wife of Granada, CO; John Brown and wife Patricia of Campo, CO; sister-in-law Cheryl and husband Paul George of Amarillo, TX; plus many nieces and nephews, and a host of friends and relatives.

Mr. Speaker, I would also like to share some thoughts his wife Paulette shared with me. ''I can truthfully say my husband was honorable. His heart dictated what was true and honest. In my eyes, many times, he always took the hard road. The easy way out was never the right way. For every situation God had already set the standard.''

Mr. Speaker, Norman Wayne Wright is a symbol of what America stands for, family values, hard work and a solid faith in the Lord. Thank you for giving me this opportunity to share his memory with the House today.

PERSONAL EXPLANATION

HON. ROBERT A. WEYGAND

OF RHODE ISLAND

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 8, 1997

Mr. WEYGAND. Mr. Speaker, I was unfortunately detained in my district Monday, October 6, 1997 and a portion of Tuesday, October 7, 1997 and missed several votes as a result.

Had I been here, I would have voted in the following way: I would have voted ''yea'' on rollcall votes 490, 491, 492, 493 and 496; I would have voted ''nay'' on rollcall votes 494 and 495.

As exporting becomes increasingly more important to U.S. businesses, the role of the Export-Import Bank must be maintained. The Export-Import Bank places businesses in my district and districts across the nation on a level playing field when competing against foreign businesses subsidized by foreign governments. This program allows for the expansion of U.S. markets thereby increasing the stability of our economy and preserving American jobs. I would, therefore, have voted in favor of reauthorizing the Export-Import Bank.

I would also have voted for the conference report on the Department of Agriculture Appropriations bill for Fiscal Year 1998. Among many important programs, this conference report includes full funding for the Food and Drug Administration's initiative to curb underage smoking in our country. In addition, the bill provides over $3.9 billion—$118 million more than approved by the House of Representatives—for the important Women Infant and Children's (WIC) nutritional program.

I would also have voted in favor of instructing the House conferees to Foreign Operations Appropriations Conference Committee to insist on the House approved provisions to reinstate the ''Mexico City'' policy. It is my belief that federal funds should not be used to fund abortions here or abroad.

MEDICARE PARTIAL HOSPITALIZATION INTEGRITY ACT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 8, 1997

Mr. STARK. Mr. Speaker, on behalf of Representative KAREN THURMAN and myself, I am today introducing legislation to reform Medicare's partial hospitalization benefit.

The partial hospitalization benefit is an important addition to Medicare, helping people with substantial mental health needs, who in the absence of this service would need to be hospitalized.

Unfortunately, Congress' effort to provide this improved benefit has become prey to some unethical and corrupt ''health care providers.'' In some areas, the benefit is being badly abused. I include an article from the Miami Herald of September 2, 1997, which describes the situation in Florida.

The bill we are introducing today will deny coverage of services in home and nursing home settings; establish quality standards that will prevent fly-by-night operators from being eligible to participate; establish a prospective payment system for the partial hospitalization benefit, so that costs are brought under control; and provide a demonstration project to determine whether more comprehensive services by quality providers can indeed save Medicare some revenues.

The administration proposed most of these changes this summer, but the partial hospitalization problem was new to Congress and we did not have time to consider these proposals in this summer's Balanced Budget Medicare Title.

I hope that these provisions can be considered early in the next session of Congress, so that this abuse of the system can be stopped. The situation in Florida indicates that we cannot afford to wait.

The partial hospitalization benefit—when done right—is an important and cost-effective tool to reduce the length of stay of an inpatient hospitalization and to prevent the need for inpatient hospitalization altogether. The reforms we are suggesting have the support of the partial hospitalization, who are as anxious as we are to expel the bad actors from this specialty.

Why partial hospitalization is a useful service is well described in the following materials provided by the Association of Behavioral Healthcare, Inc.

[From the Miami Herald, September 2, 1997]

MEDICARE ABUSES SPARK CRY FOR ANTI-FRAUD LAW

(By Peggy Rogers)

Florida's notorious Medicare cheats have yet another type of record—abusing a special psychiatric program out of all proportion to the rest of the nation.

Patient snatching is among the homegrown scams employed in this ''partial hospitalization'' program, which is supposed to provide several hours a day of intensive psychiatric care. The unwitting elderly and mentally ill, often told they are going on recreational outings, are lured from boarding homes each day to be used as patients.

The boom is astounding. In 1993, Florida outfits billed federal insurers $2.9 million for partial hospitalization. Last year, Florida's total was $112 million—half of the $220 million Medicare spent nationwide for partial hospitalization, federal anti-fraud authorities say.

So ''aberrant'' and ''alarming'' are Florida's numbers that state health-care administrators are proposing a state law to clamp down on abusers. If authorities with the Florida Agency for Health Care Administration secure a sponsor, the law requiring licensure of partial hospitalization programs would be considered during the next legislative session.

At the same time, federal authorities in Miami this summer have recommended a moratorium on Medicare billing by new companies.

In 1991, Washington expanded partial hospitalization payments to facilities outside of hospitals. It was intended to save mentally disturbed patients from full hospitalization and save taxpayers money. Services include therapy and stabilization, several hours a day, several days a week.

While Florida consumes half of the program's entire national budget, the state has 26 percent of the private companies providing the service and only 6 percent of the recipients inapplicable Medicare plans, according to a recent report by a Miami-based Medicare anti-fraud squad, Operation Restore Trust.

Eighty percent of the Florida companies are in Dade, Broward and Palm Beach counties.

''We believe that the situation in Florida . . . warrants immediable action,'' warned Dewey Price, leader of Operation Restore Trust's Miami office.

A moratorium and other recommended actions ''should be adopted as quickly as possible to protect both the [Medicare] Trust Fund and the beneficiaries who are supposed to receive partial hospitalization services at these facilities.'' Price urged policymakers in this report earlier this summer.

Audits in Florida report a ''high incidence'' of kickbacks to boarding homes for use of their residents, as well as other ''widespread, fundamental abuses''—including a lack of medical eligibility by most of the people purportedly receiving treatment.

A temporary ban on admitting new companies to the program would allow Medicare time to regain control of the situation and create lighter policies, authorities say.

One policy now allows partial hospitalization programs to provide care outside their centers. One review found billings for patients from locations as distant as 150 miles.

The companies, typically for-profit outfits, are virtually unregulated.

They are supposed to provide patients with several hours a day of therapy and stabilizing treatment. But spot federal audits found that ''none of the group sessions are being led by licensed staff as required by state law to provide psychotherapy'' and that ''no active treatment is being provided.''.

The state does not pay for partial hospitalization and has lost little money. But controlling quality is a big concern, along with helping Medicare safeguard public money, said spokeswoman Colleen David of the Agency for Health Care Administration.

''Our fundamental problem is that these programs are not licensed, and licensing is a proxy for monitoring quality,'' David said. ''The program has clearly grown exponentially over a very short period of time.''

The number of partial hospitalization centers billing Medicare in Florida grew from none in 1991, the year the federal government expanded the category, to 87 in 1994.

Since then, the number has tripled. Of the 259 Florida companies today, Dade County alone has 167, Broward County has 22 and Palm Beach, 20.

There is also a nationwide problem with increases in spending per patient. Operation Restore Trust's Dewey Price noted, ''and nowhere is the situation more alarming than in the state of Florida.''

In 1993, three of the state's partial hospitalization programs ranked among the 30 nationwide with the highest per-patient claims. A year later, Florida had 10 of the 30 highest billers. And in 1995, Florida had 22 out of 30.

''Data for 1996 has been requested, and we expect even more aberrant results,'' Price reported.

[Excerpts from recent publications of the Association for Ambulatory Behavioral Healthcare, Inc.]

The huge and expanding older adult population continues to pose a tremendous challenge to the mental health delivery system, including payers, providers, and purchasers. As the elderly cohort grows, the demands on all levels of services grows exponentially. Depression and other later life psychiatric issues such as anxiety secondary to loss of health or a permanent change in physical condition, difficulty coping with dementia in a spouse, severe grief and loss, and panic over the inability to live independently and the subsequent placement in a nursing home facility are all common events. These problems are generally acute and debilitating and frequently present themselves simultaneously as well as in the context of a limited or nonexistent social support system. At the same time, it has been well documented that the elderly tend to underutilize mental health services because of stigma surrounding psychiatric care, cost and transportation limitations, and both patient and professional bias and misunderstanding that surrounds the detection, need for treatment, and cooperation with follow through for care.

Geriatric partial hospitalization programs are a viable option to improve the mental health services available to the elderly population. First, partial hospitalization addresses the problems of accessibility and acceptability. Generally transportation for patients is provided, and since patients return home each day the stigma associated with an inpatient stay in a psychiatric care facility is averted. Additionally, the treatment takes place in the environment of an age-similar group which has been shown to foster cohesion, therapeutic learning, and consistent application to daily life problems. Second, a geriatric partial hospitalization program is able to respond to diverse patient needs on both the individual and group level, as each patient receives a specifically tailored personalized treatment plan, and the therapy provided in the groups is relevant to a wide variety of patient problems. Treatment specifics are flexible within the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 1995) and the Medicare revisions of the guidelines for partial hospitalization (HCFA, 1995). Third, the availability of intensive treatment in partial hospitalization will often avert the need for inpatient care. This fact allows the health care provider to treat the patient at the most appropriate level of care, maintain him or her in the least restrictive environment, and places less stress on the patient, as the partial hospitalization program allows the patient to participate in an intensive psychiatric care program while still maintaining outpatient status. Finally, a geriatric partial hospitalization program is designed to reduce and control psychiatric symptoms, prevent relapse or exacerbation of problems, and improve mental, emotional, and physical functioning, all of which contribute to building in the patient the ability to live as independently as possible while enjoying the highest level of health.

A geriatric partial hospitalization program should be a separate, identifiable, organized unit that provides a significant link within a comprehensive continuum of mental health services, and thus, improves the overall continuity of care for the elderly patient. It is defined as a distinct, organized, time-limited, ambulatory, coordinated, active treatment program that offers structured, therapeutically intensive clinical services, less than 24 hours per day, to elderly patients. . . . The partial hospitalization program is a complex treatment that is intended for patients who exhibit profound or disabling conditions related to an acute phase of mental illness or an exacerbation of a severe and persistent mental disorder. The program generally operates as an outpatient unit in a hospital or as a part of a community mental health center and is to operate under the direct supervision of a physician. The program is to provide regular, coordinated, diagnostic, medical, psychiatric, psychosocial, occupational therapy, and multi-disciplinary treatment modalities on a more intensive level than is generally provided in an outpatient clinic setting.

Geriatric partial hospitalization programs are designed to serve elderly patients with appropriate clinical diagnoses, diverse medical problems, and a broad band of variability in socioeconomic and educational backgrounds. The geriatric partial hospitalization program must provide active psychiatric treatment and should be clearly distinguishable from an adult day care program, which provides primarily social, custodial, and respite services. An appropriate geriatric partial hospitalization program employs an integrated, comprehensive, and complementary schedule of active treatment approaches that are behaviorally tied to the identified problems and the specific goals contained in the individualized patient treatment plan. Specifically, active treatment refers to the ongoing provision of clinically recognized therapeutic interventions which are goal-directed and based on a written treatment plan. For treatment to be considered active the following criteria must be met:

1. treatment must be directed toward the alleviation of the impairments that precipitated entry into the program, or which necessitate this continued level of intervention,
2. treatment enhances the patient's coping abilities, and
3. treatment is individualized to address the specific clinical needs of the patient.

Geriatric partial hospitalization programs typically serve individuals 65 years of age and older who are experiencing acute psychiatric problems or decompensating clinical conditions which markedly impair their capacity to function adequately on a day-to-day basis. Usually outpatient therapy has not been effective, and without the ongoing structure, support, and active treatment provided by the geriatric partial hospitalization program these patients would require inpatient psychiatric care.

Ambulatory behavioral health services are designed for persons of all ages who present with a psychiatric and/or chemical dependency diagnosis and the need for treatment which is more intensive than outpatient office visits and less restrictive than 24-hour care.

Ambulatory behavioral health services consist of a coordinated array of active treatment components which are determined by an individualized treatment plan based upon a comprehensive evaluation of patient needs.

Ambulatory behavioral health services treat patients requiring intensive therapeutic intervention in a manner which simulates real-life experience and with the least amount of disruption to their normal daily functioning.

Ambulatory behavioral health services are available to patients on a consistent basis and are augmented with 24-hour crisis backup.

Ambulatory behavioral health services require active involvement of the service team and patient with both community and family resources.

Finally, due to the matching of patient needs with targeted interventions, the provision of treatment in the most appropriate, least restrictive environment, and the reliance on patient strengths, resources and family and community support systems, ambulatory behavioral health services are cost efficient.

[From Medicare Explained, 1996, published by CCH Inc.]

PARTIAL HOSPITALIZATION COVERAGE

Medicare also covers partial hospitalization services connected with the treatment of mental illness. Partial hospitalization services are covered only if the individual otherwise would require inpatient psychiatric care. [Soc. Sec. Act §§1833(c), 1835(a)(2)(F), 1861(s)(2)(B).]

Under this benefit, Medicare covers: (1) individual and group therapy with physicians or psychologists (or other authorized mental health professionals); (2) occupational therapy; (3) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; (4) drugs and biologicals furnished for therapeutic purposes that cannot be self-administered; (5) individualized activity therapies that are not primarily recreational or diversionary; (6) family counseling (for treatment of the patient's condition); (7) patient training and education; and (8) diagnostic services. Meals and transportation are excluded specifically from coverage. [Soc. Sec. Act. §1861(ff)(2).]

The services must be reasonable and necessary for the diagnosis or active treatment of the individual's condition. They also must be reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. The course of treatment must be prescribed, supervised, and reviewed by a physician. The program must be hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care. [Soc. Sec. Act §1861(ff).] Effective October 1, 1991, partial hospitalization services also are covered in community health centers (see ¶382). [Soc. Sec. Act §1861(ff)(3).]

HONORING PETER DANNER

HON. DALE E. KILDEE

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Wednesday, October 8, 1997

Mr. KILDEE. Mr. Speaker, I rise today to honor the recipient of the 1997 Golden Door Award, Mr. Peter Danner. The award will be given posthumously to Mr. Danner at the annual dinner meeting of the International Institute of Flint on Tuesday, October 14. The International Institute of Flint presents this award annually to a foreign-born citizen who has substantially improved life in the Flint community.

Peter Danner was born in Hungary in 1931. His family owned a wholesale grocery business serving southern Hungary. During World War II the business was invaded first by the Germans and then later by the Russians who looted the food for the soldiers. After graduating from high school Peter joined the Hungarian military. He planned to study engineering but the military did not cooperate and he was assigned to work in an office.

In 1956 Peter started his long journey to the United States. Leaving Hungary during the