Beyond the VHA Directive regarding capacity, this bill seeks to modify the current VA means-test threshold. For about fifteen years, the VA has determined a nonservice-connected veteran's ability to pay by comparing a veteran's income to a predetermined ''means-test threshold.'' The threshold, expressed in annual household income, is an assumed income level that would be sufficient to a veteran to pay for health care in the community. If a veteran's income is below the ''ability to pay'' threshold, (currently $23,688 for a single veteran without dependents) he or she is eligible for VA care, and permits the veteran to avoid the co-payments charged to higher-income veterans for VA health care services.

VA's one national standard income threshold has been criticized for years because of the disparities in living costs throughout the country.

The Department of Housing and Urban Development employs a system of ascertaining poverty levels for subsidized housing that is much more reflective of the cost of living around the country than the VA's means test. The Chairman of the Full Committee and I believe the HUD index should be used by VA to better reflect differences in economic factors.

Another provision of this bill explores improved coordination of VA ambulatory and community hospital care. This calls for a 4-year, 4-site pilot project in which the VA refers enrolled veterans to local community hospitals rather than transporting them to an urban VA facility hours away. This is one more way the VA can work to bring VA services closer to the veterans they serve.

Another pilot program proposed in this bill is a 4-year, 4–VISN program for managed care through an outside contractor in VA's $500 million fee-basis and contract hospitalization program. A contractor would provide resource information and referral services to eligible veterans, RN staffed advice lines, coordination with assigned VA case managers, and a variety of reports and data on utilization, satisfaction, quality, access, and outcomes. This program provides care to service-connected veterans whose places of residence or health conditions prevents them to be geographically accessible to VA facilities, or available VA facilities cannot furnish the care or services required. This would also provide health care for life threatening emergencies when no VA facility is available.

Mr. Speaker, this bill makes important improvements in our veterans health care system. When Congress returns from the August break, the Subcommittee will consider this important legislation. I urge the members to support the bill on behalf of veterans.

LIFE OF MRS. MAMIE L. TOWNSEND

HON. JULIA CARSON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Ms. CARSON of Indiana. Mr. Speaker, it is with both sorrow and appreciation that I submit these remarks on behalf of the life and memory of Mrs. Mamie L. Harrington Townsend who departed this life last Saturday, July 28, 2001.

First I am grateful that Mrs. Townsend was loaned to us for such a long time. I feel a special kinship to her and was saddened when I learned that she had taken a flight to California and whereupon she took another flight to heaven. We were similar in so many ways: Her mother's name is Julia. We both attended Crispus Attucks High School and IUPUI. We both love children, family, community, state and nation. We have backgrounds that reflect diverse employment and have been honored by many of the same organizations.

Mamie was universal in her commitments and volunteerism. She has been acclaimed Woman of the Year by her sorority and received the prestigious Sagamore of the Wabash; distinguished citizen, outstanding businesswoman, ''Who's who among women'', Sojourner Truth award, and Mary McCloud Bethune award among her many awards. Her greatest reward is yet to come.

Time and space does not accommodate her many achievements. She was simply a unique, tireless, and selfless person.

Mamie was my friend. She had a beautiful spirit. She was a continuous helper to more than we would ever know about.

The great book reminds us that there is a time for all things under the heaven. That there is a time to be born—she was born not once but twice. There is a time to die—she died—in the arms of Jesus.

She has enriched the lives of many—she inspired me especially.

To her family: thanks for sharing Mamie with us. Be strong and of good courage. You have so much to be proud of and to celebrate.

MOTOR VEHICLE OWNERS RIGHT TO REPAIR ACT

HON. JOE BARTON

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. BARTON of Texas. Mr. Speaker, today I am introducing the Motor Vehicle Owners Right to Repair Act. As the name implies, this bill will preserve a vehicle owners' freedom to choose where, how and by whom to repair their vehicles as well as their choice in car parts.

Right now, thousands of vehicle owners who are being turned away from their local repair facility. They are being denied the choice of working on their own vehicles, or the choice of replacement parts because information necessary to make these repairs or integrate replacement parts with the vehicle computer system is not readily available or not available at all. This isn't the way it used to be. Until recently, this information was either not necessary or widely available. But language in the 1990 Clean Air Act mandated that vehicle manufacturers install computer systems in vehicles 1994 and newer to monitor emissions. This law had the unintended consequence of making the vehicle manufacturer the gatekeeper on who can repair, or produce, replacement parts for the vehicle.

This lack of consumer choice will have a huge negative economic impact. An economic study examining this lack of choice's effect on California vehicle owners concluded that motorist repair bills in California alone would increase by 17 billion through 2008. Nation-wide this would equate to a huge tax increase on the American people and severely hurt low and fixed income motorists.

I believe that most vehicle owners who have for years taken for granted that any qualified repair technician of their choice, including themselves, may repair their vehicle have relied heavily on the quality, cost and convenience of the competitive independent aftermarket parts will be surprised to find that in many cases it no longer exists.

With this legislation, we put the motor vehicle owner back in the driver's seat.

MEDICARE REGULATORY AND CONTRACTING REFORM ACT OF 2001

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. STARK. Mr. Speaker, today I am pleased to join Chairman NANCY JOHNSON (R–CT) in introducing legislation that will improve Medicare's administrative functions. Our bill addresses two very important problems in Medicare. First, it takes important steps to improve outreach and assistance to beneficiaries and providers, and to respond to certain other legitimate concerns raised by physicians and other providers. And second, it includes long overdue contracting reforms that will improve beneficiary and provider services and permit the consolidation of Medicare claims processing. Importantly, however, our legislation does not compromise the government's ability to protect taxpayer dollars from being inappropriately spent under Medicare.

Mr. Speaker, no public program can continue without strong public support, and I suggest that Medicare needs both public support and provider support. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is constantly criticized for burdensome regulations and paperwork. Yet polls of physicians and other providers have shown that providers prefer Medicare over other payers because Medicare pays faster and does less second-guessing than other payers.

We need to improve the education and information processes for providers. It is hard for even the most seasoned Medicare analyst to keep track of all the payment and policy changes that have occurred in Medicare in the last few years. How can we expect providers to keep track of all of these changes while continuing to provide services? We need to do a much better job of educating and assisting physicians and other providers about these changes, and this legislation will help the CMS/HCFA do so.

Mr. Speaker, throughout the history of Medicare, we have relied on Medicare contractors—carriers and fiscal intermediaries—to provide information to beneficiaries and providers, but that process is outdated in the face of all of the changes. Although that approach worked well for many years, I think most stakeholders would agree that we need major improvements in the Medicare contracting processes. Every President since President Carter has proposed reforms to the administrative contracting provisions in Medicare, yet they have never been enacted. I hope we succeed this time.

Mr. Speaker, our legislation takes important steps to improve outreach and assistance to

providers. It would also create a Medicare Provider Ombudsman to help physicians and other providers to address confusion, lack of coordination, and other problems or concerns they may have with Medicare policies.

Our bill reforms the Medicare contracting processes by consolidating the contracting functions for Part A and Part B of Medicare, permitting the Secretary to contract with separate Medicare Administrative Contractors to perform discrete functions, making use of the Federal Acquisition Rules in contracting, eliminating the requirements for cost contracting, and expanding the kinds of entities eligible for contracting. Our bill would permit consolidation of claims processing with fewer contractors, and it would permit separate contracting along functional lines—for beneficiary services, provider services, and claims processing.

Mr. Speaker, my support for combining the administrative contracting functions of Part A and Part B in no way implies my support for combining the Part A and Part B trust funds or otherwise combining the financing or benefits. I strongly oppose such a consolidation.

Mr. Speaker, I have tried for years to get CMS/HCFA to institute a single toll-free phone number for Medicare beneficiaries like the single toll-free phone number that Social Security has operated for years. Finally, in the BBA, the Congress mandated the establishment of a toll-free number, 1–800–MEDICARE. By all accounts, it has been a great success, and even CMS/HCFA now touts its success. However, CMS/HCFA has still been unwilling to permit Medicare beneficiaries to use this number as a single entry point to Medicare. The latest national Medicare handbook includes 14 pages of telephone numbers for beneficiaries to call with specific questions! Surely, if a beneficiary calls the 1–800–MEDICARE number, their call could be transferred to the appropriate number, rather than asking them to try to locate the correct number themselves from among 14 pages of numbers!

In addition to not having a single place to call for Medicare problems, beneficiaries also have no casework office whose responsibility is to help them with their Medicare problems. In the past, CMS/HCFA has relied on the contractors, but many of the problems beneficiaries face are with the contractors themselves. In addition, CMS/HCFA now relies on State Health Insurance Counseling and Assistance Programs (HICAP) organizations to help beneficiaries. I am a strong supporter of these organizations; however, these agencies are staffed with volunteers. It is absurd for a huge public program the size of Medicare to rely on volunteers to be the main source of assistance for its beneficiaries.

We should look to the Social Security Administration to identify ways to provide assistance for Medicare beneficiaries. For example, Social Security not only has regional teleservice centers to staff their national toll-free line and help beneficiaries with their questions, SSA also has Program Service Centers to perform casework for Social Security beneficiaries with specific problems. We need similar offices for Medicare beneficiaries to perform casework for them. Currently, Medicare casework is handled primarily by Congressional offices, since no casework office exists in Medicare.

I have proposed that Medicare staff be stationed in Social Security field offices to help answer questions and provide assistance for Medicare beneficiaries. There are 1291 SSA field offices around the world, and I would like to see Medicare staff in many, if not all of them in the near future. I am pleased that the legislation we are introducing today authorizes a demonstration program to examine the value of placing Medicare staff in SSA field offices, and I hope it will be expanded if it is found to aid beneficiaries.

Finally, Mr. Speaker, let me address Medicare administrative resources. Two years ago, in the January/February 1999 issue of Health Affairs, fourteen of our nation's leading Medicare policy analysts—ranging from conservative to liberal—published an open letter titled, ''Crisis Facing HCFA & Millions of Americans.'' The crisis they spoke about was the lack of resources to administer Medicare. Their letter is even more relevant today. As its administrative workload has increased, CMS/HCFA resources have not kept pace. The changes that we propose in our legislation today are important, but by themselves, they are not sufficient. We simply must get more resources into Medicare administration.

PERSONAL EXPLANATION

HON. ASA HUTCHINSON

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. HUTCHINSON. Mr. Speaker, I was inadvertently detained during several rollcall votes this week. If I had been present I would have voted in the following way: Rollcall No. 301—''yea''; No. 302—''nay''; No. 304—''yea''; No. 305—''yea''; and No. 320—''yea''.

TRIBUTE TO THE HONORABLE WILLIAM E. LEONARD

HON. GARY G. MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. GARY G. MILLER of California. Mr. Speaker, I rise to pay tribute and honor the accomplishments of The Honorable William E. Leonard, member of the California Assembly, 63rd District.

Mr. Leonard earned a bachelor's degree in Business Administration from UC Berkeley in 1944, and served in the United States Army from 1943 to 1946 where he rose to the rank of First Lieutenant. After his military service, he joined his father at the Leonard Realty & Building Company. He served as a member of the California State Highway Commission from 1973 to 1977, and was appointed to the California Transportation Commission from 1985 to 1993, and served as its chair in 1990 and 1991. Prior to that he was a member of the state's Athletic Commission from 1956 to 1958. He currently serves on the state's High-Speed Rail Authority.

Mr. Leonard has been actively involved in a number of community organizations. He is a member and past director of the San Bernardino Host Lions, a founding member and president of Inland Action, Inc., and a member of the National Orange Show Board of Directors, where he has served as President and Chairman of the Board of Governors. He is also a member and elder of the First Presbyterian Church of San Bernardino. He served on the San Bernardino Valley Board of Realtors, San Bernardo Valley Foundation, St. Bernadine's Hospital Foundation, and the University of California at Riverside Foundation.

In recognition of his outstanding service to the constituents of the 63rd Assembly District, and his involvement in bringing the Foothill Freeway to the Inland Empire, the California State Senate passed a resolution naming the interchange of I–15 and Route 210 as the William E. Leonard Interchange. A dedication ceremony will take place on July 20, 2001.

Mr. Leonard's exemplary record of service has earned the admiration and respect of those who have had the privilege of working with him. I would like to congratulate him on these accomplishments and thank him for the service he has provided to his community.

IN RECOGNITION OF THE COMMUNITY ACTION COUNCIL OF SOUTH TEXAS

HON. CIRO D. RODRIGUEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. RODRIGUEZ. Mr. Speaker, today I would like to recognize the important contributions of the Community Action Council of South Texas (CACST) to the improvement of the general quality of life of the citizens of South Texas. CACST is a private, nonprofit corporation that provides high quality comprehensive primary health care to the medically underserved residents in Duval, Jim Hogg, Starr, and Zapata Counties in South Texas. These counties are currently medically underserved due to geographic isolation, financial barriers, and an insufficient number of health care providers.

The CACST has made great strides in the South Texas health care system, specifically by empowering communities to develop programs to meet their specific needs. This has strengthened the local communities and enhanced opportunities for children and families. In addition, the CACST has maintained a high standard of accountability and provided health care services in accessible low-cost environments.

They have worked to improve access to quality health care by providing trained professionals in areas that had previously been underserved and promote individual responsibility and health awareness in the communities. It is critical that the CACST remain a provider of primary health care and their host of support services, including transportation, case management, outreach, and eligibility assistance. Their presence in the South Texas community has been a tremendous benefit to the individuals that reside there. I commend their efforts to help achieve primary health care for everyone and end health disparities.