

EXTENSIONS OF REMARKS

ELDERLY HOUSING QUALITY IMPROVEMENT ACT

HON. JOHN J. LaFALCE

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 29, 1999

Mr. LaFALCE. Mr. Speaker, today, I plan to introduce the "Elderly Housing Quality Improvement Act." I am pleased to be joined in this effort by ranking Banking Committee Democrats VENTO, KANJORSKI, and FRANK, as well as many other co-sponsors.

According to HUD's "Worse Case Housing Needs" study, 1.5 million elderly households pay over 50% of their income for rent or live in severely substandard housing. As our nation ages, and as our affordable housing stock continues to shrink, this problem is likely to get worse.

The Elderly Housing Quality Improvement Act addresses this growing crisis through targeted funding increases and legislative changes designed to update and expand our stock of elderly housing, and to improve the quality of life of low-income seniors.

As affordable elderly housing units built in the 1970's and 1980's have aged, project sponsors, many of them non-profits, all too often lack the resources for adequate repair and maintenance. The first goal of the Elderly Housing Quality Improvement Act is to give these sponsors additional tools and resources to properly maintain elderly housing.

Most dramatically, the bill creates a new grant program for capital repairs for federally assisted elderly housing units, to be funded at \$100 million a year. Funds would be awarded on a competitive basis, based on the need for the proposed repairs, the financial need of the applicant, and the impact on the tenants for failure to make such repairs.

The bill also amends existing programs to improve the quality of elderly housing units. It facilitates the refinancing of high interest rate Section 202 elderly housing projects, by guaranteeing that at least half of refinancing savings, plus all excess reserve funds, may be retained for the benefit of the tenants or for the benefit of the project.

The bill contains an innovative approach to accelerate the availability of 1997 Mark-to-Market Section 531 recapture grant funds, to enable affordable housing sponsors to make large capital expenditures. The bill also makes all federally assisted housing projects eligible for such grants. And, the bill increases annual income for non federally insured Section 236 affordable housing projects, by letting them keep "excess income."

The second major goal of the bill is to make assisted living facilities more available and affordable to low income elderly. Assisted living facilities provide meals, health care, and other services to frail senior citizens who need assistance with activities of daily living. Unfortu-

nately, poorer seniors who can't afford assisted living facilities are instead forced to move into nursing homes—with a lower quality of life at a higher cost.

In order to overcome this affordability problem, the bill makes conversion of federally assisted elderly housing to assisted living facilities an eligible activity under the newly created capital grant program. It also authorizes the use of Section 8 vouchers to pay the rental component of any assisted living facility. This would make the 200,000 elderly now receiving vouchers eligible to use them in assisted living facilities.

The legislation also authorizes 15,000 incremental vouchers, on a demonstration basis, for low income seniors for use in assisted living facilities. These vouchers are to be made available to ten state housing finance agencies or local public housing agencies.

Funds may be used so that an elderly tenant in project-based Section 8 project-based housing who needs assistance with activities of daily living may receive a new voucher to move to an assisted living facility. The vouchers may also be used to incentivize construction of assisted living facilities which agree to serve low-income seniors.

This demonstration would give us the opportunity to analyze whether authorizing additional Section 8 vouchers for this purpose might actually reduce government spending, by reducing the level of Medicaid expenditures that would otherwise be expended by the state and federal government in a nursing home setting.

Third, the bill promotes the use of service coordinators, which help elderly and disabled tenants gain access to local community services, thereby promoting independence. This bill doubles funding for grants for service coordinators in federally assisted housing, and lets service coordinators serve other low-income seniors in a local community. It also provides funds for new public housing service coordinator grants, and mandates renewal of all expiring grants, including those grants not renewed in the FY 1998 lottery.

Finally, the bill seeks to expand our stock of affordable housing for the elderly, by increasing Section 202 new construction of elderly housing by \$50 million. It also encourages appropriators to consider demonstration projects which encourage the leveraging of funds from other sources, such as from tax credit deals, and to encourage the development of additional housing which is affordable for moderate income elderly.

Earlier this year, the Chairmen of the Housing Subcommittee and Banking Committee introduced H.R. 202, which deals with the worthy goal of "conversion" of Section 202 elderly housing projects. The Elderly Housing Quality Improvement Act complements H.R. 202, and simply gives elderly housing sponsors additional tools to carry out their mission. It is my hope that Democrats and Republicans can

work together in a bi-partisan fashion to adopt the best of all these proposals and enact them into law.

THE 75TH ANNIVERSARY OF THE FAIRVIEW COMMUNITY CHURCH

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 29, 1999

Mr. KUCINICH. Mr. Speaker, today I rise in honor of the 75th Anniversary of the Fairview Community Church for their outstanding service to the Cleveland area for the past 75 years.

Starting as just a Sunday School, with an enrollment of 129 people, the church grew to accommodate the growing community. On January 27, 1924, the Fairview Christian Union Church was founded with 52 members from 28 families. As the community continued to grow many in the community were unchurched. In addition to expanding to bring more people in to the church the congregation supported Christian missions. Mission giving continues to be an important part of the church's tradition today, over seventy years later.

Membership doubled and in April of 1936, even through hard financial times, the need for a building became apparent. With the support of the Cleveland Baptist Association a new Baptist chapter was formed. On May 2, 1943, even through the financial challenges, the new church building was dedicated.

In its effort to better serve the citizens of Cleveland on October 13, 1968, The Fairview Church merged with the West Shore Baptist Church and became known as the Fairview Community Church. Over the years the church has become an active member in many programs such as FISH, Food For Our Brothers, and the building of Willowood Manor. To help the needy in the area the church is also involved at the Jones Home, St. Paul's Community Church, The City Mission and with the families at Garnett School.

My fellow colleagues join me in honoring The Fairview Community Church for its outstanding commitment to the whole community, and especially the needy in the Cleveland area.

TRIBUTE TO BOY SCOUT TROOP 116

HON. GEORGE RADANOVICH

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 29, 1999

Mr. RADANOVICH. Mr. Speaker, I rise today to pay tribute to Boy Scout Troop 116 which is celebrating its 50th year of service to

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Madera, California. Troop 116 has influenced the lives of approximately 700 men and boys in the values of citizenship, leadership by example, caring for the environment, respecting one's fellow man, and respecting the religious values of others.

During the troop's 50 years it has guided 42 of its members through the requirements to attain the ultimate rank of Eagle Scout. About eight percent of Troop 116's youth have attained the Eagle Scout Rank—about four times the national average. Scout training has also enabled two scouts to receive the Life Saving Awards from the National Council for saving a life while greatly risking their own.

Troop 116 has participated in several activities, and encourages volunteerism. It has sent many members to the periodic National jamborees held at various national historical sites. Scouts have initiated and participated in numerous food and clothing drives for the needy, a variety of clean-up and local improvement projects, as well as volunteering and doing a host of maintenance and upgrading projects in state and federal parks.

The Eagle Scouts will recognize their sponsor, The United Methodist Church of Madera, by presenting an Eagle's Nest as a sign of appreciation for the church's sponsorship over the past 50 years.

Mr. Speaker, I rise today to recognize Boy Scout Troop 116 in their 50th Anniversary for doing its part to positively influence the lives of men and boys in the Central Valley, and contribute to the community. I urge my colleagues to join me in wishing Troop 116 many years of continued success.

**MEDICARE MODERNIZATION BILL
NO. 3—RURAL CASE MANAGEMENT ACT OF 1999**

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 29, 1999

Mr. STARK. Mr. Speaker, it gives me great pleasure to introduce the Rural Case Management Act of 1999, a common sense approach to delivering high-quality, coordinated health care in rural America. This is the third week, and the third bill, in my campaign to modernize and improve Medicare.

Health care needs in rural areas are unique. Whereas many metropolitan areas suffer from an over-supply of providers, often there is only one provider serving a vast number of rural communities. One-size-fits-all solutions do not work for these opposite ends of the health care spectrum.

Yet, Republicans continue to promote managed care as the solution for all problems and people. Most recently, they have asked taxpayers to subsidize private managed care companies in rural counties, despite the widely acknowledged reality that managed care cannot function in rural areas due to the lack of providers. Changes made in 1997 BBA result in outlandish over-payments to private managed care plans that serve rural markets. In some counties, health plans are being paid almost twice as much as it costs traditional fee-for-service Secretary to operate there. Putting

more money into an idea that simply cannot work is ridiculous. It's like watering a garden that has no seeds.

The Rural Case Management Act of 1999 would eliminate the waste established in the BBA by making payments directly to rural providers who coordinate care for their patients. This benefit would help coordinate care for the chronically ill, such as diabetes or HIV/AIDS patients, improve notification for preventive services, such as mammograms and flu shots, and provide follow-up care for people who need it. The choice to participate would be entirely voluntary: no one would be "locked in" to the web of a rural managed care plan that had limited providers and limited budgets.

There is no evidence that managed care is better for consumers than fee-for-service Medicine. In fact, for the frail chronically ill, evidence suggests the contrary. If HMOs were established in rural communities, beneficiaries in the area might be forced to join in order to get any service from the few local doctors and the one local hospital. Then, if they needed expensive care at a specialty center, would their local providers be reluctant to refer them to that center for care, when the cost would come out of the small budget of the local, rural HMO?

In light of the Patients Bill of Rights debate and the managed care horror stories I have shared with my colleagues in the past, I wonder if we should be subjecting rural America to monopolistic "managed care" unless much stronger consumer protections and quality measures are in place.

Providers are also having a difficult time with managed care. In a recent Project Hope survey, providers reported very serious problems with HMO reimbursement, clinical review, and paperwork. We should not encourage the growth of a health system with this many problems.

The most valuable thing managed care offers is coordinated follow-up care. This is an administrative function. Providers in areas without managed care can serve this function effectively. We can reap the benefits of managed care without throwing more money at an idea that simply will not work. The bill I am proposing would pay rural providers a special amount to provide the best thing that managed care has to offer: care management.

Some Members believe that bringing managed care into rural areas would bring prescription drug coverage to rural beneficiaries. This is not likely. Managed care needs competition in order to work. But there will never be competition in many rural areas. The problem is that rural areas do not have "extra" providers to compete against one other.

Competition is also what results in extra benefits in Medicare managed care. Health plans vying for greater enrollment entice beneficiaries to their plan by providing extra benefits, such as prescription drug coverage and zero deductibles. Due to the lack of competition, these extra benefits will seldom be offered in rural areas. A recent GAO report noted that prescription drugs were the only extra benefit for which overall beneficiary access increased in 1999. However, access to prescription drugs actually decreased in lower payment (i.e., rural) areas. This decrease occurred despite the 23 percent payment in-

crease in low-payment counties (compared to only 4 percent increase in all other counties). The GAO report proves that more money will not guarantee extra benefits in rural areas. We must find creative alternatives to solve the unique problems of health access in rural America.

Managed care is not a silver bullet solution for delivering health care. In the best of worlds, managed care can offer coordinated health services for enrollees. The same function can be provided by providers who live in rural areas and have an established relationship with their patients. This bill eliminates the middle man by sending payments directly to providers in rural areas. Instead of spending money to create managed care plans in areas of provider shortages, this bill helps to improve the quality of care by putting the money where it is needed most. I strongly encourage members' support.

**IN RECOGNITION OF OCCUPATION
THERAPY MONTH**

HON. ELLEN O. TAUSCHER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, April 29, 1999

Mrs. TAUSCHER. Mr. Speaker, I rise in recognition of Occupation Therapy Month and in recognition of the invaluable services that occupational therapists provide to their patients. Occupational therapists provide people with the support, the rehabilitation, and the medical care that enables them to live full lives and function at the highest possible level, despite disability, illness, injury, or other limitations. Occupational therapists work in nursing homes, support individuals with mental illnesses, assist physically disabled individuals in performing ordinary life activities, and help children in our schools learn at the highest level. Occupational therapy is a necessary component of quality medical care in that it allows individuals who face physical challenges to retain their independence and to perform the daily activities that we all take for granted.

I know from personal experience that this is true. A number of years ago, my father contracted Guillan-Barre Syndrome, a devastating illness which leaves the individual in temporary paralyzed state. We were truly fortunate that we had the highest quality medical care. The doctors saved my father's life. The therapists gave him his life. Their expertise and specialized knowledge allowed him to resume his daily activities and stay independent.

My daughter Katherine is an active, energetic seven-year old who plays soccer and a number of other sports. Seeing her today, you would never guess that as an infant she spent a year of her life in a full body cast because of problems with her hip. Again, we had the most qualified and experienced doctors caring for her, but I believe that it was her therapists who were responsible for assuring that she would remain active and energetic for the rest of her life.

Quality medical care is a composite and I would like to recognize the contribution that occupational therapists make in assuring that our medical system not only cures patients, but allows them to live their lives to the fullest.