S. 1630. A bill to amend title III of the Public Health Service Act to include each year of fellowship training in geriatric medicine or geriatric psychiatry as a year of obligated service under the National Health Corps Loan Repayment Program; to the Committee on Health, Education, Labor, and Pensions.

By Mr. CONRAD:

S. 1631. A bill to provide for the payment of the graduate medical education of certain interns and residents under title XVIII of the Social Security Act; to the Committee on Finance.

By Mr. LIEBERMAN (for himself, Mr. DODD, Mr. SCHUMER, and Mr. MOYNIHAN):

S. 1632. A bill to extend the authorization of appropriations for activities at Long Island Sound; to the Committee on Environment and Public Works.

By Ms. SNOWE:

S.J. Res. 34. A joint resolution congratulating and commending the Veterans of Foreign Wars; to the Committee on the Judiciary.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. SPECTER:

S. 1623. A bill to select a National Health Museum site; to the Committee on Governmental Affairs.

NATIONAL HEALTH MUSEUM SITE SELECTION ACT

Mr. SPECTER. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1623

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. NATIONAL HEALTH MUSEUM PROPERTY.

(a) SHORT TITLE AND PURPOSE.—

(1) SHORT TITLE.—This section may be cited as the ''National Health Museum Site Selection Act''.

(2) PURPOSE.—The purpose of this section is to further section 703 of the National Health Museum Development Act (20 U.S.C. 50 note; Public Law 105–78), which provides that the National Health Museum shall be located on or near the Mall on land owned by the Federal Government or the District of Columbia.

(b) DEFINITIONS.—In this section:

(1) ADMINISTRATOR.—The term ''Administrator'' means the Administrator of General Services.

(2) MUSEUM.—The term ''Museum'' means the National Health Museum, Inc., a District of Columbia nonprofit corporation exempt from Federal income taxation under section 501(c)(3) of the Internal Revenue Code of 1986.

(3) PROPERTY.—The term ''property'' means—

(A) a parcel of land identified as Lot 24 and a closed interior alley in Square 579 in the District of Columbia, generally bounded by 2nd, 3rd, C, and D Streets, S.W.; and

(B) all improvements on and appurtenances to the land and alley.

(c) CONVEYANCE OF PROPERTY.—

(1) IN GENERAL.—The Administrator shall convey to the Museum all rights, title, and interest of the United States in and to the property.

(2) PURPOSE OF CONVEYANCE.—The purpose of the conveyance is to provide a site for the construction and operation of a new building to serve as the National Health Museum, including associated office, educational, conference center, visitor and community services, and other space and facilities appropriate to promote knowledge and understanding of health issues.

(3) DATE OF CONVEYANCE.—

(A) NOTIFICATION.—Not later than 3 years after the date of enactment of this Act, the Museum shall notify the Administrator in writing of the date on which the Museum will accept conveyance of the property.

(B) DATE.—The date of conveyance shall be—

(i) not less than 270 days and not more than 1 year after the date of the notice; but

(ii) not earlier than April 1, 2001, unless the Administrator and the Museum agree to an earlier date.

(C) EFFECT OF FAILURE TO NOTIFY.—If the Museum fails to provide the notice to the Administrator by the date described in subparagraph (A), the Museum shall have no further right to the property.

(4) QUITCLAIM DEED.—The property shall be conveyed to the Museum vacant and by quitclaim deed.

(5) PURCHASE PRICE.—

(A) IN GENERAL.—The purchase price for the property shall be the fair market value of the property as of the date of enactment of this Act.

(B) TIMING; APPRAISERS.—The determination of fair market value shall be made not later than 180 days after the date of enactment of this Act by qualified appraisers jointly selected by the Administrator and the Museum.

(D) REPORT TO CONGRESS.—Promptly upon the determination of the purchase price, and in any event at least sixty days in advance of the conveyance of the property, the Administrator shall report to Congress as to the purchase price.

(E) DEPOSIT OF PURCHASE PRICE.—The Administrator shall deposit the purchase price into the Federal Buildings Fund established by section 210(f) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 490(f)).

(d) REVERSIONARY INTEREST IN THE UNITED STATES.—

(1) IN GENERAL.—The property shall revert to the United States if—

(A) during the 50-year period beginning on the date of conveyance of the property, the property is used for a purpose not authorized by subsection (c)(2);

(B) during the 3-year period beginning on the date of conveyance of the property, the Museum does not commence construction on the property, other than for a reason not within the control of the Museum; or

(C) the Museum ceases to be exempt from Federal income taxation as an organization described in section 501(c)(3) of the Internal Revenue Code of 1986.

(2) REPAYMENT.—If the property reverts to the United States, the United States shall repay the Museum the full purchase price for the property, without interest.

(e) AUTHORITY OF MUSEUM OVER PROPERTY.—The Museum may—

(1) demolish or renovate any existing or future improvement on the property;

(2) build, own, operate, and maintain new improvements on the property;

(3) finance and mortgage the property on customary terms and conditions; and

(4) manage the property in furtherance of this section.

(f) LAND USE APPROVALS.—

(1) EFFECT ON OTHER AUTHORITY.—Nothing in this section shall be construed to limit the authority of the National Capital Planning Commission or the Commission of Fine Arts.

(2) COOPERATION CONCERNING ZONING.—

(A) IN GENERAL.—The United States shall cooperate with the Museum with respect to any zoning or other matter relating to—

(i) the development or improvement of the property; or

(ii) the demolition of any improvement on the property as of the date of enactment of this Act.

(B) ZONING APPLICATIONS.—Cooperation under subparagraph (A) shall include making, joining in, or consenting to any application required to facilitate the zoning of the property.

(g) ENVIRONMENTAL HAZARDS.—Costs of remediation of any environmental hazards existing on the property, including all asbestos-containing materials, shall be borne by the United States. Environmental remediation shall commence immediately upon the vacancy of the building and shall be completed not later than 270 days from the date of the notice to the Administrator described in subsection (c)(3)(A).

(h) REPORTS.—Following the date of enactment of this Act and ending on the date that the National Health Museum opens to the public, the Museum shall submit annual reports to the Administrator and Congress, regarding the status of planning, development, and construction of the National Health Museum.

By Mr. WARNER:

S. 1624. A bill to authorize the Secretary of Transportation to issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for the vessel Norfolk; to the Committee on Commerce, Science, and Transportation.

CERTIFICATE OF DOCUMENTATION FOR THE VESSEL ''NORFOLK''

Mr. WARNER. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 1624

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. CERTIFICATE OF DOCUMENTATION.

Notwithstanding section 27 of the Merchant Marine Act, 1920 (46 U.S.C. App. 883), section 8 of the Act of June 19, 1886 (24 Stat. 81, chapter 421; 46 U.S.C. App. 289), and section 12106 of title 46, United States Code, the Secretary of Transportation may issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for the vessel NORFOLK, United States official number 1077852.

By Ms. SNOWE:

S. 1625. A bill to amend title XVIII of the Social Security Act to provide for a special reclassification rule for certain old agencies as new agencies under the home health interim payment system; to the Committee on Finance.

MEDICARE HOME HEALTH CARE

• Ms. SNOWE. Mr. President, I rise today to offer legislation that will remedy a problem facing one of Maine's home health agencies—Home Health & Hospice of St. Joseph, in Bangor, Maine. This bill would reclassify Home Health & Hospice of St. Joseph as a ''new agency'' under the Medicare Home Health Interim Payment System, allowing it a higher per-beneficiary rate.

When Congress passed the Balanced Budget Act, the intention was to modestly control the dramatic growth rate of home health care agencies. But the broad financing constraints and administrative regulations codified in the Balanced Budget Act have had unintended consequences. Almost every week I hear concerns from home care agencies in Maine about the implementation of regulations and restrictions on these agencies.

Since enactment of the Balanced Budget Act, many of our home healthcare agencies have found themselves in a position of financial insolvency. Nationwide, more than 2,000 agencies have closed since BBA's passage. The State of Maine had 90 Medicare/Medicaid certified home health care agencies in the beginning of 1998. By the beginning of 1999, 16 of those agencies had closed.

At the time of the BBA's enactment, the Congressional Budget Office expected home health care expenditures to drop by $75 billion over ten years. In March of this year, CBO examined the Medicare program expenditures of the home health agencies and increased the expected savings by $56 billion—a three-quarter increase over the same ten years!

As a component of the general funding reductions enacted by the Balanced Budget Act, the law created detailed regulations in determining agency per-beneficiary payment limits. These regulations have had several unforeseen and unintended consequences when applied to real-life agencies.

Home Health & Hospice of St. Joseph serves over 700 patients in Bangor, Maine and the surrounding area. Under the BBA, per-patient cost reimbursement is based solely on cost reporting ending in fiscal year 1994. Unfortunately for Home Health & Hospice of St. Joseph—an established and vital component of Bangor's health care system—fiscal year 1994 was an unprecedented period of clinical and financial upheaval. As a result of these problems, the agency's per-patient reimbursement limitation is artificially low. And in spite of the extensive clinical and financial reforms enacted during this unique and transitional period, the cost data for this one year is significantly and permanently flawed.

As a result of the anomalous cost report, the Medicare payment amount for Home Health & Hospice of St. Joseph is only 59 percent of the true costs of treating each patient. For every patient the agency treated in 1998, it lost $1,148. The agency is a cost effective home health care agency: its actual per-patient cost of $2,752 is substantially below the national medial of approximately $3,200. Unfortunately, St. Joseph's anticipates an aggregate loss of $780,000 for its service to Medicare patients over 1998. Simply put, they cannot sustain such a deep loss of funding and continue to operate.

Mr. President, I introduce this bill today in order to address the problem faced by Home Health & Hospice of St. Joseph. This legislation will reclassify Home Health & Hospice of St. Joseph as a ''new agency'' under the BBA, and is targeted to St. Joseph's. Mr. President, my state relies on home health agencies for much of its healthcare, and we cannot face the prospect of losing such a fine agency.•

By Mr. HATCH (for himself, Mr. NICKLES, Mr. BREAUX, Mr. GRASSLEY, Mr. MURKOWSKI, and Mr. BAYH):

S. 1626. A bill to amend title XVIII of the Social Security Act to improve the process by which the Secretary of Health and Human Services makes coverage determinations for items and services furnished under the Medicare Program, and for other purposes; to the Committee on Finance.

THE MEDICARE PATIENT ACCESS TO TECHNOLOGY ACT OF 1999

Mr. HATCH. Mr. President, I rise to introduce the Medicare Patient Access to Technology Act of 1999. I am pleased to be joined by the distinguished Assistant Majority Leader, Senator NICKLES, and Senators BREAUX, GRASSLEY, MURKOWSKI, and BAYH in introducing this legislation.

While we all recognize that medical technologies and treatments are improving the lives of millions of Americans daily, gaining access to these innovations is becoming more difficult. Each day, new implantable medical devices are correcting or repairing failing organ systems in patients. People are receiving new tests that permit the diagnosis of diseases in their earliest stages without the use of surgery or other more complicated procedures. Tens of thousands of individuals owe their lives to small, powerful miniature devices that monitor and regulate vital physiological functions and allow patients to live more productive lives.

The latest advances in pharmaceutical and biologics are not only extending the length of life, but significantly improving the quality of life for hundreds of millions of people. Life-saving and life-enhancing innovations must be available to all Americans, and it is our duty to ensure that those patients who need them most, America's nearly 40 million Medicare beneficiaries, have access to them.

As part of the Balanced Budget Act (BBA) of 1997, we authorized the Health Care Financing Administration (HCFA) to adjust periodically Medicare's coverage and payment systems to account for changes in technology, treatment, and medical care. Unfortunately, without Congressional input, there is no guarantee that these expedited procedures will take place.

The Medicare Patient Access to Technology Act of 1999 has arisen out of growing evidence that without intervention, Medicare beneficiaries will be denied access to the most modernized treatments and innovations in health care.

After medical technologies, devices, and drugs are approved by the Food and Drug Administration, they still must meet several critical HCFA requirements before they are available to Medicare beneficiaries.

First, before technologies are approved by HCFA for reimbursement, they must be covered, that is fulfill the definitions of ''reasonable and necessary.'' Second, they must have an identifying procedure code. New device technologies receive this ''procedure code,'' a four or five digit identification number that allows health care providers to submit claims to payers. Finally, the technologies must be reimbursed through one of Medicare's payment systems. The problems arise because each of these levels is plagued by inefficiency, coding delays, and lack of data usage by HCFA.

My legislation addresses these concerns in five specific ways.

First, Medicare payment levels and payment categories will be adjusted at least annually to reflect changes in medical practice and technology. A recent Institute of Medicine study reported that most medical technologies have an average life span of 18 months with many modernizations occurring rapidly. These innovations must, therefore, be rapidly processed so that they are accessible to beneficiaries. While BBA 97 authorized HCFA to adjust payment systems ''periodically'' to account for changes in technology, there is little promise that this will occur in a systematic, timely and beneficial manner.

My bill requires HCFA to review and revise payment categories and payment levels for all prospective payment systems (PPS) at least annually. These prospective payment systems include hospital inpatient and outpatient, physicians, ambulatory surgery facility services. It also calls for public input on the review process.

Second, this legislation mandates that valid external sources of information be used to update payment categories if Medicare's data are limited in scope or, are not yet available. Traditionally, HCFA has only used its own data set, known as the Medicare Provider Analysis and Review (MEDPAR)

data systems, to evaluate a given technology before assigning an appropriate code. The average waiting period for the assignment of a new code is 18 months or longer.

Furthermore, HCFA refuses to consider partial year or externally generated data in its decision-making processes. My bill directs HCFA to use external sources of data on the cost, charges and use of medical technologies. This language allows HCFA to utilize high quality data from private insurers, manufacturers, suppliers, providers, and other sources.

Third, my legislation will require that national procedure codes are updated more frequently to reduce delays in accessing new technologies. Currently, new products must have an identification code before they are eligible for appropriate reimbursement by Medicare. Assigning this code can take 18 months or longer because of the way HCFA has structured its calendar year.

This legislation allows HCFA to accept applications quarterly, on a rolling basis, thereby allowing the processing of new technologies throughout the year instead of bundling them at one annual submission.

Furthermore, the Medicare Patient Access to Technology Act will eliminate the HCFA requirement that new products be on the market for six months before they are eligible for a new code. This provision will ensure that new technologies are brought to Medicare beneficiaries more rapidly.

Fourth, the bill guarantees that local procedure codes for medical technologies will continue to be used. HCFA has proposed to eliminate Common Procedure Coding System (HCPCS) Level III Local Codes beginning in 2000 and replace it with the Level II National Codes. This is potentially detrimental to new technologies that are often introduced into local, smaller health care systems before they are expanded into nationwide markets. Without the Level III Local Codes, new technologies must be placed into a ''miscellaneous'' code that is often rejected by payers thereby denying access of the technology to beneficiaries. The maintenance of the current system will ensure that technologies will be encoded at the earliest possible date and processed before moving to the national level.

Finally, the legislation authorizes HCFA to create an Advisory Committee on Medicare Coding and Payment. As a result, when HCFA has to make coding and payment decisions, it will be prompt, permit public participation, and will guarantee Medicare beneficiaries access to the highest quality products and services. The panel would ensure that safe medical technologies are approved, covered, coded and paid by Medicare as expeditiously as possible.

In addition to the above authorizations, the Medicare Patient Access to Technology Act proposes several refinements to the Administration's proposed outpatient prospective payment system (PPS). The legislation affects three changes to HCFA's implementation of the Balanced Budget Act (BBA) of 1997.

The first change mandates HCFA to restructure the proposed ambulatory payment classification (APC) system to create groups of procedures that are more similar in cost and most closely related clinically. The current HCFA proposal would create unusual financial incentives that would clearly discourage the use of the most appropriate, cutting-edge technology. Furthermore by grouping very disparate technologies, hospitals will face serious underpayments for certain procedures. I believe that illogical categorization creates disincentives to use newer, but more expensive products and procedures that provide far superior patient care.

The second change mandates that HCFA retain the current cost-based system for another four years to compile the cost studies and use data and conduct the analysis necessary to classify them in the appropriate APC. The development of these data sets are mandatory and without proper clarification. Therefore, these products could receive substantial underpayment, and, as a result, patient access to newer procedures and products could be limited.

Third, the implantable medical technologies should be reimbursed under the new APCs along with other similar medical technologies. They should not be reimbursed through the durable medical technology fee schedule. By placing the implantables within the DME propective payment system, the fee schedule will lock implantables into defined categories that will limit their use and inhibit their access to seniors. By placing them into the proposed APCs with the other medical devices, they will be treated as other new, innovative medical technologies.

Again, I am pleased to be joined by my Senate colleagues, Senators NICKLES, BREAUX, GRASSLEY, MURKOWSKI, and BAYH, in introducing this important piece of legislation. This bill supports both our Medicare beneficiaries and our technology, pharmaceutical, and biotechnical industries by continuing to promote life-enhancing innovations. I firmly believe that these significant improvements to our Medicare coding and payment systems will increase the access to modern medical innovation to Americans who need them most, our senior citizens.

Mr. President, I urge my colleagues to join us in support of this important legislation.

By Mr. REID (for himself, Mr. GRASSLEY, Mr. HARKIN, and Mr. CLELAND):

S. 1628. A bill to amend title XVIII of the Social Security Act to increase the number of physicians that complete a fellowship in geriatric medicine and geriatric psychiatry, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

MEDICARE PHYSICIAN WORKFORCE IMPROVEMENT ACT OF 1999

S. 1630. A bill to amend title III of the Public Health Service Act to include each year of fellowship training in geriatric medicine or geriatric psychiatry as a year of obligated service under the National Health Corps Loan Repayment Program; to the Committee on Health; Education, Labor, and Pensions.

GERIATRICIANS LOAN FORGIVENESS ACT OF 1999

Mr. REID. Mr. President, I rise today to introduce two pieces of legislation that address our national shortage of geriatricians. I am pleased that Senators GRASSLEY, HARKIN and CLELAND are joining me as original cosponsors.

Our nation is growing older. Today, life expectancy is 79 years for women, and 73 years for men. While the population of the United States has tripled since 1900, the number of people age 65 or older has increased eleven times—to more than 33 million Americans. One-third of all health care costs can be attributed to this group. The fastest growing part of the Medicare population—those over 85—number more than three-and-a-half million. But, according to reports from the Institute of Medicine, the National Institute on Aging, and the Council on Graduate Medical Education, the number of doctors with special training to meet the needs of the oldest and frailest Americans is in critically short supply.

I first became concerned about this problem when I read a report issued by the Alliance for Aging Research in May of 1996 entitled, ''Will You Still Treat Me When I'm 65?'' The report concluded that there are only 6,784 primary-care physicians certified in geriatrics. This number represents less than one percent of the doctors in the United States. The report goes on to state that the United States should have at least 20,000 physicians with geriatric training to provide appropriate care for the current population, and as many as 36,000 geriatricians by the year 2030 when there will be close to 70 million older Americans.

I first introduced legislation to address the national shortage of geriatricians during the 105th Congress. While I am encouraged that greater attention has been focused on this issue, little has been accomplished to improve the shortage of geriatricians. The two bills I am introducing today, the ''Medicare Physician Workforce Improvement Act'' and the ''Geriatrician Loan Forgiveness Act of 1999'' aim—in modest ways and at very modest cost—to encourage an increase in the number of the doctors Medicare clearly needs,

those with certified training in geriatrics.

One provision of the ''Medicare Physician Workforce Improvement Act of 1999'' will allow the Secretary of Health and Human Services to double the payment made to teaching hospitals for geriatric fellows. This provision is limited to a maximum of 400 individuals in any calender year. This is intended to serve as an incentive to teaching hospitals to promote and recruit geriatric fellows.

Another provision of the Medicare Physician Workforce Improvement Act would direct the Secretary of Health and Human Services to increase the number of certified geriatricians appropriately trained to provide the highest quality care to Medicare beneficiaries in the best and most sensible settings by establishing up to five geriatric medicine training consortia demonstration projects nationwide. In short, this would allow Medicare to pay for the training of doctors who serve geriatric patients in the settings where this care is so often delivered. Not only in hospitals, but also ambulatory care facilities, skilled nursing facilities, clinics and day treatment centers.

The second bill I am offering today, ''The Geriatricians Loan Forgiveness Act of 1999,'' has but one simple provision. That is to forgive $20,000 of education debt incurred by medical students for each year of advanced training required to obtain a certificate of added qualifications in geriatric medicine or psychiatry. My bill would count their fellowship time as obligated service under the National Health Corps Loan Repayment Program.

While almost all physicians care for Medicare patients, many are not familiar with the latest advances in aging research and medical management of the elderly. Too often, problems in older persons are misdiagnosed, overlooked or dismissed as the normal function of aging because doctors are not trained to recognize how diseases and impairments might appear differently in the elderly than in younger persons. As a result, patients suffer needlessly, and Medicare costs rise because of avoidable hospitalizations and nursing home admissions.

A physician who takes special training in the care of the elderly becomes sensitive to the need to evaluate and address the patient's behaviors and moods, as well as her physical symptoms. This is especially important, as the rates of undiagnosed depression and suicide among the elderly are scandalous. By allowing doctors who pursue certification in geriatric medicine to become eligible for loan forgiveness, and by offering an incentive to teaching institutions to promote geriatric fellowships, my bills will provide a measure of incentive for top-notch physicians to pursue fellowship training in this vital area.

Increasing the number of certified geriatricians will not be easy for a number of reasons. Geriatrics is the lowest paid medical specialty, because the extra time required for effective and compassionate treatment of the elderly is barely reimbursed by Medicare and other insurers. It takes a special individual to commit himself or herself to the work of helping older patients preserve vitality and functional abilities over time. Often the goal for a geriatrician is not to cure disorders, but to delay the onset of disability—that is, simply to help seniors live as well as possible. For these reasons, existing slots in geriatrics training programs sometimes go unfilled today. But while the work may be difficult and not well compensated, protecting quality of life for the elderly is extraordinarily important, and we need physicians whose training explicitly recognizes that.

It is similarly difficult for teaching programs to build and remain committed to maintaining fellowship training in geriatric medicine, because geriatric faculty are scarce and the type of patients brought in by a training program often require extremely complex and high cost care. Simply, it is cheaper to train other specialties, and more lucrative in terms of graduate medical education payments to the hospital. In fact, there are only two departments of geriatrics at academic medical centers across the entire country.

Another barrier to alleviating the shortage of geriatricians is the result of an unintended consequence of the Balanced Budget Act of 1997 (BBA). A provision in this law established a hospital-specific cap on the number of residents based on the number of residents in the hospital in 1996. Because a lower number of geriatric residents existed prior to December 31, 1996, these programs are underrepresented in the cap baseline. The implementation of this cap has resulted in the reduction of, and in some cases, the elimination of geriatric training programs. This is one obstacle that should not be overlooked when Congress considers legislation to correct some of the unintended consequences of the BBA.

When it comes to training the doctors we need, Medicare's current payment system is part of the problem, not part of the solution. The Medicare Payment Advisory Commission's (MEDPAC) August 1999 report to Congress entitled ''Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals'' examines this very issue. According to the MEDPAC report:

Where Medicare does not pay for services generally associated with a particular specialty, it may discourage training. For example, although several studies have indicated an inadequate supply of geriatricians, the number of geriatric training slots exceeds the number of people who choose to enter the specialty. This may reflect a lack of payment for services such as palliative care and geriatric assessment.

Clearly, the incentives in Medicare's payment system are poorly aligned when training doctors specifically to care for the elderly is avoided. Again, my bill provides a modest incentive for hospitals to increase the number of training slots available.

Medicare should be providing incentives to community-based programs to participate in the education of doctors, especially geriatricians, by directing graduate medical education payments appropriately to all facilities that incur the additional costs of providing training. My bill directs the Secretary to undertake up to five demonstration projects that will do just that.

Many reports have highlighted the shortage of geriatricians we have today. The response to the problem needs to be a national one, and it would be most unwise to simply hope that the labor market will produce the kinds of doctors we will increasingly need. I am especially grateful to the American Geriatrics Society for its assistance in discussing ways to address the problem. I believe that the Medicare Physician Workforce Improvement Act and the Geriatrician Loan Forgiveness Acts are steps in the right direction, and I ask my colleagues to join me in supporting these bills.

I ask unanimous consent that letters of support from the American Geriatrics Society and the Alliance for Aging Research be printed in the RECORD.

There being no objection, the letters were ordered to be printed in the RECORD, as follows:

AMERICAN GERIATRICS SOCIETY,
New York, NY, September 17, 1999.

Hon. HARRY REID,
U.S. Senate,
Washington, DC.

DEAR SENATOR REID: The American Geriatrics Society (AGS), an organization of over 6,000 geriatricians and other health care professionals who are specially trained in the management of care for frail, chronically ill older patients, offers our strongest support to the Medicare Physician Workforce Improvement Act of 1999 and the Geriatricians Loan Forgiveness Act of 1999.

The AGS is dedicateed to improving the health and well being of all older adults. While we provide primary care and supportive services to all patients, the focus of geriatric practice is on the frailest and most vulnerable elderly. The average age of a geriatrician's caseload exceeds 80, and our patients often have multiple chronic illnesses. Given the complexity of medical and social needs among our nation's elderly, we are strongly commited to a multi-disciplinary approach to providing compassionate and effective care to our patients.

As you know, America faces a critical shortage of physicians with special training in geriatrics. Even as the 76 million persons of the baby boom generation reach retirement age over the next 15 to 20 years, the number of certified geriatricians is declining. In fact, the August 1999 MedPAC report noted the shortage in geriatricians, despite the availability of training positions. The

MedPAC report noted that the shortage is caused by faulty system incentives, such as inadequate Medicare reimbursement to geratricians. By providing modest incentives—which will encourage teaching hospitals to increase the number of training fellowships in geriatric medicine and psychiatry, provide loan assistance to physicians who pursue such training, and support development of innovative and flexible models for training in geriatrics—your bills present very positive steps toward reversing that trend.

The AGS has been pleased to work closely with your office to develop initiatives to preserve and improve the availability of highest quality medical care for our oldest and most vulnerable citizens. We believe that the ''Medicare Physician Workforce Improvement Act'' and the ''Geriatricians Loan Forgiveness Act'' represent a cost-effective approach to training the physicians our nation increasingly will need. We commend you for your leadership on an issue of such vital importance to the Medicare program and our elderly citizens.

Sincerely,

JOSEPH G. OUSLANDER, M.D.,
President.

ALLIANCE FOR AGING RESEARCH,
Washington, DC, September 23, 1999.

Hon. HARRY REID,
Hart Senate Office Building,
Washington, DC.

DEAR SENATOR REID: As the Executive Director for the Alliance for Aging Research, an independent, not-for-profit organization working to improve the health and independence of older Americans, I am writing in support of the ''Medicare Physician Workforce Improvement Act'' and the ''Geriatricians Loan Forgiveness Act.''

The Alliance has worked for many years to bring attention to the critical need for more geriatricians, those physicians who are trained to address the complex needs of older patients. Best estimates suggest that there is a need for at least 20,000 geriatricians at present and nearly 40,000 by the year 2030 to care for the graying baby boomers. Not only are we far short of current needs, with less than 7,000 geriatricians in practice, but far too few doctors in training are choosing this field.

The two bills you are introducing represent important first steps in solving this problem.

In addition to increasing the number of physicians trained in geriatrics, we need to develop a strong cadre of academics and researchers within our medical schools to help mainstream geriatrics into both general practice and specialties. Increasing the number of fellowship positions in geriatric medicine will improve the situation.

We must have this kind of support and commitment from the federal government, along with private and corporate philanthropy if we are to sufficiently provide care for our aging population. The Alliance for Aging Research is encouraged by your leadership and support in this area and we look forward to working with you to bring these issues before Congress.

Best regards,

DANIEL PERRY,
Executive Director.

By Mr. SMITH of Oregon (for himself and Mr. WYDEN):

S. 1629. A bill to provide for the exchange of certain land in the State of Oregon; to the Committee on Energy and Natural Resources.

OREGON LAND EXCHANGE

● Mr. SMITH of Oregon. Mr. President, I rise before the Senate today to introduce legislation which would facilitate two exchanges of public and private lands in my home State of Oregon: the Triangle Land Exchange and the Northeast Oregon Assembled Land Exchange (NOALE). In terms of acreage, approximately 54,000 acres of BLM and Forest Service land is proposed to be traded for nearly 50,000 acres currently held by private landowners in northeast Oregon. As a result of 4½ years of delays with administrative process, there is enormous support from my constituents for a legislative resolution to the exchange.

Both the government and the public have deeply rooted interests in this exchange. Federal agencies are seeking to acquire sensitive river corridors which will improve the efficiency of their protection efforts for threatened and endangered fish. Currently, many of these selected lands are intermingled with private parcels and make resource management difficult for the agencies. As you know, the improvement of fish-bearing streams and riparian areas is critical to the survival of many struggling species of fish in the Northwest.

Communities and landowners will also benefit from these exchanges. Each and every aspect, from the consolidation of ownership patterns to the release of previously inaccessible timber stands, will boost local economies and enhance the ability of the private sector to manage its own lands.

In addition, these land exchanges have received the strong collective support of several Oregon Indian tribes; conservation groups such as the Oregon Natural Desert Association, Oregon Trout and the Sierra Club; the Governor and scores of concerned citizens at large.

While these exchanges hold enormous benefit for all interested parties and for Oregon's natural resources, it is apparent that the only sure means of completing them is through legislation. Mr. President, I am hopeful that the Senate will take this opportunity and support my colleague from Oregon and me in the swift passage of legislation to facilitate the Triangle and Northeast Oregon Assembled Land Exchanges.●

By Mr. CONRAD:

S. 1631. A bill to provide for the payment of the graduate medical education of certain interns and residents under title XVIII of the Social Security Act; to the Committee on Finance.

GRADUATE MEDICAL EDUCATION FAIR TECHNICAL AMENDMENT ACT OF 1999

● Mr. CONRAD. Mr. President, today I am pleased to introduce the Graduate Medical Education Fair Technical Amendment Act of 1999. This legislation will take important steps to sustain and improve the availability of medical professionals in communities in my State.

Mr. President, as you know, the Balanced Budget Act of 1997 (BBA) included many measures to control rising health care spending, including provisions that reduced the level of resources for graduate medical education. In particular, the BBA set a limit on the amount of medical residents for which teaching hospitals can receive reimbursement. This cap was set according to the number of medical residents on staff as of December 31, 1996. While this reimbursement limit has helped to contribute to the overall savings generated by the BBA, I am concerned that it has unfairly limited the ability of certain programs to adequately train future health care providers.

Over the last few years, we have heard much discussion about the issue of physician oversupply. As you may know, various experts suggest that the true problem regarding physician supply is an unequal distribution of physicians across the country. In my State of North Dakota, for example, more than 85 percent of the counties are in health professional shortage areas. There certainly isn't a physician oversupply in my state—we are grateful for the health care providers serving our communities and we are grateful to have facilities with the capability to train medical residents.

Recently, it came to my attention that one of the teaching hospitals in my State had committed to training an increased level of medical residents. This situation arose because another facility in my State was no longer able to offer these residents an adequate training experience. The facility's decision to take on the new residents was important—while we cannot guarantee that physicians trained in my State will pursue permanent practice in the State, we know that providers are more likely to serve where they are trained. And it is important to note that the University of North Dakota produces a higher percentage of graduates who practice in rural settings than any medical school in the Nation.

The facility took on these residents assuming that they would receive adequate Medicare graduate medical education reimbursement to train these individuals. Unfortunately, retroactively set BBA limits capped the allowable reimbursement level just prior to the time the residents in question came on board. Thus, the facility was already committed to training these residents but the funds they depended on to do so were no longer available. The result of this situation is that the entire graduate medical residency program is suffering and I am concerned tat this could result in reduced services for beneficiaries.

The legislation I introduce today will correct the unintended consequence of the BBA by allowing a technical adjustment to medical resident caps in certain situations. I am confident this legislation will help ensure we have adequate resources to meet our health care needs well into the future. I urge my colleagues to support this important effort.●

By Mr. LIEBERMAN (for himself, Mr. DODD, Mr. SCHUMER, and Mr. MOYNIHAN):

S. 1632. A bill to extend the authorization of appropriations for activities at Long Island Sound; to the Committee on Environment and Public Works.

REAUTHORIZATION OF THE LONG ISLAND SOUND OFFICE

● Mr. LIEBERMAN. Mr. President, I rise today to introduce a reauthorization bill of critical importance to the future of Connecticut's most valuable natural resource, the Long Island Sound. This bill, which I offer with my colleagues Mr. DODD, Mr. SCHUMER, and Mr. MOYNIHAN, reauthorizes the Long Island Sound Office through the year 2005, and increases the grant authorization amount to $10 million.

The Long Island Sound is among the most complex estuaries in the National Estuary Program, both in terms of the physical features and scientific understanding of the estuary system, and in the context of ecosystem management. Unlike most estuaries, Long Island Sound has two connections to the sea. Rather than having a major source of fresh water at its head, flowing into a bay that empties into the ocean, Long Island Sound is open at both ends, flowing to the Atlantic Ocean to the east and to New York Harbor to the west. Most of its fresh water comes from a series of south-flowing rivers, including the Connecticut River, the Housatonic, and the Thames, whose drainages reach as far north as Canada. The Sound's 16,000 square mile drainage basin also includes portions of New York City and Westchester, Nassau, and Suffolk Counties in New York State. The Sound combines this multiple inflow/outflow system with a diverse and complex shoreline, and an uneven bottom topography. Taken together, they produce unique and complex patterns of tide and currents.

The interaction between the Sound and the local human population is also complex. The Sound is located in the midst of the most densely populated region of the United States. In total, more than 8 million people live in the Long Island Sound watershed and millions more flock yearly to the Sound for recreation. The Sound provides many other valuable uses, such as cargo shipping, ferry transportation and power generation. It is largely because the Sound serves such a concentrated population that the economic benefits of preserving and restoring the Sound are so substantial. More than $5.5 billion is generated annually in the regional economy from water quality-dependent activities such as boating, commercial and sport fishing, swimming, and beach going.

In 1994, the Long Island Sound Management Conference, sponsored by the EPA, the New York State Department of Environmental Conservation, and the Connecticut Department of Environmental Protection, completed a $15 million Comprehensive Conservation and Management Plan (CCMP). That plan was adopted by the Governors of New York and Connecticut and the EPA Administrator.

The EPA Long Island Sound Office coordinates the implementation of the plan among the many program partners, consistent with the Long Island Sound Improvement Act of 1990. The office is small, staffed by two EPA employees, whose salaries are covered by EPA's base budget, and a Senior Environmental Employment Program secretary. In addition, the office supports two outreach positions, with one in each state. It avoids duplicating existing efforts and programs, instead focusing on better coordination of federal and state funds, educating and involving the public in the Sound cleanup and protection, and providing grants to support implementation of the Long Island Sound restoration effort. By coordinating the activities of numerous stakeholders involved in the Sound's management program, in addition to serving as an educational and informational interface with the public, the Long Island Sound office provides an integral local outreach and meeting point.

While the quality of the Sound has improved dramatically over the years, there is still much work to be done. Implementation of the CCMP will help restore fish populations that have been impacted by hypoxia, will improve and restore degraded wetlands, and will begin to address the toxic mercury pollution that has lead to health advisories for fish consumption in many of the Sound's waters. Specific near term goals of the office include reducing nitrogen loadings which degrade water quality by depleting the Sound of oxygen, supporting local watershed protection efforts to reduce nonpoint source pollution, monitoring and expanding scientific understanding of the Sound, and educating the public and regional stakeholders about the sound and cleanup activities. Federal, State, and private funds have been well-spent over the years to research the conditions in the Sound and to identify conservation needs. We are now moving to apply critical funding toward implementing these projects, directly improving the water quality and habitat of the Long Island Sound.

Overall, recent federal funding of the program and the office are small relative to state commitments. New York State has approved $200 million for Long Island Sound as part of a $1.75 billion bound act. Connecticut has awarded more than $200 million in the past three years to support upgrades at sewage treatment plants and is a national leader on wetlands restoration. The Long Island Sound Office now faces a daunting task, orchestrating a multi-billion dollar effort to implement efforts to reduce nitrogen loadings that degrade the waters of the Sound. The modest increase in the authorization levels, and the reauthorization of the Long Island Sound Office, therefore represent timely, important contributions to the cooperative regional effort to restore the waters of the Long Island Sound.●

By Ms. SNOWE:

S.J. Res. 34. A joint resolution congratulating and commending the Veterans of Foreign Wars; to the Committee on the Judiciary.

VFW DAY JOINT RESOLUTION

● Ms. SNOWE. Mr. President, I rise today to introduce legislation honoring the centennial of the Veterans of Foreign Wars (VFW) of the United States, which will occur on the 29th of this month.

Earlier this year, the Senate passed my legislation designating September 29, 1999, as ''National VFW Day.'' I would like to express my sincere appreciation to my colleagues for joining me in honoring the more than 2 million members of the VFW, and urge the approval of this legislation, which congratulates all members of the VFW on the occasion of the organization's centennial. Similar legislation passed the House on June 29 and awaits approval by the Senate. I hope that we can pass this legislation before September 29 in order to pay tribute to these brave protectors of liberty.

As I indicated, September 29, 1999, marks the centennial of the VFW. As veterans of the Spanish-American War and the Philippine Insurrection of 1899 and the China Relief Expedition of 1900 returned home, they drew together in order to preserve the ties of comradeship forged in service to their country.

They began by forming local groups to secure rights and benefits for the service they rendered to our country. In Columbus, OH, veterans founded the American Veterans of Foreign Service. In Denver, CO, veterans started the Colorado Society of the Army of the Phillippines. In 1901, the Philippine War Veterans organization was started by the Philippine Veterans in Altoona and Pittsburgh, PA. In 1913, these varied organizations with a common mission joined forces as the Veterans of Foreign Wars of the United States. I am truly honored to salute this proud organization.

The joint resolution I am introducing today recognizes the unselfish service

VFW members have rendered over the last 100 years to the Armed Forces, to our communities, and other veterans. It also highlights the historic significance of this important day in the lives of so many veterans, and calls upon the President to issue a proclamation recognizing the anniversary of the VFW and the contributions made by the VFW to our Nation.

I have nothing but the utmost respect for those who have served their country. With this legislation, we say ''thank you'' the men and women and their families who have served this country with courage, honor and distinction. They answered the call to duty when their country needed them, and this is but a small token of our appreciation.

The centennial of the founding of the VFW will present all Americans with an opportunity to honor and pay tribute to the VFW and to all veterans. I thank my colleagues for joining me in a strong show of support and an expression of thanks to the VFW and all veterans.●

ADDITIONAL COSPONSORS

S. 35

At the request of Mr. GRASSLEY, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 35, a bill to amend the Internal Revenue Code of 1986 to allow a deduction for the long- term care insurance costs of all individuals who are not eligible to participate in employer-subsidized long-term care health plans.

S. 53

At the request of Mr. KYL, the name of the Senator from Florida (Mr. MACK) was added as a cosponsor of S. 53, a bill to amend the Internal Revenue Code of 1986 to provide a reduction in the capital gain rates for all taxpayers and a partial dividend income exclusion for individuals, and for other purposes.

S. 329

At the request of Mr. ROBB, the name of the Senator from Tennessee (Mr. FRIST) was added as a cosponsor of S. 329, a bill to amend title 38, United States Code, to extend eligibility for hospital care and medical services under chapter 17 of that title to veterans who have been awarded the Purple Heart, and for other purposes.

S. 348

At the request of Ms. SNOWE, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 348, a bill to authorize and facilitate a program to enhance training, research and development, energy conservation and efficiency, and consumer education in the oilheat industry for the benefit of oilheat consumers and the public, and for other purposes.

S. 371

At the request of Mr. GRAHAM, the name of the Senator from California (Mrs. FEINSTEIN) was added as a cosponsor of S. 371, a bill to provide assistance to the countries in Central America and the Caribbean affected by Hurricane Mitch and Hurricane Georges, to provide additional trade benefits to certain beneficiary countries in the Caribbean, and for other purposes.

S. 386

At the request of Mr. GORTON, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 386, a bill to amend the Internal Revenue Code of 1986 to provide for tax-exempt bond financing of certain electric facilities.

S. 660

At the request of Mr. CRAIG, the name of the Senator from Vermont (Mr. JEFFORDS) was added as a cosponsor of S. 660, a bill to amend title XVIII of the Social Security Act to provide for coverage under part B of the medicare program of medical nutrition therapy services furnished by registered dietitians and nutrition professionals.

S. 758

At the request of Mr. ASHCROFT, the names of the Senator from Florida (Mr. MACK) and the Senator from Arizona (Mr. KYL) were added as cosponsors of S. 758, a bill to establish legal standards and procedures for the fair, prompt, inexpensive, and efficient resolution of personal injury claims arising out of asbestos exposure, and for other purposes.

S. 914

At the request of Mr. SMITH, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 914, a bill to amend the Federal Water Pollution Control Act to require that discharges from combined storm and sanitary sewers conform to the Combined Sewer Overflow Control Policy of the Environmental Protection Agency, and for other purposes.

S. 956

At the request of Ms. SNOWE, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 956, a bill to establish programs regarding early detection, diagnosis, and interventions for newborns and infants with hearing loss.

S. 1016

At the request of Mr. DEWINE, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1016, a bill to provide collective bargaining rights for public safety officers employed by States or their political subdivisions.

S. 1053

At the request of Mr. BOND, the name of the Senator from New Hampshire (Mr. SMITH) was added as a cosponsor of S. 1053, a bill to amend the Clean Air Act to incorporate certain provisions of the transportation conformity regulations, as in effect on March 1, 1999.

S. 1070

At the request of Mr. BOND, the names of the Senator from New Hampshire (Mr. SMITH) and the Senator from Oregon (Mr. SMITH) were added as cosponsors of S. 1070, a bill to require the Secretary of Labor to wait for completion of a National Academy of Sciences study before promulgating a standard, regulation or guideline on ergonomics.

S. 1133

At the request of Mr. GRAMS, the names of the Senator from Minnesota (Mr. WELLSTONE), the Senator from Idaho (Mr. CRAIG), and the Senator from Idaho (Mr. CRAPO) were added as cosponsors of S. 1133, a bill to amend the Poultry Products Inspection Act to cover birds of the order Ratitae that are raised for use as human food.

S. 1140

At the request of Mrs. BOXER, the name of the Senator from Minnesota (Mr. WELLSTONE) was added as a cosponsor of S. 1140, a bill to require the Secretary of Labor to issue regulations to eliminate or minimize the significant risk of needlestick injury to health care workers.

S. 1155

At the request of Mr. ROBERTS, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 1155, a bill to amend the Federal Food, Drug, and Cosmetic Act to provide for uniform food safety warning notification requirements, and for other purposes.

S. 1277

At the request of Mr. GRASSLEY, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. 1277, a bill to amend title XIX of the Social Security Act to establish a new prospective payment system for Federally-qualified health centers and rural health clinics.

S. 1333

At the request of Mr. BENNETT, the names of the Senator from Kentucky (Mr. BUNNING) and the Senator from Nevada (Mr. BRYAN) were added as cosponsors of S. 1333, a bill to expand homeownership in the United States.

S. 1419

At the request of Mr. MCCAIN, the names of the Senator from Mississippi (Mr. COCHRAN), the Senator from Massachusetts (Mr. KENNEDY), the Senator from Idaho (Mr. CRAPO), the Senator from California (Mrs. BOXER), the Senator from Texas (Mr. GRAMM), the Senator from New Mexico (Mr. BINGAMAN), and the Senator from Alabama (Mr. SESSIONS) were added as cosponsors of S. 1419, a bill to amend title 36, United States Code, to designate May as ''National Military Appreciation Month.''

S. 1449

At the request of Mr. CONRAD, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 1449, a bill to amend title XVIII of the Social Security Act to increase the