

provisions that will leave many Americans without food, without basic nutrition, hungry. Under the Senate bill, we will cut another \$1.2 billion, over 5 years, from the Food Stamp Program. The savings from this new cut in food stamps will go to other agriculture programs.

Mr. Speaker, I do not oppose more funding for those agriculture programs, however, I do oppose further cuts in the Food Stamp Program.

Over 877,000 North Carolinians live in poverty. Of those poor North Carolinians, over 600,000 of them, on average, receive food stamps. Many are senior citizens and children. Last year's welfare reform bill significantly affected food stamp recipients in several ways by: cutting \$27 billion from the Food Stamp Program; freezing the standard deduction, the vehicle deduction, the shelter cap and the minimum allotment; setting strict time limits on the eligibility of so-called able-bodied people between the ages of 18 and 50. These persons will only be eligible 3 months out of 36, unless they are enrolled in a work placement or training program—exceptions are made for areas of high unemployment, but only if the governor of the State requests a waiver.

Our Governor did not see fit to ask for a waiver that included all 37 areas that qualified. Our Governor only asked for a waiver that served seven areas and disqualifying most legal immigrants from receiving benefits until they become actual citizens—even though they pay taxes.

The Senate bill continues to take funds from a program for the poor. The projects that will be funded are worthy. Those who felt the brunt of last year's welfare reform bill, should now feel the relief of these savings. I hope we will provide that relief in the conference agreement on this bill.

TRIBUTE TO HYSTERCINE RANKIN

HON. BENNIE G. THOMPSON

OF MISSISSIPPI

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Mr. THOMPSON. Mr. Speaker, I rise today to pay tribute to Mrs. Hystercine Rankin. Mrs. Rankin, a quilter, received the 1997 National Heritage Fellowship. The award is the National Endowment for the Arts' most prestigious honor in folk and traditional arts.

Mrs. Rankin, a native of Port Gibson, MS, has been a quilter all of her life. She has taught many workshops throughout the State and worked with quilters to help them improve their skill. Mrs. Rankin has also influenced others to become more involved in the quilting community. She is truly an asset to the State of Mississippi.

During her trip to Washington, she had the opportunity to meet with First Lady Hillary Clinton. When asked about her new found acquaintance, Mrs. Rankin simply stated that she never knew that a needle would take her this far from home.

Mr. Speaker, it gives me great pleasure to pay tribute today to Mrs. Hystercine Rankin, one of Mississippi's precious jewels.

HELP FOR THE NATION'S COMMUNITY HEALTH CENTERS

HON. CHARLES B. RANGEL

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Saturday, November 8, 1997

Mr. RANGEL. Mr. Speaker, I am today sponsoring legislation to help the Nation's frontline health delivery organizations survive the move to managed care. The bill I am introducing today will provide Medicare wrap-around payments to federally qualified health centers [FQHC's] and parallels a provision in this summer's Balanced Budget Act which provided Medicaid wrap-around payments to FQHC's.

FQHC's, such as community health centers [CHC's], receive about 8 percent of their revenues—or about \$200 million annually—in payments for care furnished to Medicare beneficiaries. For the services they provide, health centers are on a so-called reasonable cost basis, which is designed to ensure that sufficient funds are provided to cover the costs of care.

As Medicare patients choose to move into managed care plans which include FQHC's as providers, the payment rates that the health maintenance organizations [HMO's] have been willing to pay the centers is often less than the FQHC payment described in the previous paragraph. My legislation is designed to correct this payment shortfall by providing that each FQHC will receive a supplemental wrap-around payment from Medicare in an amount equal to the difference—if any—between the FQHC rate and the amount the FQHC receives from the HMO. This type of wrap-around provision was included in the Balanced Budget Act for Medicaid payments, but not for Medicare. Today's bill provides parallel treatment for Medicare and Medicaid payments to these frontline health delivery organizations.

Why do these centers need an additional payment? Why can't they live with the managed care payment rate? Basically, these centers do so much additional, uncompensated care and outreach in their neighborhoods that they need what is the equivalent of a disproportionate share payment to help them finance these essential, extra services—and HMO's are unlikely to contract with providers who have these extra disproportionate share costs. If CHC's are to be able to continue their mission of service, they will need Medicare's help in financing these extra costs.

Following is a memo from the National Association of Community Health Centers elaborating on the essential work of the Nation's CHC's and explaining why these extra wrap-around payments are so necessary.

WHY HEALTH CENTERS MERIT A SPECIAL WRAP-AROUND PAYMENT

The current reasonable-cost reimbursement provisions for health centers were established by Congress to ensure that Medicare and Medicaid cover the reasonable cost of furnishing covered services to their beneficiaries. Underpayment to these centers is particularly onerous because the revenue to cover unreimbursed costs can only come from federal and state grants intended to support services for the uninsured and essential, non-covered services for others. Health centers cannot absorb risk for several reasons:

Their Patients: Health center patients comprise the most vulnerable populations in

America today—persons who, even when insured, remain isolated from traditional forms of medical care because of where they live, who they are, and their frequently far greater levels of complex health care needs. Because of factors such as poverty or hopelessness (not to mention the social-environmental threats that permeate low income/underserved communities), health center patients are at higher risk for serious and costly conditions (diabetes, hypertension, TB, high-risk, pregnancies, HIV) than the general population.

Their History and Mission: Health centers were founded to make their services available to all in their communities, and particularly to those who can't get care elsewhere (again because of who they are and their often complex health and social problems). They have already proven their efficiency, but their fundamental mission and purpose should not be compromised by placing them at risk for the care their patients need. On the contrary, because they serve disproportionate numbers of high-risk patients, adequately compensating the health centers for their care can serve to make risk levels more reasonable for other providers.

Their Services: Health centers offer comprehensive, "one-stop" primary care rather than a traditional medical model for chronic and acute care. Prevention is the focus. These services need to be promoted, not restricted or reduced, as would be the case under risk based contracting. For their patients and communities, in particular, expanding the availability of preventive and primary care services will be vital in increasing access and reducing costs. Here, too, the success of managed care will depend on this.

Improving Access: As has been noted, health center patients—whose health problems are typically more serious and more complicated than it true of other Americans—frequently need special services that may not be recognized as reimbursable, but which are essential to ensure that effectiveness of the medical care provided. These services, such as multilingual/translation services, health/nutrition education, patient case management services, outreach and transportation, will need to be provided, even if they are not covered and reimbursable; thus, the centers cannot rely on their other funding sources to cover them against excessive risk.

No Reserves. Because of their historic mission and the restrictions placed on them by their funding sources, health centers have no available capital, limited marketing capability, poor and sicker patients and thus no leverage in the marketplace. Moreover, all revenues received by health centers (all of which are either public or not-for-profit organizations) are reinvested in patient care services—there are no "profits," and they have no reserves to protect them against risk. Consequently placing too much risk on health centers would force them to remain outside the managed care system rather than being centrally involved.

Perhaps most importantly, development of primary and preventive care in underserved communities has been particularly effective in reducing unnecessary and inappropriate use of other settings such as emergency rooms which are much more costly. This is especially true of public-private partnerships such as the federally-assisted health center programs, which today provide care to nearly 10 million low income people in underserved rural and urban communities across the nation. Because of their experience, the health centers—together with other key community providers—form the backbone of the local health care system for most underserved people and communities, and have