Approved January 30, 1984
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m./~~p.m.~~ on January 27, 1984 in room 526-S of the Capitol.

All members were present except:

Senator Morris, excused, and Senator Bogina

Committee staff present:

Emalene Correll, Legislative Research Department

Conferees appearing before the committee:

Don Wilson, President, Kansas Hospital Association

Others present: see attached list

Don Wilson, President, Kansas Hospital Association, explained the reimbursement systems currently in place and their impact on hospitals in Kansas. (Attachment #1).

He stated that during 1982, Blue Cross, Medicare, and Medicaid, the three major third party payors in Kansas, all implemented separate utilization review programs in Kansas hospitals. During 1983, they began to implement a prospective pricing system for hospital services.

Mr. Wilson explained that under cost-based reimbursement, Medicare payments were determined by the Medicare cost report. Under the Prospective Pricing System, payment for inpatient services will be determined by the number of patients treated in each Diagnosis Related Group (DRG) and a schedule of DRG prices. Medicare's new PPS, while based on DRG, is substantially different from the Blue Cross System in the pricing and payment procedures employed.

Prospective pricing, by changing hospital incentives, is a step toward the long term financial stability of the Medicare program, according to Mr. Wilson, and allows hospitals to benefit financially from improvements in management.

Mr. Wilson further explained that the approach to Medicare prospective pricing sets prices for each Diagnosis Related Group (DRG); severs the traditional relationship between Medicare revenues and costs; and puts the hospital fully "at risk" for differences between average costs within DRGs and the DRG prices. Medicare's and Blue Cross' CAP are causing Kansas hospitals to modify their internal operations and reporting systems. The hospitals go into the system based on when their Fiscal Year starts. Most start on July, and some on October 1. Under this system, Medicare utilization has dropped by 7.2% for admissions and 22% for inpatient days. The Medicare and Blue Cross new prospective pricing systems demonstrate the potentially positive impact that cooperative and private initiatives can generate.

Since a DRG-based payment system has not been tested in a rural setting, both Medicare and Blue Cross need maximum opportunity to experiment and work with providers in order to successfully implement and administer such a system.

Mr. Wilson said KHA has been meeting with Secretary Harder to develop a

new utilization review system and a prospective Medicaid payment system. This reflects the positive spirit of cooperation that has developed between SRS and the hospitals of Kansas. However, the agreed upon payment rate for services provided to Medicaid patients is quite a bit less than the actual cost to the hospitals.

Mr. Wilson commented that the health care industry is in a period of rapid, evolutionary change and these changes hold great promise for bringing the rate of health care cost increase more into line with consumer expectations and willingness to pay.

KHA believes that the solution to rising health care costs lies not in an increase in government intervention, but in developing delivery and financing systems that create appropriate consumer and provider incentives. Incentive based approaches can be developed only through cooperative efforts of all affected parties, working at the local level.

Senator Meyers asked Mr. Wilson to return Monday for further discussion.

Senator Francisco moved that the minutes of January 25, 1984, be approved, with the correction that Line 5, Paragraph 2, be changed to read "it will be completed in time for an interim committee to prepare legislation for next year". Senator Ehrlich seconded the motion and it carried.

The meeting was adjourned.

SENATE

PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 1-27-84

(PLEASE PRINT) NAME AND ADDRESS	ORGANIZATION
Ed Grigg - Employee Relations	Div. of Personnel Services
Cliff Doel - Employee Relations	Div. of Personnel Svcs.
Bill Overbey	KHA
Rebecca Kupper	KHA
Harold Riehm	KAOM
Dr Lois R. Scibetta	Ks St Bd of Nursing
Cathy Rooney	KDHE
Mary Corrigan	KDHE
Barbara Duncan	DOA
JoAnn Klesath	KAPE
Paul Johnson	PACK
Marilyn Bradt	KINH
Diane Bottorff	KSNA
Gary Betz	KDoA
B. Sabol	KDH&E
R. Harder	SRS

H/— 1-27-84

KANSAS HOSPITAL ASSOCIATION

January 27, 1984

CURRENT REIMBURSEMENT REFORMS

Over the past two years, Kansas hospitals have been experiencing significant reform in the major third party reimbursement systems and the regulatory and contractual requirements these parties levy upon the operations of hospitals in order for a hospital to participate in these programs.

During 1982, Blue Cross, Medicare and Medicaid, the three major third party payors in Kansas, all implemented separate and unique utilization review programs in Kansas hospitals. Whereas these programs have had some form of utilization review in Kansas hospitals in the past, these are now more restrictable and complex programs. Each of these programs, though different in their requirements, are designed to scrutinize the practice of medicine and, where appropriate, modify that pattern.

During 1983, each of these three major third-party payors developed and began to implement a prospective pricing system for hospital services. Thus, in 1984 over 80 percent of the payments to Kansas hospitals for services provided will be under one of three prospective pricing systems.

Marlon Dauner already reviewed the prospective payment system implemented January 1, 1984 by Blue Cross and Blue Shield of Kansas, so I will not spend time highlighting that system.

First, with respect to Medicare --

Atch. 1

On August 19, 1982, Congress passed the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA. The health related provisions of TEFRA are producing the most extensive changes in Medicare since its inception in 1965. The financial and operational implications of TEFRA were profound. Effective for hospital fiscal years beginning on or after October 1, 1982, these regulations established hospital payments on a total cost-per-case basis, rather than the traditional per diem plus ancillary cost approach. TEFRA substantially modified the manner in which hospitals were reimbursed and the incentives that had previously been established.

On March 24, 1983, Congress approved, in cooperation with the hospital industry, a Medicare prospective pricing plan for most inpatient services as part of the Social Security Amendments of 1983. This action continues the movement--begun by TEFRA--away from retrospective cost-based reimbursement as the basis for hospital payment by the Medicare program. On September 1, 1983, the Health Care Financing Administration issued interim final regulations implementing the Medicare prospective pricing system (PPS). Final regulations were issued January 3, 1984. The new payment system became effective for hospital cost reporting years beginning on or after October 1, 1983, and will replace the system of cost-per-case limits created by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

Under cost-based reimbursement, Medicare payments were determined by the Medicare cost report, which identified "allowable," "reimbursable," and "reasonable" costs. Under the prospective pricing system, payment for inpatient services will be determined by the number of patients treated in each Diagnosis Related Group (DRG) and a schedule of DRG prices. Medicare's new PPS, while based upon DRG, as is the Kansas

Blue Cross new payment system, is substantially different from the Blue Cross system in the pricing and payment methodologies and procedures employed.

Under Medicare, the price for a DRG is calculated by applying a DRG weight to a base or standard Medicare price. The DRG weights reflect the average cost of treating a patient in each DRG during 1981. For example, DRG 236 has a weight of 1.3855, as patients admitted for a fracture of the hip or pelvis incurred costs that were, on average, 38.55 percent higher than the "average" Medicare patient.

During the first three years under prospective pricing, the standard Medicare price is a blend of a hospital-specific rate and a federal rate, which in turn is a blend of a national rate and a regional rate. During a hospital's first year under prospective pricing, its price schedule is based on:

- 75 percent of the hospital-specific rate; and
- 25 percent of the federal rate, which until September 30, 1984 will be equal to the regional rate.

During the hospital's second prospective year, the blend factors are 50 percent of the hospital component and 50 percent of the federal rate. During the third year the blend is 25 percent of the hospital rate and 75 percent of the federal rate.

Prospective pricing, by changing hospital incentives, is a step toward the long term financial stability of the Medicare program and allows hospitals to benefit financially from improvements in management. Unlike the system of the Tax Equity and Fiscal Responsibility Act cost-per-case limits, the approach to Medicare prospective pricing adopted by Congress:

- o sets prices for each Diagnosis Related Group (DRG) rather than establishing a case mix adjusted cost-per-case limit for the hospital;
- o severs the traditional relationship between Medicare revenues and costs;
- o puts the hospital fully "at risk" for differences between average costs within DRGs and the DRG prices.

Because prices will be fixed at the beginning of the year, costs must be managed within the limits of available revenues. In addition, physician involvement in the management of patient services is essential under prospective payment as the hospital is "at risk" for the length of stay and use of services, as well as the mix of patients admitted, within each DRG.

Thus, Medicare's PPS and Blue Cross' CAP are causing Kansas hospitals to considerably modify their internal operations and reporting systems. New types of management reports and budgetary and accounting processes are having to be developed; computer programs changed; medical staff and employees informed and educated about the new systems. In fact, recent data indicates Medicare's PPS is already having an impact on Kansas hospitals' utilization. Information gathered from those Kansas hospitals which started October 1 on Medicare's PPS shows that for these hospitals' first quarter (October-December, 1983) under the system, Medicare utilization has dropped from that same quarter last year (October-December, 1982) by 7.2 percent for admissions and 22 percent for inpatient days.

The Medicare and Blue Cross new prospective pricing systems demonstrate the potentially positive impact that cooperative and private initiatives can generate. However, it must be pointed out that these

two different approaches are experimental. Even though the state of New Jersey has been using a DRG-based prospective payment system, the payment methodologies used in New Jersey are significantly different from those now employed by Medicare and Blue Cross. In addition, a DRG-based system has never been attempted in a state like Kansas which has a significant portion of elderly patients and consists primarily of small, rural hospitals. The average hospital bed-size in New Jersey is approximately 300 beds; in Kansas 75 percent of our hospitals are under 100 beds. Obviously, the managerial and operational resources feasibly available to Kansas hospitals, as compared to New Jersey hospitals, are significantly less.

In addition, these new systems will inevitably undergo a number of adjustments and modifications before it is consonant with beneficiaries' interests and the longevity of the health care system. These two new systems must be given the opportunity to be fine-tuned and to reduce the rate of increase in health care expenditures. We must continue to keep in mind that these systems are still in the experimental stage. Since a DRG-based payment system has not been tested in a rural setting, both Medicare and Blue Cross need maximum opportunity to experiment and work with providers in order to successfully implement and administer such a system.

With respect to Medicaid, the Kansas Hospital Association has been meeting in a cooperative effort with Secretary Harder over the past two years to develop first a new utilization review system and then most recently a prospective Medicaid payment system which was implemented July 1, 1983 for all Kansas hospitals. This cooperative process is unique among states and reflects the very positive spirit of cooperation

that has developed between the Department of Social and Rehabilitation Services and the hospitals of Kansas. Agreement reached with SRS and the Kansas Hospital Association for a prospective payment system was one that would accommodate the current budget constraints in the Medicaid program. The hospital industry was pleased to work out an arrangement for providing hospital services to Medicaid recipients during a period when the State is dealing with limited resources. However, it must be pointed out that the agreed upon payment rate for services provided to Medicaid patients is quite a bit less than the actual cost to the hospitals.

The health care industry is in a period of rapid, evolutionary change. Medicare prospective pricing is one sign of this change. The new Competitive Allowance Program launched January 1 by Blue Cross and Blue Shield of Kansas is another. The development of these two major prospective payment programs; preferred provider organizations; alternative delivery arrangements; risk-sharing joint ventures by hospitals, physicians, insurers and employers; health care coalitions; and self-insurance by employers is dramatically changing many financial arrangements that have previously driven up costs. These changes hold great promise for bringing the rate of health care cost increase more into line with consumer expectations and willingness to pay. The success of these efforts, however, depends on the continuing ability of hospitals, insurers, employers and consumers to innovate in response to local conditions and expectations. The solution to rising health care costs lies not in an increase in government intervention, but, rather in developing delivery and financing systems that create appropriate consumer and provider incentives. An incentive-based approach will allow hospitals, physicians, employers and consumers to work together to

design a financing system that will provide the kind of care they both need and want at a price they are willing to pay. Incentive-based approaches can be developed only through cooperative efforts of all affected parties, working at the local level and considering local needs, conditions and resources.