

known as DRG's. Certain providers of care were exempted from this system because a way to appropriately group their patients did not exist. Among these were rehabilitation hospitals and rehabilitation units in general hospitals. These continued to be reimbursed based on costs incurred, but subject to limits on payment per discharge. These limits are imposed under the Tax Equity and Fiscal Responsibility Act of 1982, and commonly known as TEFRA limits.

TEFRA limits were to be a short-term expedient to reduce the rate of increase in hospital payments. TEFRA limits are based on Medicare operating cost of a hospital or unit in an assigned base year divided by the number of Medicare discharges in that year. This value is updated annually by an update factor, which is intended to reflect inflation. A hospital's or unit's ceiling on Medicare reimbursement is the TEFRA limit for a given year times the number of its Medicare discharges in that period, the TEFRA ceiling.

For cost reporting periods beginning on and after October 11, 1991 the Medicare Program reimburses a portion of a provider's cost over its TEFRA ceiling in an amount which is the lower of 50 percent of cost over the ceiling or 10 percent of the ceiling. Provision for such payment was made by the Omnibus Budget Reconciliation Act of 1990 [OBRA 90]. If a provider's costs are less than its TEFRA ceiling, the provider is paid an incentive payment equal to the lower of 50 percent of the difference between its Medicare operating costs and its TEFRA ceiling or 5 percent of that ceiling.

When this system was adopted, it was assumed that it would be in place only a short time and then be replaced with a PPS for excluded hospitals and units. New hospitals and units coming on line after the TEFRA system was in place were in a much better position than older facilities, simply because their more current base years included more contemporary wage rates and other operating costs.

This now very old temporary system is flawed for the following reasons:

Medicare pays widely varying amounts for similar services, producing serious inequities among competing institutions.

New hospitals and units can establish limits based on contemporary wage levels and otherwise achieve much higher limits than older hospitals, putting them at a great advantage.

By treating all rehabilitation discharges as having the same financial value, the TEFRA system provides a strong incentive to admit and treat short-stay, less complex cases and to avoid long-stay, more disabled beneficiaries. This is not a good policy for Medicare to continue to support.

Because any change in services that will increase average length of stay or intensity of services will likely result in cost over a TEFRA limit, the system inhibits the development of new programs. This is also not a good direction and does not encourage implementation of current practices.

The process for administrative adjustment of limits does not provide a remedy because it is not timely. HCFA does not decide cases within the 180-day period required by law and does not recognize many legitimate costs.

The very strong incentive to develop new rehabilitation hospitals and units has resulted in an increase in the number of rehabilitation hospitals and units. PROPAC reports that in

1985 there were 545 such hospitals and units. In 1995 there were 1,019. Between 1990 and 1994 Medicare payments to such facilities increased from \$1.9 to \$3.7 billion. Some of this increase reflects the lack of needed service capacity in 1983. At the same time, many older facilities had and have to live with very low limits of Medicare reimbursement and were paid less than the cost of operation, while new facilities were being paid much higher cost reimbursement and bonuses as well. It is hard to imagine a worse system.

The clear solution to this situation is to introduce a prospective payment system for rehabilitation facilities under which providers are paid similar amounts for similar services and payments are scaled to the duration and intensity of services required by patients. Such a system has been devised by a research team at the University of Pennsylvania. It is based on the functional abilities of patients receiving rehabilitation services.

It is now being used by the RAND Corp., under contract with the Health Care Financing Administration, to design a payment system. This work is to be completed before the end of 1996.

My bill would require that a PPS for rehabilitation be implemented by the Secretary of HHS for Medicare cost reporting years beginning on and after October 1, 1997. This date would allow adequate time to adopt regulations and administrative procedures. And my bill requires that this payment system is budget neutral.

Enactment of this bill would have multiple benefits. It would benefit patients by removing the implied financial penalty for treating severely disabled patients; it would benefit providers of services by putting all rehabilitation facilities on a level playing field; and it would benefit the Medicare trust fund by eliminating the enormous incentive in present law to duplicate service capacity.

I look forward to support from my colleagues in passing this important legislation.

20TH ANNIVERSARY OF CHERRY VERSUS MATHEWS

HON. SANFORD D. BISHOP, JR.

OF GEORGIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 18, 1996

Mr. BISHOP. Mr. Speaker, July 19 is the 20th anniversary of the U.S. District Court decision known as Cherry versus Mathews, the historic ruling that opened the door to full and equal citizenship for disabled citizens.

The plaintiff, Dr. James L. Cherry, is a Georgian. His landmark suit led to the Department of Health, Education, and Welfare's regulation under section 504 of the 1973 Rehabilitation Act assuring disabled citizens reasonable access to public programs and facilities. This regulation became the model for the Americans with Disability Act, which expanded protection from discrimination to all persons with disabilities. It was also Dr. Cherry who first proposed Georgia's voting accessibility law, on which a similar Federal statute is patterned.

Twenty years ago, many disabled citizens could not use public transportation; or go to most schools and colleges; or have access to many Government parks and buildings and

other services; or even have access to voting booths.

This changed following the decision by Judge John Lewis Smith. It changed almost overnight. Suddenly, the country's promise of equal opportunity became a reality for millions of disabled Americans. It was one of the great moments in America's march toward justice and opportunity for all.

As we observe the 20th anniversary of Cherry versus Mathews, I urge all Americans to rededicate themselves to the principle of equality of opportunity which is one of the cornerstones of the country's greatness.

CYPRUS DISPUTE

HON. LEE H. HAMILTON

OF INDIANA

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 18, 1996

Mr. HAMILTON. Mr. Speaker, I rise today to join my colleagues in recognizing and marking the 22d anniversary of the Turkish invasion of northern Cyprus.

Since 1974 when one-third of the island of Cyprus was invaded by Turkish troops, the United States and other interested parties around the world have worked tirelessly to try to bring a just and lasting solution to a problem that has threatened the peace and stability of that country and that region. Unfortunately, little progress has occurred.

Mr. Speaker, substantial progress toward a settlement of Cyprus dispute is long overdue. Progress on Cyprus should be a high priority at all levels of our government. Many in the Congress have been committed to reaching a solution over the years, and I commend the efforts on the part of my colleagues.

My colleagues and I have urged the administration to launch a full-scale initiative to move the Cyprus negotiations forward. It is only through high-level and sustained United States attention that the parties on the island will take the steps necessary to resolve this issue.

Mr. Speaker, Turkey remains the key to a solution of the Cyprus problem. While many of us have been frustrated by the lack of progress on the issue, we have reasons today to be hopeful and to encourage all parties to maintain their commitment. The United States, as well as the United Nations, and members of the European Union, all have stepped up efforts to bring the parties together.

I am encouraged by this activity, as well as by the bipartisan support of this Congress for an intensified American effort. It is in the United States national interest as well as that of all parties in the region that we find a just and viable solution for Cyprus.

We should dedicate ourselves to that goal and seek to make 1996 the year we achieved substantial progress toward a settlement of the Cyprus dispute.

EUROPEAN UNION SANCTIONS

HON. GERALD B.H. SOLOMON

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, July 18, 1996

Mr. SOLOMON. Mr. Speaker, the European Union is considering imposing visa requirements for American travelers and even freezing some United States assets in retaliation for