Approved: Feb. 4, 1998
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Dave Kerr at 11:00 a.m. on January 26, 1998 in Room 123-S of the Capitol.

All members were present except:

Committee staff present: Alan Conroy, Legislative Research Department
Russell Mills, Legislative Research Department
April Holman, Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Revisor of Statutes
Judy Bromich, Administrative Assistant
Ann Deitcher, Committee Secretary

Conferees appearing before the committee: Marlin Rein, Office of the Chancellor, Kansas University
Donald Hagen, M.D., Executive Vice-Chancellor, Kansas University
Dr. Irene Cumming, Kansas University Hospital C.E.O.

Others attending: See attached list

Chairman Kerr advised members of the Committee that the handout entitled "University of Kansas Hospital" had been distributed for their review.

Dr. Donald Hagen, M.D., Executive Vice Chancellor of the University of Kansas introduced Dr. Irene Cumming, C.E.O. of the University of Kansas Hospital, who took the Committee members through the overview of the recent operating trends and financial results of KU Hospital. She pointed out the information in the exhibits included in the handout (Attachment 1), and the Admissions Trend. (Attachment 2).

When asked about the number of indigents treated at the hospital, and if there seemed to be a trend toward an increase in the numbers, Dr. Cumming said that they seem to be holding at 12%. They do not turn away any Kansas residents. COBRA laws are very strict and very protective -- patients cannot be turned away. Of the 12%, about 2% are from Missouri. Being the only burn center, they cannot turn a burn victim away no matter where they're from.

The hospital has no agreements with neighboring states. Although Kansas pays for Kansas Medicaid patients to go to Missouri, Missouri's payment to Kansas Hospitals is negligible for Missouri patients. She said that the Kansas Legislature could possibly influence Missouri Legislature to work something out.

Marlin Rein, of the K.U. Chancellor's office, said that the change in regard to Missouri Medicaid really hurt us in the mid '80s when they went to a primary care network in Jackson County. At that time, those Medicaid recipients had to go to their primary care physicians. If they did not and came to the Medical Center, Missouri Medicaid refused to pay. At that time, Kansas policy was that if they came to them, they would try to stabilize the patient and then return them to a Missouri hospital.

This has been an issue for several years because by contrast, Kansas Medicaid pays millions of dollars to Missouri providers. Several SRS Secretaries have tried to work through some kind of resolution. A reduction in payment to the Missouri hospitals has been initiated within the last few months by the present Secretary of SRS.

Senator Feleciano thought that there must be a way that the Administrators of Medicaid in Kansas and Missouri could sit down together and work out something that is amicable to all. He once again asked what the legislature could do to facilitate this.

Dr. Hagen said they would welcome a forum between the two states where they could work something out.

Senator Kerr asked for it to be broken down as to total amount being paid for Missouri residents and what we would be getting reimbursed if paid at the same rate that Kansas pays Missouri. He also asked if the increase in the average length of stay was running counter to the expected trend.

Dr. Cumming said what they were seeing was that the average length of stay was running equal to the expected trend but the true impact was with the more serious cases that come into the hospital.

Senator Kerr asked since the hospital's cash situation was precarious at one point, what their cash balance was at the end of the fiscal year of 1997.

Dr. Cumming said that it was $14 million.

The chairman adjourned the meeting at 11:50 a.m.

The next meeting is scheduled for January 27, 1998.

SENATE WAYS AND MEANS COMMITTEE GUEST LIST

DATE: 1/26/98

NAME	REPRESENTING
IRENE CUMMING	KU MED CTR.
SCOTT GLASMAN	KU MED CTR
Marlin Rein	KU
DON. HAGEN	KUMC
Ken Bahr	KHA
Dave Wilson	KAPE
TK Shively	KS Legal Services
Elaine Frisbie	Div of the Budget

UNIVERSITY OF KANSAS HOSPITAL

SENATE WAYS & MEANS COMMITTEE PRESENTATION

JANUARY 26, 1998

Mr. Chairman and members of the Committee, we appreciate the opportunity to provide you with an overview of the recent operating trends and financial results of KU Hospital. We understand that there have been questions regarding the FY 1998 budget, specifically, the reasons for the substantial increase of $17.2 million in expenditures over the original September 1996 budget submission. To provide you with a better perspective, I'll begin with the Hospital's trends over fiscal years 1994 through 1996 with regard to utilization, cash receipts and expenditures. These trends were the basis from which the original FY 1998 budget submission was prepared. We can then review more recent operating results for FY 1997, which were more favorable than anticipated, and discuss our revised operating budget for FY 1998.

We have previously reported to you the decline in inpatient utilization that the Hospital has experienced in recent years. Exhibit 1 illustrates that, at the time of the original FY 1998 budget submission, the Hospital had experienced a 9.3 % decline in admissions over the two year period covering FY 1995 and FY 1996. The bar chart in Exhibit 2 shows that patient days had an even more dramatic decline (a cumulative 14.3%) over the same two year period. This steeper decline was, in part, due to a 5.7% decline in average length of stay, from 7.0 days in FY 1994 to 6.6 days in FY 1996, which is also shown in Exhibit 2. A combination of factors influenced these results including increased competition, managed care penetration and advanced technology. The Hospital's inpatient mix included 20.0% coming from managed care payers in FY 1997 (vs) 13.1% in FY 1994. This resulted from the transition of traditionally insured patients into HMOs and PPOs. Because these trends were largely due to external forces, in the original FY 1998 budget submission, management projected continued steep declines through FY 1998. Exhibit 1 shows that admissions were budgeted to decline another 10.2% to 12,500 by FY 1998 and patient days were budgeted to decline another 8.9% to 83,750 by FY 1998.

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Attachment 1-1

KU Hospital is a major business which relies totally on its patient revenues for support. Unlike other state agencies, the Hospital's budget (receipts and expenditures) is very sensitive to changes in activity. Exhibit 3 shows the trend in cash receipts over the same two year period. While total cash receipts increased to $172.7 million in FY 1995 due to substantial prior year settlements, the Hospital experienced a steep decline of nearly $10 million in FY 1996 to a level of $162.8 million. Given the previously mentioned FY 1997 and FY 1998 budgeted volume declines, as well as increases in managed care penetration, management projected in the September 1996 budget submission that receipts would continue to decline to $153.8 million by FY 1998.

Exhibit 4 shows the trend in total expenditures over the same time frame. Because the Hospital had relatively little cash reserves at the time (<$10 million), any decline in revenue mandated a corresponding decrease in outlays for salaries and other operating costs. In FY 1996, the Hospital responded to the $10 million decline in receipts by slashing expenditures $8.5 million to a level of $162.0 million, including a reduction of 167 full-time employees. As previously mentioned, the institution expected its cash receipts to continue to decline to $156.7 million in FY 1997 and $153.8 million in FY 1998. Consequently, FY 1998 expenditures were also budgeted to decline to $153.1 million. In fact, after the FY 1998 budget request was initially prepared using Board of Regents guidelines, the Hospital had to adjust its expenditure request downward by $10.3 million based on projected patient volumes and resulting income. This included a significant amount of unidentified salary shrinkage.

Exhibit 5 summarizes budget comparisons for FY 1996 through FY 1998. At the time the FY 1998 budget was initially prepared (September 1996) the institution had just completed FY 1996, during which cash receipts had fallen $11.8 million short of the $174.6 million budget. However in FY 1997, while inpatient volumes continued to decline slightly, admissions remained 2.6% favorable to budget. The Hospital did not experience further reductions in cash receipts. Significant increases in Hospital case mix (relative severity of illness) and outpatient revenues, along with moderate increases in average payment rates more than offset the impact of declining

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Attachment 1-2

inpatient volume. FY 1997 receipts totaled $168.7 million, or $12.0 million favorable to budget and $5.9 million greater than the prior year. Consequently, during the FY 1999 budget submission (September 1997), FY 1998 receipts were revised upward to $170.0 million, $1.3 million higher than in FY 1997.

Exhibit 6 shows the overall four year trend in receipts and expenditures for FY 1994 through budgeted FY 1998. The Hospital has consistently managed to operate within its means. The recovery of cash receipts in FY 1997 and FY 1998 have allowed management to make much needed investments in facilities and organizational infrastructure. Although the Hospital was able to greatly reduce costs during FY 1996, it did not come without a price. Because of low cash reserves and lower revenues, much needed facilities renovations and equipment replacements were postponed. The revised FY 1998 budgeted expenditures are expected to increase $5.5 million or 3.3% from FY 1997 levels. This increase results primarily from normal inflation. However, significant investments are being made this year in staff and other resources to enhance several key areas. Due to restrictions placed on costs in recent years, the Hospital has been without key infrastructure components relative to its competition. An organizational improvement department is being developed to lead the Hospital in cost reduction and quality improvement efforts including medical cost management and corporate compliance programs. The materials management area has been operating in a manual environment which has been greatly inefficient. Financial reporting has also been operating with antiquated systems. Consequently, the information systems area is in the midst of several major installations to develop a general financial system. Other significant investments are being made in radiology for a replacement information system and clinical equipment. Other increased staff costs included necessary market adjustments in areas such as information systems, where reclassification and upgrading of positions was required to retain key employees who are in great demand in the marketplace.

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Attachment 1-3

Exhibit 7 illustrates how the Hospital has held the line on costs over the last number of years. From FY 1994 to FY 1997, total annual expenditures actually declined overall by $700,000. This trend shows that the Hospital has been able to absorb inflation, while declining its workforce through attrition to match its patient revenue base. Even with the $5.5 million increase expected during FY 1998, the average annual increase in expenditures since FY 1994 has only been 0.7%.

This is further illustrated by Exhibit 8 which shows the trend in overall workforce for the Hospital. I previously mentioned that in FY 1996, the Hospital reduced 167 full-time equivalent (FTE) employees. During FY 1997, although the Hospital overall maintained a level workforce, it actually trimmed another 200 FTEs while bringing on 207 FTE housekeeping/switchboard staff which were transferred from the Medical Center. The Hospital's overhead reimbursement to the Medical Center was adjusted downward by $4.6 million to reflect the transfer. Although year-to-date FY 1998 is seeing a slight increase of 46 FTE, it is likely that further attrition will occur in the future.

In summary, to date the Hospital has been fortunate that its cash receipts trends have stabilized over the past two years, which have allowed greatly needed investments in the Hospital's infrastructure. However, substantial market pressures still remain which will require rapid responses. The fact that the revised FY 1998 budget projects a cash loss illustrates the significant challenges that lie ahead.

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Attachment 1-4

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Attachment 2-1

University of Kansas Hospital

Admissions Trend

September 1996

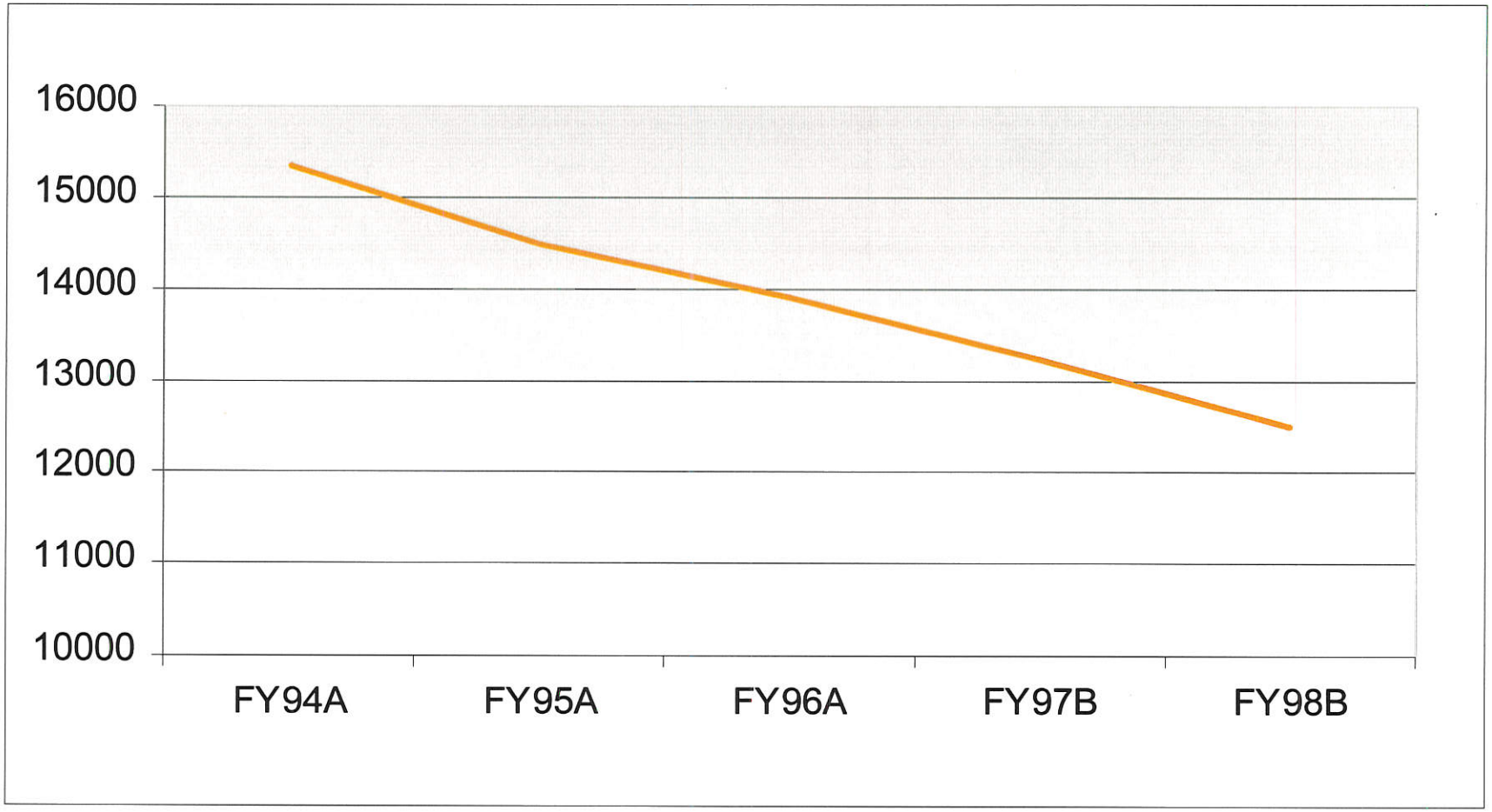

Exhibit 1

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Attachment 2-2

University of Kansas Hospital

Patient Days Trend - September 1996

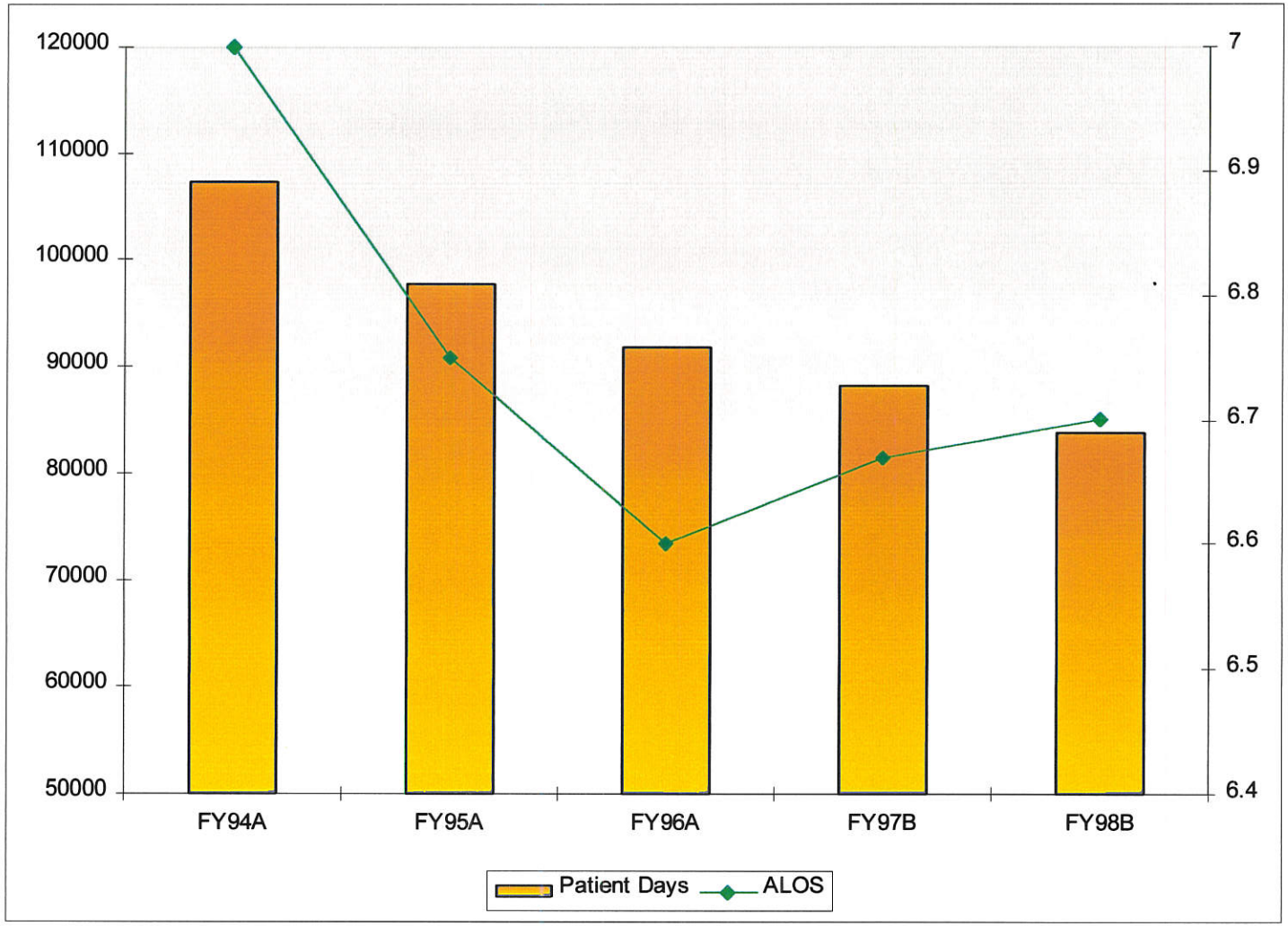

Exhibit 2

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Attachment 2-3

University of Kansas Hospital

Cash Receipts Trend - September 1996

(In Millions)

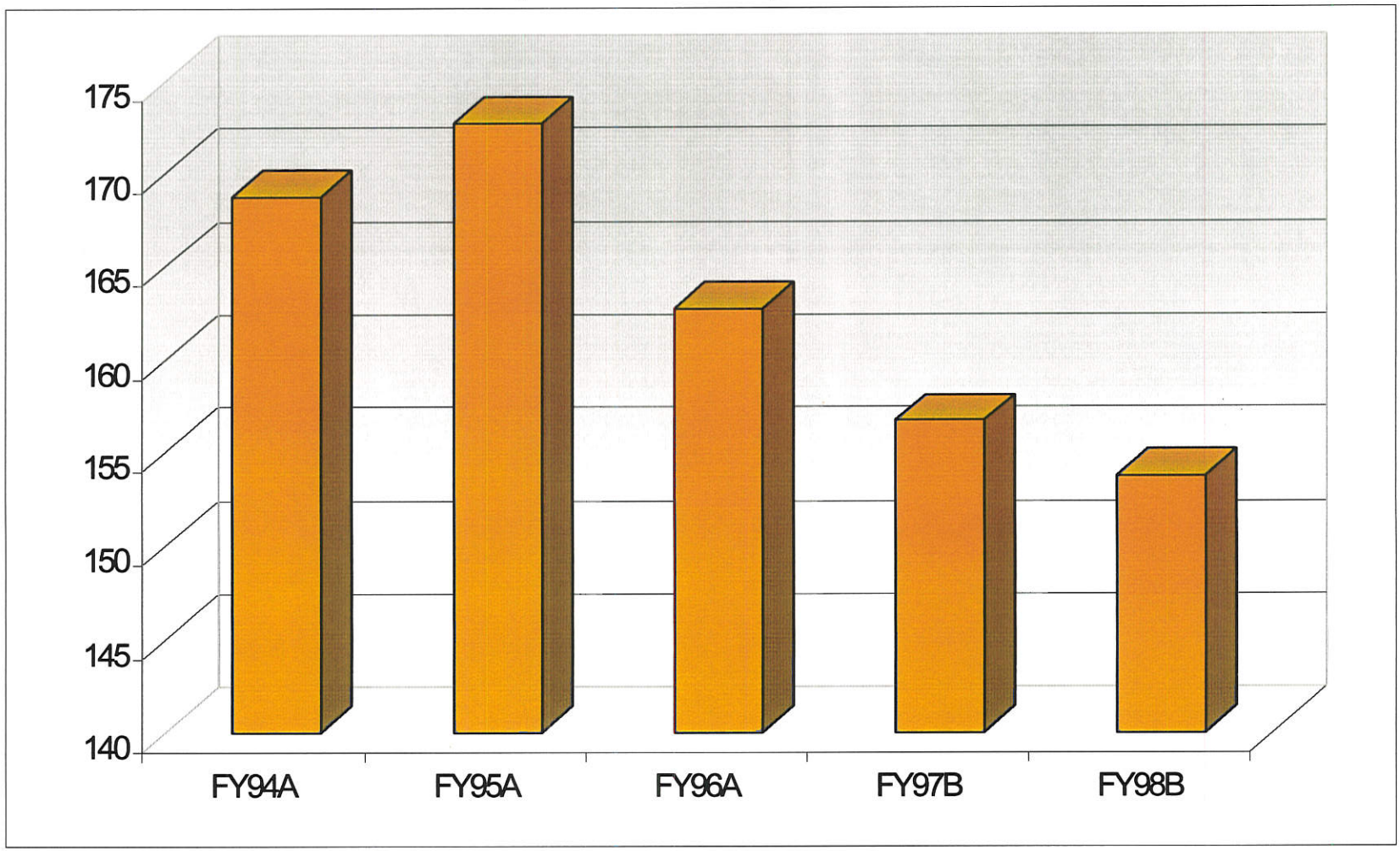
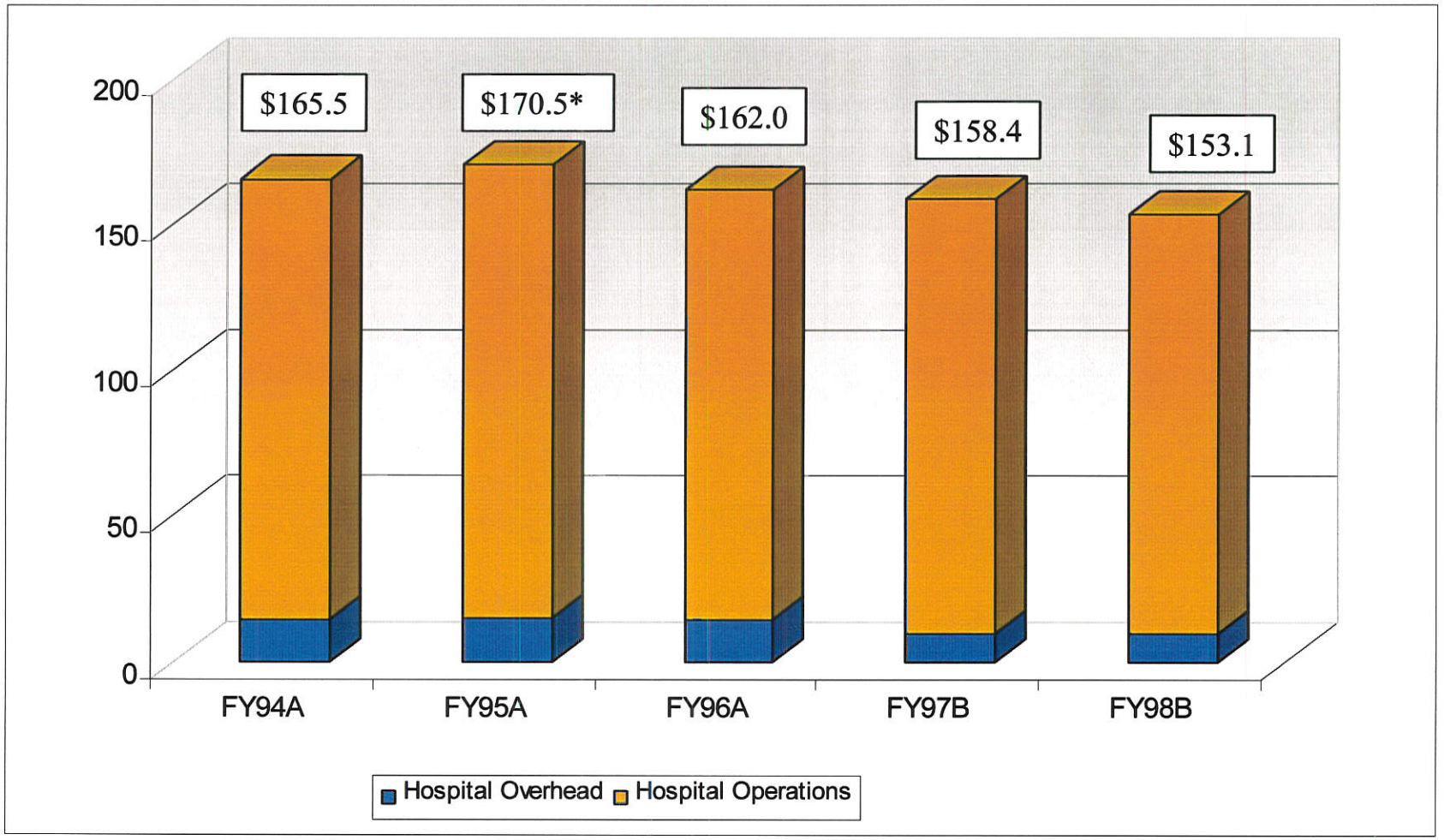


Exhibit 3

University of Kansas Hospital

Total Expenditures Trend - September 1996

(In Millions)



*Excludes contribution of $3 Million to Depreciation Reserve Fund.

Exhibit 4

4-2

University of Kansas Hospital

Budget Comparisons FY 1996 - FY 1998

2-5

Fiscal Year	$ (In Millions) Receipts	Expenditures	Gain (Loss)
1996			
Budget	$ 174.6	$ 171.2	$ 3.4
Actual	$ 162.8	$ 162.0	$ 0.8
Variance	$ (11.8)	$ (9.2)	$ (2.6)
1997			
Budget	$ 156.7	$ 158.5	$ (1.8)
Actual	$ 168.7	$ 164.8	$ 3.9
Variance	$ 12.0	$ 6.3	$ 5.7
1998			
9/96 Budget	$ 153.8	$ 153.1	$ 0.7
9/97 Budget	$ 170.0	$ 170.3	$ (0.3)
Variance	$ 16.2	$ 17.2	$ (1.0)

Exhibit 5

University of Kansas Hospital

Total Receipts/Expenditures Trend

(In Millions)

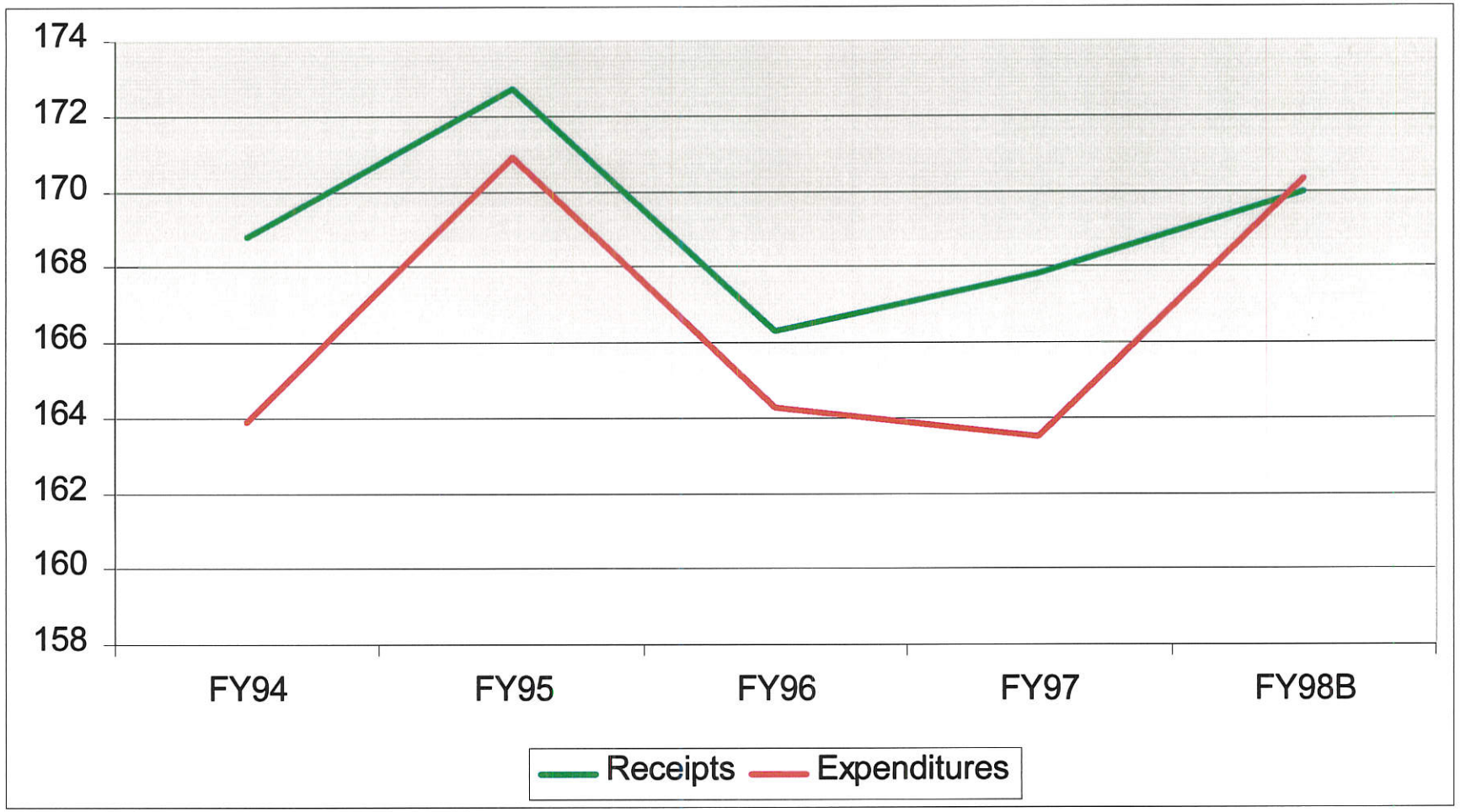


Exhibit 6

University of Kansas Hospital

Expenditures Trend

Annual Percent Change

Fiscal Year	$ (Millions)		Cumulative % Change*	Avg. Annual % Change
1994	$ 165.5			
1995	$ 170.5	**	3.0%	3.0%
1996	$ 162.0		(2.1)%	(1.0)%
1997	$ 164.8	**	(0.4)%	(0.1)%
1998B	$ 170.3		2.9%	0.7%

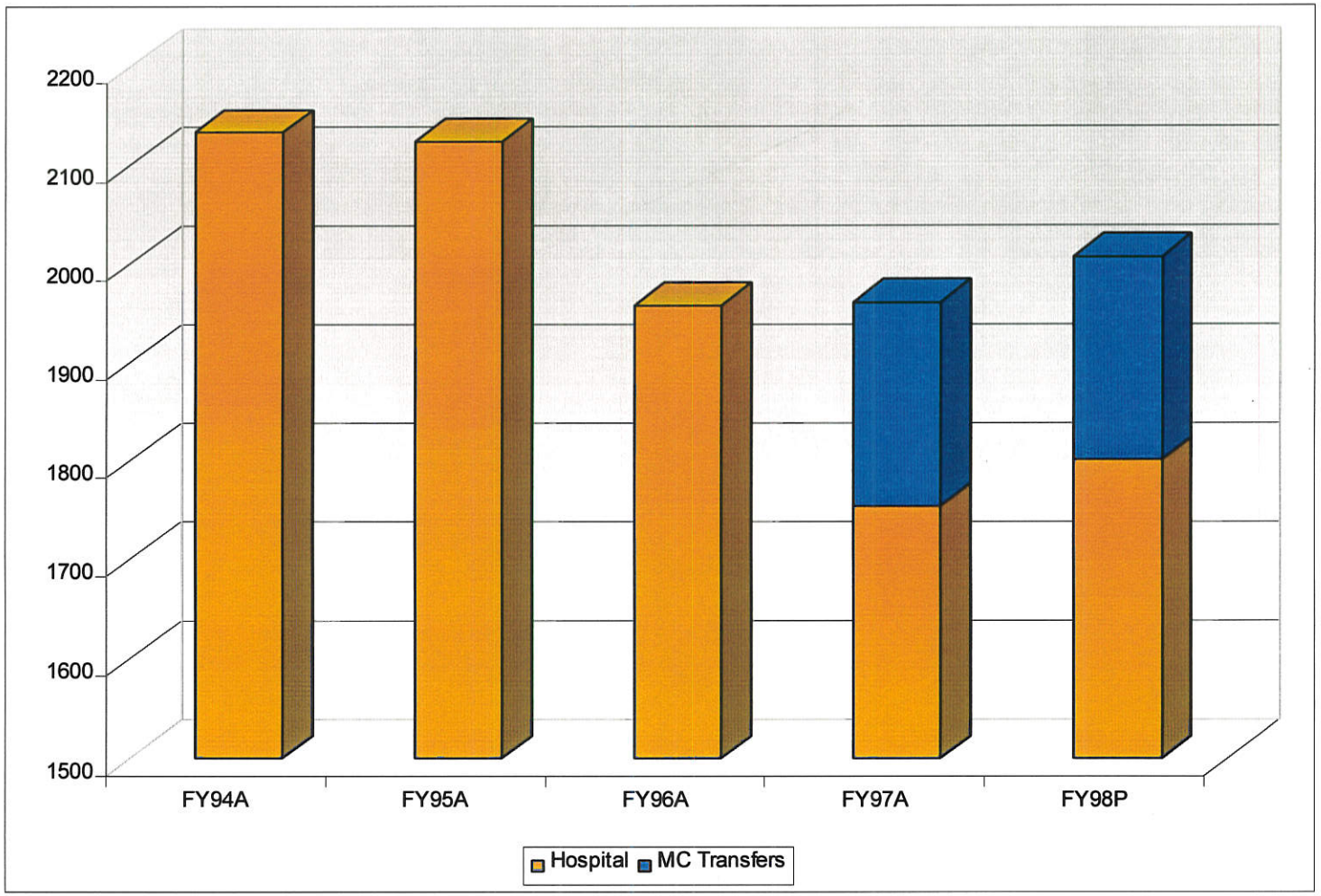
* Cumulative Change using 1994 as a base.

** Excludes contributions to Depreciation Reserve Fund.

Exhibit 7

University of Kansas Hospital

Full Time Equivalent Employees



8-8

Exhibit 8