Wyoming Valley has changed, so has St. Patrick's. The church's current vibrancy and dedication reflects its commitment to the Wyoming Valley community.

Mr. Speaker, I am pleased to bring this milestone anniversary to the attention of my colleagues and to send my best wishes for the continued prosperity of St. Patrick's Church.

ESSENTIAL HEALTH FACILITIES INVESTMENT ACT OF 1996

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 12, 1996

Mr. STARK. Mr. Speaker, today, I am introducing the Essential Health Facilities Investment Act of 1996. This legislation will provide a financial helping hand to those hospitals and health centers that are in the frontlines of dealing with our national health care crisis. This legislation allows for the expansion of community health services and the capital needs of safety-net health care facilities while at the same time attempting to limit the further duplication of unnecessary high-technology services.

This bill is similar to legislation that a number of us introduced in the 103d Congress and which was included in the national health reform legislation that was approved by the Ways and Means Committee. I am introducing this bill now so that groups may focus on it before the start of the 105th Congress to see what changes they would recommend and, if they agree with the goals of the legislation, begin to work for the passage of such legislation in the New Congress.

In this time of continually shrinking budgets and fiscal austerity, it is more important than ever to appropriate Federal moneys in the most cost-effective manner available while reaping the most benefit for all of our citizens. In terms of health care, this means establishing and expanding community health programs designed to provide low cost primary care to underserved populations to avoid subsequent high-cost emergency room visits. In addition, we must help to support those not-for-profit and public hospitals that deal with a disproportionate number of uninsured patients. Urban public hospitals averaged over 19,000 admissions, 242,000 outpatient visits, and nearly 4,000 live births per hospital in 1986. In comparison, urban private hospitals in the same areas registered just 7,000 admissions, 50,000 outpatients visits, and 760 live births. These safety-net facilities—the public and not-for-profit hospitals that serve a disproportionate share of uninsured and low-income patients—are in essence the family doctor for many in our country. Though it would be far better to incorporate the uninsured into our national insurance pools, giving them access to any health care facility they choose to visit, the stark reality is that they are dependent upon these safety-net hospitals for any and all of their health care.

Gun violence in our metropolitan areas adds to the burden that our safety-net hospitals must bear. Roughly half of all urban safety-net hospitals are equipped with a trauma center and thus are the first in line to treat the victims of America's growing obession with guns. By the year 2003, according to the Federal Centers for Disease Control and Prevention, gunfire will have surpassed auto accidents as the leading cause of injury and heath in the United States. Unlike victims of car crashes, who are almost always privately insured, 4 out of 5 gunshot victims are on public assistance. More than 60 urban trauma centers have already closed in the past 10 years, leaving less than one-quarter of the Nation's population residing anywhere near a trauma center. Gunshot wounds account for fewer than 1 percent of injuries in hospitals nationwide but account for roughly 9 percent of injury treatment costs. It is estimated that for every 1 of the 40,000 patients who die from a gunshot wound annually, 3 others are injured seriously enough to be hospitalized.

Yet another assault on urban hospitals comes from the influence of managed care organizations. Managed care's ability to bring tougher competition to the health care sector has decreased the urban safety-net hospital's ability to cost-shift to offset some of the heavy losses incurred providing uncompensated care. As a result, according to a June 1996, Prospective Payment Assessment Commission [ProPAC] report, hospitals in urban areas with high managed care penetration saw their payment-to-cost ratio decrease by 2 percent from 1992 to 1994. Declining margins have forced many urban hospitals to cut their level of charity care. ProPAC found that uncompensated care fell by 4.5 percent during the same time period, clear evidence that more and more of the burden is being shifted to the public safety-net hospitals.

OUTLINE OF THE ESSENTIAL HEALTH FACILITIES INVESTMENT ACT OF 1996

In title I of this legislation, Medicare's Essential Access Community Hospital Program [EACH] would be expanded to all States and a new urban Essential Community Provider Program [ECP] would be created. Funding would be provided for the creation of hospital and community health clinic networks that improve the organization, delivery, and access to preventive, primary, and acute care services for underserved populations.

In title II, financial assistance for capital needs would be provided by the Secretary of HHS to safety-net facilities which serve a disproportionate share of uninsured and low-income patients. Funds for this legislation would be provided by a one-half percent on hospital gross receipts tax.

In title III, financial and technical assistance would be provided to States engaged in review of capital expenditures for health care facilities and high-technology equipment. Consideration of alternative, less costly, and existing services would be considered before any funds would be distributed.

REBUILDING THE URBAN SAFETY NET

Even though these essential access facilities fulfill a pivotal role in our Nation's health care system, their infrastructure suffers from gross neglect and under-investment. The buildings and systems that comprise this safety net are often antiquated. Without future reinvestment, the holes in this system will continue to grow, causing even more of America's underprivileged population to be medically abandoned.

The average age of the physical plant of urban, public hospitals is nearly 26 years, compared to a national average for all hospitals of 7 years. The average capital expenditure for urban hospitals is $12,600 per bed compared to a national average expenditure for all hospitals of $23,500.

A national survey of the Nation's safety-net hospitals found that a lack of available hospital beds is resulting in severe overcrowding. Hospital corridors surrounding emergency rooms have begun to resemble triage units at the height of a military campaign. A recent study showed that 50 percent of the hospitals in the three most severely impacted areas, Los Angeles, Detroit, and New York were forced to restrict emergency department access over 25 percent of the time. This is occurring in spite of the fact that the occupancy rates of all hospitals have steadily decreased during the last decade and are now barely above 60 percent. The average occupancy rate for safety-net hospitals is roughly 82 percent with some reporting 100 percent, while private urban hospitals averaged just 67 percent. At any given time, approximately one-third of America's 924,000 staffed hospital beds are empty. Our national priorities have created an excess of beds in areas where the need doesn't exist and a severe shortage in areas where the demand is bulging at the seams. This bill attempts to relieve some of the pressure built up within the safety-net system.

It is wise to remember that while the economic viability of these urban safety-net hospitals is crucial for the medically underserved of America, these same hospital systems often provide specialty care services used by everyone in the community. Burn, neonatal units, trauma care centers, and other highly specialized tertiary care services are located within safety-net hospitals. All members of a community benefit from both a well-maintained safety-net hospital and a broad network of community health centers.

Health care institutions have historically found it difficult to secure financing for capital renovation and expansion products. The financing exists within the market, but the level of debt service required to often too burdensome for the public institution to manage. Even when revenue bonds may be supported by local means, oftentimes the bond ratings are too low and thus the interest rates are too high. Afterall, these safety-net hospitals treat a high proportion of low-income patients resulting in lower operating margins. These ratings often have little to do with the ability of hospital administrators to manage their facilities well. It is more often the case that market analysts consider the local appropriations that sustain these facilities to be too uncertain. Thus, the facility is simply prohibited from securing the needed capital.

For the facilities with the greatest demand placed upon them in our inner-city and rural areas, the traditional method of financing, Federal funding, is no longer available. Many of these facilities were originally built with grants or loans under the Hill-Burton Program. These funds have not been available for years. The lack of Federal moneys available to repair and rebuild these facilities combined with the strain on the resources of local governments, means the capital needs of safety-net facilities have gone unmet.

This legislation does not propose that the Federal Government take on a massive rebuilding program like the Hill-Burton Program. Nor does it propose that the Federal Government take sole responsibility to solve this problem. However, this legislation is designed to support State and local efforts to upgrade

the capacity of these facilities. In drafting this bill, we recognized that the Federal Government has limited resources it can tap for this purpose. Therefore to fund this program, a 0.5 percent—one half of 1 percent—tax would be levied against the gross revenues of all hospitals. Hospital revenues received from Medicaid would not be subject to the tax.

Revenue from this relatively modest trust fund would be used by those inner-city and rural facilities across America with the greatest need for assistance. Eligible facilities would be those designated as essential access community hospitals, rural primary care hospitals, large urban hospitals qualified health clinics that are members of community health networks.

Assistance from the capital financing trust fund would be provided in the form of loan guarantees, interest rate subsidies, direct matching loans, and in cases of urgent life and safety needs, direct grants. The Federal assistance would be used to leverage State and local government and private sector financing. Repayment would be made back to the trust fund.

For fiscal years 1997 through 2002, $995 million will be made available each year through the capital financing trust fund for these safety-net facilities.

With relatively limited resources available to meet the tremendous health facility infrastructure needs across the Nation, decisions to finance the reconstruction, replacement or acquisition of facilities and equipment must be made only after first considering whether existing service capacities could be tapped to meet the needs of the underserved more efficiently. The next section of this bill is designed to ensure that the capital expenditure decisions supported by this legislation are considered within the context of the entire community's needs and capacities.

MAXIMIZING CAPITAL RESOURCES

Many communities, particularly those in rural and inner-city areas, lack the facilities and equipment to adequately meet the needs of their residents while other hospitals are experiencing a capital oversupply. This oversupply leads to inflationary price pressures. The Essential Health Facilities Investment Act of 1996 will expand medical services to those in need only if the planning authorities feel that the current local medical facilities are unable to meet the needs of the community. In addition, this bill specifically states that only projects that will lead to an increase in the quality of care rendered will be funded. In other words, requests for frivolous, redundant facilities will be denied funding.

One area of oversupply is hospital beds. According to the Dartmouth Atlas of Health Care, published by the Dartmouth Medical School in 1996, there were more than 827,000 acute care hospital beds in the United States in 1993. The average number of beds per thousand residents was 3.3. After adjusting for demographic differences, the numbers of hospital beds per thousand persons varied by a factor of 2.8 across the Nation. The numbers ranged from fewer than 2 beds per thousand residents to more than 5 beds per resident. Some of these hospitals with excess capacity can and need to be closed, or at the very least, denied additional public capital improvement funds. However, we must also make every effort to first ensure that every geographic and community area receives adequate hospital service. Safeguards and criteria for the allocation of Capital Financing Trust, EACH, and ECP funds must be satisfied in order to avoid exacerbating the oversupply of hospital beds.

With 4.7 percent of the world's population, we have one-half of the world's CT scanners and about two-thirds of the world's magnetic resonance imagers [MRI's]. In 1987, the United States had 7.4 times as many radiation therapy units and 8 times as many MRI's per million people as did Canada. The United States has twice as many open heart surgical units per million persons as does Canada. The startup costs for each of these open heart surgery programs are between $6 and $13 million. Annual operating costs average between $7 and $10 million at each location. For each open heart surgery center that is not needed and not created, millions of dollars can be saved each year.

Redundancies and inefficiencies of hospital facilities and services are well known. In 1991, a study in the Annals of Internal Medicine showed that although America had 10,000 mammography machines, we essentially only used 2,600 of them. This same study asserts that if every women in America had a mammogram every time the American Cancer Association suggested it was appropriate, we would use only 5,000 of the 10,000 functioning mammography machines.

In addition to wasting valuable resources, this excess capacity can be considered detrimental to the health of patients. Applying the guidelines endorsed by the American Hospital Association and the American College of Cardiologists, 35 percent of the open-heart surgery centers in California perform less than the minimum number of procedures required to achieve an acceptable level of competence and quality. We should not reward those hospitals that insist upon maintaining high cost, redundant, tertiary care services that fail to maintain a minimum level of quality. Admittedly, the availability of reliable outcome studies covering high-technology procedures is limited, but there exists reputable data concerning hip replacement surgery and coronary artery bypass surgery [CABS] success factors. The October 25, 1995, issue of the Journal of the American Medical Association cites a study titled ''Regionalization of Cardiac Surgery in the United States and Canada'' which shows that:

> in California, age and sex-adjusted mortality rates in hospitals performing 500 or more CABS operations per year were 49% lower than in hospitals performing fewer than 100 CABS operation . . .
>
> Hip replacement surgery data and this coronary artery bypass surgery study effectively demonstrate a direct correlation between the volume of procedures performed and the resulting success rates.

I propose that a coronary artery bypass surgery hospital must meet the minimum criteria for quality outlined by the Secretary in the Medicare Centers of Excellence for CABS operations to be considered for Medicare reimbursement. Expanding on this idea, I suggest that any hospital wishing to improve a tertiary care service using resources in excess of $1 million from the Capital Financing Trust Fund must not only demonstrate that they are indeed a safety-net health care provider but also meet standards of quality for that particular service outlined by the Secretary. As additional reliable outcome studies for other expensive, capital-intensive services become available, disbursement of Capital Financing Trust Fund for improvements will be dependent upon demonstration of adequate quality performance measured by the HCFA's chosen quality outcome measurement.

EXPANDING THE EACH PROGRAM

A third provision of this legislation is designed to facilitate the organization, delivery, and access to primary, preventive, an acute care services for medically underserved populations by fostering networks of essential community providers.

The Essential Access Community Hospital Program was enacted in 1989. This Medicare initiative provides a unique Federal-State partnership to assure the availability of primary care, emergency services, and limited acute inpatient services in rural areas. The EACH Program was created to maximize resources available to rural residents by establishing regional networks of full-service hospitals [EACH's] connected to limited-service rural primary care hospitals [RPCH's]. Since 1991, over $17 million has been awarded in the seven participating States.

In a recent assessment by the Alpha Center, the strengths of the EACH Program were clearly articulated. Their March 1993, report stated:

> The EACH Program has released an enormous amount of creative energy focused on the development of regional networks that link health care providers in remote areas with those in more densely populated communities.

A letter from the project directors of the seven EACH States contained the following comment:

> We believe the EACH concept will assist policymakers, regulators and changemakers in the long process of refocusing rural health care delivery.

I am confident that the EACH Program provides a framework for greatly improving the quality and efficiency of primary care, emergency services, and acute inpatient services in rural areas across the country. As a result, this legislation contains language that would extend the EACH Program to all States.

In addition, creating a new urban Essential Community Provider Program [ECP] would carry the network concept to our Nation's inner cities. While different from the rural EACH Program, the urban ECP Program would concentrate on networking hospitals with primary care service centers, particularly federally qualified health centers. In addition, ECP networks could combine with rural networks.

A February 1993, report by the General Accounting Office found that ''more than 40 percent of emergency department patients had illnesses or injuries categorized as nonurgent conditions.'' The growth in the number of patients with nonurgent conditions visiting emergency departments is greatest among patients with little or no health insurance coverage—exactly those populations served by essential community providers. Networks of essential community provider hospitals and clinics will help steer clients to more appropriate clinical settings and, as a result, maximize the resources available in both emergency and nonemergency settings.

The concept of inner-city provider networks designed to ease access and improve continuity of care is not new. Initiatives are currently

being pursued in urban areas across this country to do just that. This legislation would boost these efforts through critical financial and structured technical assistance.

Funding under the ECP Program would be available for the expansion of primary care sites, development of information, billing and reporting systems, planning and needs assessment, and health promotion outreach to undeserved populations in the service area. Facilities eligible to participate in the ECP networks—those designated as ''essential community providers''—include Medicare disproportionate share hospitals, rural primary care hospitals, essential access community hospitals, and federally qualified health centers [FQHC] or those clinics which otherwise fulfill the requirements for FQHC status except for board membership requirements.

In order to facilitate the integration of hospitals and clinics into these community health networks, physicians at network clinic sites would be provided admitting privileges at network hospitals. In addition, the placement of residents at network-affiliated FQHC's would be counted in the total number of residency positions when determining the indirect medical education [IME] reimbursement to hospitals under Medicare. The authorized funding level for rural EACH and urban ECP would be increased tenfold, from the current level of $25 to $250 million annually.

I am introducing the Essential Health Facilities Investment Act of 1996 because I believe this legislation is an important and necessary component of the effort to reform our Nations' health care delivery system. The initiatives in this bill are essential to ensuring access to high-quality and efficient services for everyone in our communities.

PERSONAL EXPLANATION

HON. EARL POMEROY

OF NORTH DAKOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 12, 1996

Mr. POMEROY. Mr. Speaker, during rollcall vote No. 404, I was unavoidably detained at a meeting off the Hill. I regret that I was absent for this vote.

COMMENDING THE WORK OF FORT GUIJARROS MUSEUM FOUNDATION

HON. DUNCAN HUNTER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 12, 1996

Mr. HUNTER. Mr. Speaker, I would like to take this opportunity to commend the work of the Fort Guijarros Museum Foundation and the U.S. Navy Submarine Base, San Diego. The foundation and the submarine base have brought history alive to the people of California.

This effort began in 1980 when the U.S. Navy Commander, submarine force, U.S. Pacific Fleet invited a civilian volunteer committee to work with the submarine support facility to research the history of a 1796 Spanish fort on Ballast Point. Since that time the committee has conducted scientific investigation, analysis, reports, and public exhibits on their findings.

The foundation has established public education programs for our elderly and retired citizens. Through traveling exhibits to high schools, banks, and government buildings the foundation has brought hands-on history to our citizens. One particular exhibit in Old Town San Diego reaches 11,000 children each year. Further walking tours of the historical buildings, slide lectures, and education programs maximize use of the ruins of Fort Guijarros.

In addition, the foundation has been analyzing the thousands of artifacts in former U.S. Army World War II buildings assigned by the U.S. Navy. Recently, congressional legacy grant funding enable adaptive reuse of the former Army morgue to a refrigerated repository to ensure preservation of the artifacts and field notes well beyond the year 2000.

Each year, the submarine force hosts the annual battle of San Diego Bay fiesta at Monument Circle near the Fort Guijarros site. This year the event will be held on September 21 and I would like to take this opportunity to commend the work of both the submarine force and the Fort Guijarros Museum Foundation. Many people have given their time and effort to this important project. In particular I would like to recognize Capt. Bruce Scott for his support in preserving this part of our history.

I know my colleagues join me in recognizing the Fort Guijarros Museum Foundation and wish them continued success in the future.

CLUSTER RULE

HON. JOHN M. SPRATT, JR.

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 12, 1996

Mr. SPRATT. Mr. Speaker, I rise to address the EPA's proposed cluster rule for the American pulp and paper industry. This rule is intended to simplify and coordinate air and water quality standard setting.

EPA's stated goal is to develop a long-term approach to environmental improvement consistent with reasonable capital expenditures. Its most recent proposal has two options that are to be given equal weight as a potential basis for best available technology. Option A calls for the elimination of elemental chlorine in bleaching operations by complete substitution of chlorine dioxide. Option B would supplement complete substitution with oxygen delignification.

Technical complexity aside, EPA acknowledges that both approaches will reduce the level of dioxins and furans in wastewater of bleached papergrade kraft and soda mills below the current analytical minimum level. By EPA's own estimate, option B would cost industry a billion dollars more than option A.

One facility where the difference between these two options is made abundantly clear is operated by Bowater Inc. in Catawba, SC. The facility employs 1,150 people and produces 2,300 tons of market pulp, coated paper, and newsprint per day. On a tour of this plant last year, I was shown how EPA's option B would require a complete overhaul and rearrangement of the plant's paper production processes including the shifting or replacement of most of their equipment. The cost such a shift would impose is simply unjustifiable given the existence of an equally safe, and cheaper, option. This option, complete substitution, should be adopted in the final rule.

For 3 years, EPA and the pulp and paper industry have worked to identify a workable approach to the cluster rule. For the most part, this period of deliberation has been helpful in evaluating costs and benefits of various proposals. However, the uncertainty and the possibility of the huge costs associated with option B have made it difficult for plants like Bowater to plan for the future. It is time to for a resolution, and I call on EPA to finalize the water guidelines along with MACT I and III air standards by the end of the fiscal year with the selection of option A.

REPORT FROM INDIANA—THOMAS JACKSON

HON. DAVID M. McINTOSH

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 12, 1996

Mr. McINTOSH. Mr. Speaker, I rise today to give my report from Indiana.

Each weekend, my wife Ruthie and I travel across Indiana to meet with Hoosiers.

And every time, we travel the Second District of Indiana, we become more amazed with the hundreds and hundreds of individuals who are out-there working day and night to make a difference taking responsibility to make our communities better places to live.

I like to call these individuals Hoosier Heros. Hoosier Heros because they do good things for their friends and neighbors.

Today I recognize, Thomas Jackson of Anderson, IN as a Hoosier Hero.

Ruthie recently spent a day with Thomas. Afterwards she shared with me Tom's tireless efforts to help children in Madison County.

You see Tom owns and operates his own restaurant—the ''Prime Time Deli and More.''

And between spending time with his family and the responsibilities of running his own business, his free time is stretched thin.

But that doesn't stop Tom from helping others. He has taken on a crucial challenge.

Thomas has taken on himself, the mission, to spread the message ''Just Say No!'' to our young people.

Tom travels to schools in Madison County educating, warning and teaching children to say: ''No to drugs and alcohol.'' Thomas' mission is special and close to his heart.

Nine years ago, his own son Thomas Jr., became involved with a drug cartel in the neighboring city of Muncie.

His son almost lost his own life. Thomas Jr. was in pretty bad shape but with the love of his father and family, he survived. He turned his life around.

Thomas Jr. was recently married and today lives a happy life. Thomas Jackson decided that the best way for others to avoid the same tragedy as his own son, was to take a leadership role in warning children.

He started an alcohol and drug awareness program: ''Youth Needs Prime Time.'' that's reassuring.

Today he educates children about the very real danger and possible lethal consequences of drugs and alcohol use.

One of his volunteers is a 24-year-old, ex-gang member, Roosevelt Rees.