

When he first took office at age 35 in 1951, the city had just suffered the devastating exodus south of the textile industry which resulted in the loss of thousands of jobs. He started Operation Bootstrap to revitalize the city at a time when Federal and State programs were unavailable. Thus began a 14-year term as mayor in which he brought 70 new businesses and 12,000 jobs into the city.

After a one-term hiatus, Mayor Buckley regained the office in 1971 to serve his eighth term. He urged the citizens of Lawrence, the "Immigrant City" to embrace the influx of Hispanic immigrants just as their parents and grandparents had been welcomed in the early part of the century. During his time in office, the city built a new post office, public library, police station and boys club. Mayor Buckley came roaring back in 1983 after two defeats for his 17th and final run for mayor. This last hurrah and victory capped off his 22-year career as chief executive of the city of Lawrence. But even during the periods when he was out of elected office, he devoted himself to the public through service organizations and appointed positions.

In later years it was not uncommon to see John Buckley strolling Lawrence's main street as citizen after citizen greeted him with "Good morning, Mr. Mayor." He loved the city of Lawrence and it indeed loved him. This weekend, I will join with my friends in Lawrence to pay a final tribute to John J. Buckley, who died last Monday at the age of eighty, leaving the city he loved with a legacy of accomplishments.

MUSIC TO LIVE BY

HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, February 6, 1997

Mr. KUCINICH. Mr. Speaker, I rise to honor Frankie Yankovic, America's Polka King, the Elvis of ethnic musical expression, ambassador of the great American melting pot, prolific composer, band leader, performer, and Cleveland.

Frankie Yankovic was born to Slovene immigrants in 1915. In their hardscrabble working lives, music expressed their hope and joy. Frankie began by playing accompaniment to the boarders in his family home.

He was an obvious talent and was instantly loved by all who heard his music. At age 23, Frankie had his first band and his first hit album. He began a lifetime of touring. Frequently, he made 300 appearances per year. Over the years, his bands have played in every major concert hall in America.

Frankie Yankovic heralded many polka tunes known widely to American listeners. In 1948, Frankie recorded "Just Because" with Columbia records. The tune was a breakthrough release, attracting both a polka and popular music audience. "Just Because" sold 1 million copies. In 1949, Frankie released the "Blue Skirt Waltz," which attained the coveted gold status even more quickly.

Frankie was also a great mentor. He discovered and cultivated the talent of the famous virtuoso, Joey Miskulin.

Frankie received many honors in his lifetime. He was inducted into the International Polka Association Polka Hall of Fame as well

as the Cleveland Style Polka Hall of Fame. In 1986, Frankie received the first Grammy awarded for polka music.

Beyond being the consummate performer, Frankie was also a lifetime union member of Local 4, American Federation of Music, and a patriot. Married and the father of two, he nevertheless voluntarily enlisted in the U.S. infantry in World War II and fought at the Battle of the Bulge. There, under extreme weather conditions, Frankie contracted gangrene in his limbs. Against the advice of doctors, Frankie resisted amputation. With a great deal of courage and persistence, Frankie brought his fingers and hands back to life. How fortunate we all are.

I commend Frankie Yankovic for his skill, his energy, and his ability to make people happy through the sounds and rhythms of polka.

THE REHABILITATION HOSPITALS AND UNITS MEDICARE PAYMENT EQUITY ACT OF 1997—A BILL TO PROVIDE FOR A NEW PAYMENT SYSTEM FOR PPS EXEMPT REHABILITATION HOSPITALS AND UNITS—THE TIME IS NOW

HON. FRANK A. LOBIONDO

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, February 6, 1997

Mr. LOBIONDO. Mr. Speaker, today I introduce legislation to provide for a Medicare prospective payment system [PPS] for inpatient rehabilitation hospital and rehabilitation unit services.

Prior to 1983, the Medicare Act paid hospitals the reasonable cost of treating Medicare patients. Generally, this meant that the more a hospital spent, the more it was paid from the Medicare Trust Fund. The result was a rapid rate of increase in Medicare spending for hospitalization. In 1983, this system was replaced with a prospective payment system under which hospitals were paid fixed rates for various types of diagnostic groups, commonly 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 are commonly known as TEFRA limits.

TEFRA limits were to be a short term solution to reduce the rate of increase in hospital payments pending adoption of a PPS for rehabilitation hospitals and units. 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.

Under the current—and flawed—TEFRA system, 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 in 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 the latter 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 faulty and misguided public policy;

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 faulty and misguided policy; and

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 billion to \$3.7 billion. This increase in part reflects the fact that rehabilitation services were not widely available in 1983.

Consequently, many older facilities have had to live with very low limits of Medicare reimbursement and have been paid less than their costs of operation. To the contrary, many new facilities are 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