find it troubling that those charged with enforcing the law ignore the law and proceed as though the law does not apply to their actions, but only to the actions of others. We must change the culture in HCFA and in HHS that repeatedly issues manual instructions in violation of the law.

The substance of the 1996 HCFA ruling was also inconsistent with the law. Nothing in section 1861(ff) limits the partial hospitalization benefit to services ''in lieu of either:

- Admission to an inpatient hospital; or
- A continued inpatient hospitalization.''

However, in issuing this new ruling, HCFA relied on a technical inconsistency in the statute. Although the partial hospitalization benefit is defined in section 1861(ff), section 1835(a)(2)(F) provides that a physician must certify that the individual would require inpatient psychiatric care in the absence of such services. Despite HCFA's February 11, 1994 regulation to the contrary, HCFA issued a manual instruction limiting the benefit to the level of the physician certification requirement provided in section 1835.

Based on the new HCFA instruction that severely limited the benefit, HCFA and the Inspector General began intensive investigations of partial hospitalization claims, and not surprisingly, they found that high percentages of the claims did not meet the new standards. When HCFA severely restricted the benefit, programs suddenly found themselves out of compliance. HCFA and the Inspector General then proclaimed that there was widespread ''fraud and abuse'' in the partial hospitalization benefit. HCFA has been seeking repayments of substantial amounts paid to mental health programs that had been operating on the basis of the earlier published regulation and the manual instructions that were consistent with the regulation and the law.

We need to refocus our attention on the beneficiaries who use the partial hospitalization benefit. In 1997, about 88,000 Medicare beneficiaries were using this benefit. About 60 percent of them were disabled beneficiaries, under the age of 65, and about 60 percent of them were dually eligible for both Medicare and Medicaid. The beneficiaries who need and use this benefit are among the poorest and most disabled beneficiaries in the entire Medicare program. They need our help and our protection, and they need these services.

My record of fighting fraud and abuse in Medicare is long. I hate fraud. We must do everything we can to eliminate fraud in Medicare, including any fraud in the partial hospitalization benefit. But the way to eliminate fraud is not to eliminate the benefit itself. By that standard, it would be easy to eliminate all fraud in Medicare. We would simply eliminate the program! No, instead, we must take steps to address those areas of the benefit where fraud has been found, but we must also restore this benefit for those Medicare beneficiaries who need it.

Today, I am introducing legislation, ''The Medicare Partial Hospitalization Services Restoration and Integrity Act of 2000,'' that would restore the partial hospitalization benefit as the Congress intended, while also taking steps to limit fraud in the benefit.

First, the bill would require a face-to-face visit with a physician to certify the need for the services.

Second, the bill would tighten the language regarding ''individual activity therapies'' ((ff)(2)(E)), using limits already in the statute for other approved services (requiring the services to be directly related to the therapy program).

Third, the bill would tighten the survey and certification requirements in (ff)(3) for community mental health centers.

And fourth, the bill would correct the technical flaw in the statute, which HCFA has used

to limit the benefit, making the physician certification language under section 1835 the same as that defining the benefit in section 1861(ff).

To address HCFA's lack of publishing regulations, the bill would require a negotiated rule making process to define the benefit, establish quality of care standards, and establish survey and certification standards for CMHCs.

I am introducing this bill now so that interested parties can study it over the adjournment period and suggest improvements. I will reintroduce the bill early in the new Congress, with appropriate refinements. For the sake of some of the most vulnerable in our society, I hope we can enact this kind of legislation early in 2001.

PIPELINE SAFETY IMPROVEMENT ACT OF 2000

SPEECH OF

HON. EARL BLUMENAUER

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 10, 2000

Mr. BLUMENAUER. Mr. Speaker, pipeline safety is literally a matter of life and death. Legislation this important must be crafted carefully, allowing for the input of every member of Congress, since pipeline safety impacts every American community. Legislation this important must be brought through committee and to the Floor of the House of Representatives in an inclusive, nonpartisan manner. Sadly, this was not the case for yesterday's consideration of the Pipeline Safety Improvement Act.

S. 2438 faced significant opposition from consumer, environmental and labor groups, and was opposed by my own committee leadership. The bill did not ensure that pipelines would be inspected and did not do enough to help local emergency management agencies react to pipeline emergencies. Given these, and other concerns, and given the considerable opposition the bill faced, S. 2438 should not have been brought to the floor as a suspension calendar item. Mr. Speaker, we all know that the suspension calendar is meant to move noncontroversial, routine items. As such, these items are given little time for debate and no opportunity for amendment.

Had S. 2438 been brought for a vote in a more open manner, it could have won my support. It is my sincerest hope that the Republican leadership will take pipeline safety seriously and bring S. 2438 back to the House of Representatives in a manner that permits its further debate and possible improvement.

STATEMENT ON THE IMPORTANCE OF DATABASE PROTECTION

HON. HOWARD L. BERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 11, 2000

Mr. BERMAN. Mr. Speaker, I want to take a moment to discuss the importance of legal protection for databases. Databases are extremely important to the continued growth of our hightech based economy. Within databases—organized collections of information—lie the basic tools of the Information Age. The continued development of new and exciting database products depends on adequate legal protection from piracy. Over the past two Congress' we have grappled with the scope of protection that should be afforded database producers. We have worked hard to produce a well balanced approach. Unfortunately, we were unable to bring the development of this legislation to a close in time for consideration before this body. I believe that addressing this issue must be a priority for the 107th Congress and will do all that I can to facilitate passage of database protection legislation in the next Congress.

PERSONAL EXPLANATION

HON. DAVID WU

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 11, 2000

Mr. WU. Mr. Speaker, yesterday, October 10, 2000, I was unavoidably detained due to airline mechanical problems. Had I been present, I would have voted the following ways:

No on rollcall No. 519, S. 2438, the Pipeline Safety Act.

Yes on rollcall No. 520, H.R. 208, a bill to amend title 5, United States Code, to allow for the contribution of certain rollover distributions to accounts in the Thrift Savings Plan, to eliminate certain waiting-period requirements for participating in the Thrift Savings Plan, and for other purposes.

Yes on rollcall No. 521, H.R. 762, Lupus Research and Care Amendments.

A TRIBUTE TO JAMES HILL FOR 25 YEARS OF GOVERNMENT SERVICE

HON. GERALD D. KLECZKA

OF WISCONSIN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 11, 2000

Mr. KLECZKA. Mr. Speaker, I rise today to honor my good friend, Jim Hill, who is celebrating 25 dedicated years of government service.

I've known Jim since he worked as my chief of staff when I served in the Wisconsin State Senate in the 1970s. He came to the job an intelligent, energetic, enthusiastic and strongly principled young man, and quickly became a highly respected name in public service in the Wisconsin legislature. Jim's impressive understanding of issues made him a trusted and valued advisor during my years on the Senate's Joint Finance Committee, and his continued support was critical to my decision to run for Congress in 1984.

Jim remained in Wisconsin, and joined the staff of Wisconsin's Dane County Executive Jonathan Barry, where he gained experience in the challenges of county government. But soon he and I had the opportunity to work together again, this time in Washington, DC, where he became my administrative assistant (AA). Jim was a fast learner and an outstanding AA, quickly developing expertise on a myriad of issues while providing strong leadership to a young and inexperienced DC staff.

And although I know that Jim enjoyed the challenges of working on Capitol Hill, his first priority was and is his family. Knowing that the job of AA was incredibly demanding and meant frequent long hours, Jim decided to go back to Wisconsin, where he joined the staff of the City of Milwaukee's Department of City Development and later worked for the Milwaukee Metropolitan Sewerage District.

Jim's strong sense of social justice and his outstanding management skills then led him to his current employment with Milwaukee County's Department of Human Services, where he serves as administrator of the Division of Management Services. And, after 25 years of public service, he remains a well-respected and active member of our community, a man of unquestioned integrity and dedication.

And despite holding positions of enormous responsibility, Jim has always maintained a healthy balance between his job and his family life. He is a dedicated father of two wonderful and talented sons, Patrick (who I am proud to say is my godson) and Daniel. He's also a devoted and loving husband to his wife, Christine.

Throughout the past 25 years, Jim has remained one of my closest and most valued friends. He's always been there for me, in good times and in bad, and has been a trusted advisor and an ardent, vocal and hardworking supporter. I thank him for his friendship, and commend him for 25 years of outstanding service to our community, our state, and our nation. Congratulations, Jim!

CONGRATULATING THE AFRICA BUREAU OF THE DEPARTMENT OF STATE

HON. DONALD M. PAYNE

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 11, 2000

Mr. PAYNE. Mr. Speaker, I rise today to commend and congratulate the Africa Bureau of the Department of State for leading a successful campaign against the candidacy of the government of Sudan to the rotating seat of the United Nations Security Council.

On October 10th the United Nations voted 113–55 in favor of Mauritius over Sudan to take a seat on the Security Council. I would like to single out Assistant Secretary of State for Africa, Dr. Susan E. Rice, for her courage, determination, and hard work in this campaign. Dr. Susan Rice has stood firm against the brutal dictatorship of the National Islamic Front government in Sudan. In that light, she has exemplified the leadership ability that is required and needed to move those countries on the African continent toward good governance and democratic reform.

For the last five years, both at the National Security Council and the Africa Bureau of the Department of State, she consistently and tirelessly fought for the helpless and the innocent victims of the NIF regime.

TRIBUTE TO JOHN MOULTRIE ''MOOT'' TRULUCK, III

HON. JAMES E. CLYBURN

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 11, 2000

Mr. CLYBURN. Mr. Speaker, I rise today to ask my colleagues to join me in paying tribute