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COMMENTS BY SENATOR BOB DOLE

IMPACT OF CONGRESSIONAL ACTION ON
HEALTH CARE IN WESTERN KANSAS

I. INTRODUCTION

This year the Federal Government will spend approximately $55 billion dollars on the Medicare program. Of this amount, approximately $34 billion will be spent on hospital services. We expect to spend $19 billion for services to the poor under the Medicaid program. The States will spend another $16 billion. In summary, the Federal Government will spend approximately $75 billion this year for these two programs. Naturally, because of the extraordinary size of the two programs, increasing attention has been given to ways to moderate their growth. In these discussions, the most frequently mentioned area of potential reform is reimbursement policy. It is not the only area of potential reform, but it is the largest.

Keeping these numbers in mind, I'd like to discuss with you what our Federal health care delivery system is likely to resemble in the future, how the Congress might act to shape that future, and what it means to those of you here in Western Kansas.

Institutions and individual providers located in rural areas face a particularly difficult set of problems. They have a desire to provide high quality care, but sometimes find it difficult to maintain the resources necessary to do so.

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CERTAINLY THOSE OF US AT THE FEDERAL LEVEL MUST DO WHAT WE CAN TO HELP AND NOT HINDER THESE EFFORTS.

CURRENT ISSUES

HOSPITAL REIMBURSEMENT

HOSPITALS, OF COURSE, ARE BEARING THE LARGEST BURDEN OF THE CUTS MADE IN THE LAST TWO YEARS. THIS SHOULD NOT BE VIEWED AS UNUSUAL GIVEN THAT OVER TWO-THIRDS OF ALL MEDICARE DOLLARS ARE SPENT ON HOSPITAL SERVICES ($37 BILLION IN 1983).

LAST WEEK THE CONGRESS COMPLETED ACTION ON LEGISLATION THAT HOLDS OUT THE PROMISE OF A MEDICARE HOSPITAL REIMBURSEMENT SYSTEM THAT ENCOURAGES INSTITUTIONAL EFFICIENCY. THIS LEGISLATION PROVIDES FOR A MAJOR CHANGE IN THE WAY MEDICARE PAYS FOR HOSPITAL SERVICES, A CHANGE WHICH WAS INITIATED BY THE SENATE LAST YEAR.

AS YOU MAY RECALL, THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 CONTAINED A PROVISION DIRECTING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO DEVELOP, IN CONSULTATION WITH THE FINANCE COMMITTEE AND THE COMMITTEE ON WAYS AND MEANS, PROPOSALS FOR THE REIMBURSEMENT OF HOSPITALS UNDER MEDICARE ON A PROSPECTIVE BASIS. THE DEPARTMENT'S REPORT WAS SUBMITTED IN LATE

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1982, AND HEARINGS WERE HELD BY THE FINANCE COMMITTEE IN FEBRUARY. WITNESSES PRESENT AT THE HEARINGS REPRESENTING THE HOSPITAL INDUSTRY, PROVIDER GROUPS, THE INSURANCE INDUSTRY, CONSUMERS AND REPRESENTATIVES OF THE BUSINESS COMMUNITY, RAISED A GREAT MANY ISSUES; MANY OF WHICH WERE CLEARLY ADDRESSED IN THE DRAFTING OF THIS LEGISLATION.

THE NEW PROSPECTIVE PAYMENT SYSTEM

SPECIFICALLY, THE LEGISLATION ESTABLISHES A HOSPITAL REIMBURSEMENT SYSTEM WHEREBY PAYMENT FOR INPATIENT OPERATING COSTS WOULD BE DETERMINED IN ADVANCE, AND MADE ON A PER CASE BASIS. MEDICARE WOULD PAY A FIXED AMOUNT FOR EACH TYPE OF CASE, IDENTIFIED BY THE "DIAGNOSTIC RELATED GROUP" (DRG) INTO WHICH THE CASE IS CLASSIFIED.

THE PROVISIONS CONTAINED IN THIS BILL ARE INDEED, NOT PERFECT. ANY TIME YOU ATTEMPT TO DEVISE A NEW SYSTEM OF THIS MAGNITUDE, PROBLEMS OCCUR WHICH YOU WERE EITHER UNAWARE OF, OR UNABLE TO RESOLVE AT THE OUTSET. THE MEDICARE PROSPECTIVE PAYMENT SYSTEM IS NO DIFFERENT. HOWEVER, I BELIEVE AMPLE FLEXIBILITY HAS BEEN PROVIDED, GIVING THE SECRETARY OF HEALTH AND HUMAN SERVICES THE OPPORTUNITY TO ADJUST THE SYSTEM AS WE LEARN MORE AND MORE ABOUT THE SYSTEM'S IMPACT.

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Diagnostic-related groups and rates

The bill requires the Secretary to determine prospectively a payment amount for each Medicare hospital discharge. DRG rates would be established for urban and rural areas both nationally and in each of nine census divisions.

These rates would be increased for fiscal year 1984 and fiscal year 1985 by the marketbasket plus one percentage point. Adjustments for future years would be decided upon by the Secretary, based in part upon recommendations made by an independent commission, comprised of health care experts.

Changes in relative weights of the DRG's would be made in 1985 and at least every four years thereafter to reflect changes in treatment patterns, technology, and other factors which may change the relative use of hospital resources. The independent commission will assist the Secretary in making these changes.

Provisions for Special Treatment

The legislation offers an institution the opportunity to apply to the Secretary for additional payments where the length

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OF STAY FOR A PARTICULAR CASE IS UNUSUALLY LONG, OR THE COST UNUSUALLY HIGH AS COMPARED TO THE DRG RATE.

IN ADDITION, THE SECRETARY MAY MAKE ADJUSTMENTS OR EXCEPTIONS AS HE DEEMS APPROPRIATE TO TAKE INTO ACCOUNT THE SPECIAL CIRCUMSTANCES OF HOSPITALS CARING FOR A LARGE NUMBER OF LOW INCOME PATIENTS. SOLE COMMUNITY PROVIDERS ARE GIVEN SPECIAL TREATMENT, AS ARE PSYCHIATRIC HOSPITALS, CHILDRENS HOSPITALS, AND REHABILITATION HOSPITALS.

PROBLEMS FOR SMALL RURAL HOSPITALS

SMALL INSTITUTIONS, PARTICULARLY THOSE LOCATED IN RURAL AREAS, ARE OFTEN FACED WITH FEDERAL PROGRAMS DESIGNED FOR LARGE URBAN CENTERS. HISTORICALLY WE HAVE TRIED TO MAKE PROVISION FOR THE DIFFERENCES IN CIRCUMSTANCES, AND HAVE HAD SOME LIMITED SUCCESS. THE SWING-BED PROVISIONS AGREED TO BY THE CONGRESS AND THE EXCEPTION FROM THE SO-CALLED 223 LIMITS CONTAINED IN LAST YEAR'S TEFRA LEGISLATION ARE TWO EXAMPLES.

WHEN THE ADMINISTRATION PROPOSED THE PROSPECTIVE PAYMENT SYSTEM FOR MEDICARE, IT INCLUDED A PROVISION TO ALLOW EXEMPTIONS AND ADJUSTMENTS FOR SOLE COMMUNITY PROVIDERS. BUT I HAD ONE PROBLEM WITH THAT--I DID NOT THINK THE LANGUAGE WENT FAR ENOUGH.

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To start with, there have been problems with some of the applications filed by hospitals here in Kansas and neighboring States to obtain sole community provider status: problems as to how hospitals demonstrate that they are the only source of inpatient care in an area and problems negotiating adjustments to accommodate their needs.

The other problem for small rural hospitals is the design of the so-called DRG system. This system establishes payment rates per diagnosis that do not vary with the occupancy rates of a hospital. The argument has been made that small, rural hospitals experience significant volume changes from year to year while a good number of their costs remain fixed. As a result, fixed costs are not covered in low volume years. Alternatively, when volume is high, these hospitals are more than adequately compensated under a prospective rate.

The legislation finally agreed upon helps to address some of these problems.

Sole Community Provider Designation

First of all, we added to those factors taken into consideration for designation of sole community providers,

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WEATHER AND TRAVEL CONDITIONS. WE ALSO REQUIRE THE SECRETARY TO REPORT ON THE CRITERIA USED TO GRANT SOLE COMMUNITY PROVIDER STATUS AND THE UNIFORM APPLICATION OF THAT CRITERIA. THE SECRETARY IS ALSO DIRECTED TO EXAMINE WAYS WE MIGHT REIMBURSE SMALL, RURAL HOSPITALS IN THE FUTURE, TAKING INTO ACCOUNT THE PROBLEMS THEY HAVE WITH A CHANGING VOLUME OF PATIENTS, AND TO EXAMINE WHETHER OR NOT WE SHOULD CONTINUE TO CALCULATE SEPARATE RATES FOR URBAN HOSPITALS AND RURAL HOSPITALS.

REIMBURSEMENT FOR SOLE COMMUNITY PROVIDERS

IN PLACE OF EXEMPTING ALL SMALL HOSPITALS FROM THE PROSPECTIVE SYSTEM, AN AGREEMENT WAS REACHED TO ALLOW SOLE COMMUNITY HOSPITALS TO BE TREATED SOMEWHAT DIFFERENTLY FROM OTHER HOSPITALS. THEY WOULD BEGIN ON THE SAME BASIS AS ALL OTHER HOSPITALS; HOWEVER, THEY WOULD CONTINUE TO BE PAID INTO THE FUTURE ON THE BASIS OF A MIX OF 75% OF THEIR COSTS, AND 25% OF THE NATIONAL/RURAL DRG RATE. IN ADDITION, DURING THE TRANSITION PERIOD (3 YEARS), THE SECRETARY WOULD BE REQUIRED TO PROVIDE AN ADJUSTMENT TO A SOLE COMMUNITY PROVIDER THAT EXPERIENCES A CHANGE OF MORE THAN 5% IN ITS TOTAL VOLUME OVER A PREVIOUS YEAR DUE TO CIRCUMSTANCE BEYONDS ITS CONTROL. THE ADJUSTMENT WOULD HAVE TO FULLY COMPENSATE THE HOSPITAL FOR THE FIXED COSTS IT INCURS AND

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FOR THE REASONABLE COST OF MAINTENANCE OF CORE STAFF AND SERVICES.

THESE ADJUSTMENTS SHOULD HELP TO INSURE THAT THE RESIDENTS OF RURAL COMMUNITIES IN SUCH AREAS AS WESTERN KANSAS CONTINUE TO HAVE ACCESS TO QUALITY HEALTH CARE. IN ADDITION, I BELIEVE OUR RECENT DISCUSSIONS CONCERNING SMALL, RURAL HOSPITALS WILL LEAD TO A THOROUGH EXAMINATION OF THEIR TREATMENT UNDER MEDICARE, AND RESULT IN REFORM MEASURES TO ADDRESS THEIR UNIQUE ROLE IN THE NATION'S HEALTH CARE SYSTEM.

FURTHER, THE LEGISLATION REQUIRES THE SECRETARY TO REPORT TO THE CONGRESS BY APRIL 1985 WITH LEGISLATIVE RECOMMENDATIONS FOR BRINGING THESE HOSPITALS UNDER A PROSPECTIVE SYSTEM, GIVING CONSIDERATION TO THEIR SPECIAL NEEDS.

WHY NOT OUTRIGHT EXEMPTION?

LET ME BRIEFLY OUTLINE SOME OF THE REASONING BEHIND OUR DECISIONS REGARDING THE PAYMENTS TO SMALL RURAL HOSPITALS. THE EXCLUSION OF ALL SMALL HOSPITALS (LESS THAN 50 BEDS), RATHER THAN THIS SPECIAL TREATMENT OF SOLE COMMUNITY PROVIDERS, IS NOT NECESSARILY IN THE BEST INTERESTS OF ALL SMALL HOSPITALS. NOT ALL SMALL HOSPITALS DESIRE SUCH AN EXCLUSION SINCE IT IS THE

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SMALL HOSPITALS THAT COULD, IN THE AGGREGATE, HAVE THE MOST TO GAIN FROM A PROSPECTIVE SYSTEM.

EXCLUSION FROM THE PROPOSED SYSTEM WOULD RESULT IN CONTINUED COST REIMBURSEMENT OF SMALL HOSPITALS UNDER THE PROVISIONS CONTAINED IN TEFRA. THESE HOSPITALS WILL FIND THE IMPACT OF THE RATE OF INCREASE LIMITATIONS UNDER TEFRA TO BE AS ADVERSE OR MORE SO THAN THE IMPACT OF THE PROSPECTIVE SYSTEM. INDEED, CERTAIN GROUPS OF SMALL HOSPITALS ARGUED AGAINST BEING REIMBURSED UNDER TEFRA. THERE IS NO CLEAR ALTERNATIVE IF WE ARE TO MAINTAIN BUDGET NEUTRALITY IN 1984 AND 1985.

I BELIEVE WE MUST MOVE AWAY FROM COST-BASED REIMBURSEMENT TO THE GREATEST EXTENT POSSIBLE. THE DESIRE IS TO BRING ALL HOSPITALS UNDER A SINGLE PROSPECTIVE SYSTEM. WHERE THE DRG DATA IS NOT AVAILABLE TO DO THAT, AS WITH PSYCHIATRIC CARE, IT IS SIMPLY NOT POSSIBLE. WHERE PROSPECTIVE CAN BE USED, IT SHOULD BE USED. THE SOLE COMMUNITY PROVIDER PROVISION DOES THAT. WHOLESALE EXCLUSION OF SMALL HOSPITALS DOES NOT. IN ADDITION, ADJUSTMENTS FOR ALL SMALL, RURAL HOSPITALS AND OTHERS THAT ARE AFFECTED BY EVENTS BEYOND THEIR CONTROL HAVE BEEN PROVIDED FOR UNDER THE PROSPECTIVE PROPOSAL.

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THE OTHER BENEFIT THAT PROSPECTIVE PAYMENT BRINGS IS A REDUCTION IN THE NEED FOR ENORMOUS AMOUNTS OF INFORMATION FROM HOSPITALS. THE MEDICARE COST REPORTS, AS YOU CURRENTLY KNOW THEM, WILL BE DONE AWAY WITH AND IN THEIR PLACE A MORE REASONABLE DATA SYSTEM WILL BE ESTABLISHED.

OUTLIERS

ANOTHER PROVISION INCLUDED IN THE PROSPECTIVE PAYMENT SYSTEM TO INSURE AGAINST INEQUITABLE TREATMENT OF PARTICULAR HOSPITALS DEALS WITH SO-CALLED "OUTLIERS", THOSE UNUSUALLY COSTLY CASES. THE SYSTEM ALLOWS THE SECRETARY TO PAY HOSPITALS ADDITIONAL AMOUNTS FOR THEIR UNUSUALLY EXPENSIVE CASES OR THOSE WITH PARTICULARLY LONG LENGTHS OF STAY.

EXCLUSION OF CAPITAL-RELATED EXPENSES AND MEDICAL EDUCATION EXPENSES

IN THE CASE OF CAPITAL COSTS AND DIRECT EDUCATION COSTS, WE WILL CONTINUE TO REIMBURSE HOSPITALS AS WE DO UNDER CURRENT LAW UNTIL OCTOBER 1, 1986, AFTER WHICH TIME CAPITAL COSTS WILL NO LONGER BE "PASSED THROUGH." IN THE CASE OF INDIRECT MEDICAL EXPENSES THE PROPOSAL DOUBLES THE CURRENT TEACHING ADJUSTMENT.

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Exceptions, Adjustments, and Exemptions

As I mentioned earlier, certain hospitals are excluded from the prospective system and adjustments and exceptions are provided for others to accommodate certain concerns, such as unusual patient caseloads or geographic location.

Studies and Reports

A vital part of the legislation calls for the Secretary to complete a number of studies and reports on issues of concern to the Congress in establishing this new prospective system.

Of particular note are the studies and reports dealing with the severity of illness, intensity of care, or other such modifications to the diagnosis related groups. These issues are critical to our efforts to ensure that institutions receive a DRG payment that is reasonably sensitive to the care being provided to patients.

I look forward to the implementation of the prospective payment system for Medicare, and the long term savings potential it holds. Access to hospital care will not, I believe, suffer in any way under the new system. We were also very cautious in

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DETERMINING THE TREATMENT OF SMALL, RURAL HOPITALS UNDER PROSPECTIVE PAYMENT, RECOGNIZING THE UNIQUE SITUATION THESE HOSPITALS FACE IN TERMS OF LARGE SHIFTS IN VOLUME FROM ONE YEAR TO THE NEXT. WE WOULD HOPE THAT HOSPITALS IN WESTERN KANSAS WILL NOT BE ADVERSELY AFFECTED BY THE NEW SYSTEM--BUT IF A PROBLEM SHOULD BECOME APPARENT, THE PLAN WE HAVE DEVELOPED ALLOWS FOR APPROPRIATE ADJUSTMENTS. HOWEVER, WE WILL NEED TO HEAR FROM YOU OFTEN ABOUT ANY PARTICULAR PROBLEMS YOU EXPERIENCE SO WE CAN CHANGE THE SYSTEM AS NECESSARY. IT IS CERTAINLY NOT SET IN STONE.

OTHER ISSUES OF PARTICULAR CONCERN TO HEALTH CARE PROVIDERS IN WESTERN KANSAS

Cost-Shifting

THE PROBLEM OF COST SHIFTING TO PRIVATE PAYERS AS A RESULT OF REDUCTIONS IN MEDICARE PAYMENTS IS OF GREAT CONCERN TO ME. THIS ISSUE WAS DISCUSSED AT GREAT LENGTH DURING OUR CONSIDERATION OF THE PROSPECTIVE PAYMENT SYSTEM WHICH ONLY INVOLVES THE MEDICARE PROGRAM. THE COMMERCIAL INSURANCE INDUSTRY EXPRESSED CONCERN OVER THE POTENTIAL FOR HOSPITALS TO SHIFT COSTS TO PRIVATE-PAYING PATIENTS TO MAKE UP FOR MEDICARE'S LOWER PAYMENTS. WHILE I CERTAINLY DO NOT WANT TO ENCOURAGE THE DEVELOPMENT OF A TWO-

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TIERED SYSTEM OF HEALTH CARE, THERE ARE A NUMBER OF REASONS WHY IT SEEMS UNWISE TO EXTEND THE NEW SYSTEM TO ALL PAYERS.

FIRST, OUR MAIN PURPOSE FROM THE FEDERAL LEVEL IN DESIGNING A PROSPECTIVE PAYMENT PROPOSAL WAS TO MAKE MEDICARE A WISER PURCHASER OF SERVICES. THIS SAME OPPORTUNITY IS AVAILABLE TO OTHER PAYERS IN NEGOTIATING THEIR REIMBURSEMENT SYSTEMS WITH HOSPITALS. IN FACT, OTHER PAYERS MAY BE ABLE TO WORK OUT AGREEMENTS WITH INSTITUTIONS THAT ARE MORE FAVORABLE THAN MEDICARE'S SYSTEM. SO WHY TIE THEM UP WITH OUR PROPOSAL AND LIMIT THEIR OPTIONS?

THE PROPOSAL AGREED TO BY CONGRESS WAS NOT DESIGNED TO, AND DOES NOT NECESSARILY MEET THE NEEDS OF ALL PAYERS, SOME OF WHOM MAY PREFER ARRANGEMENTS OTHER THAN DIAGNOSTIC RELATED GROUPS (DRG'S). THEY SHOULD HAVE THE OPPORTUNITY TO DESIGN SYSTEMS SUITED TO THEIR REQUIREMENTS.

SECONDLY, THE PROVISION AS AGREED TO BY THE CONGRESS INCLUDES BROAD DISCRETION FOR THE STATES TO DEVELOP STATEWIDE REIMBURSEMENT SYSTEMS. INDEED, SOME OF THESE MAY BE ALL-PAYER, WHILE SOME MAY NOT. CERTAINLY, A STATE IS IN AN EXCELLENT POSITION TO JUDGE WHAT KIND OF SYSTEM MIGHT BEST SUIT ITS NEEDS. THIS DECISION SHOULD NOT BE MADE ON A NATIONAL LEVEL, LOCKING THE

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States into position. In fact the States have clearly indicated a strong desire to be allowed to continue their own programs.

Finally, and perhaps most importantly, an all-payer system implies that what works for the Medicare program is workable for everybody else. Of greater concern, it transforms the Federal Government from a prudent buyer into a marketplace abolisher. By Federal dictate, we would remove demand completely from the price-setting mechanism. The marketplace would cease to function.

An all-payer hospital reimbursement system implies that the Federal Government would become the agency to collect and analyze cost data, establish nationwide rates, and enforce compliance. This is exactly the opposite to the prudent buyer, free market situation we should be fostering.

Hospice Care

Over the past few years, a particularly difficult question has presented itself in the health care arena--How far should the medical profession go to save the life of a terminally ill patient. Traditionally, care has been oriented toward intensive curative treatment for patients, which often means heroic

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INTERVENTION IN THE CASE OF A DYING PERSON. MORE RECENTLY, HEALTH CARE PROFESSIONALS HAVE BEEN ASKING--AT WHAT POINT TOWARD THE END OF A TERMINAL PATIENT'S LIFE DOES PALLIATIVE CARE BECOME MORE APPROPRIATE? THE RAPID GROWTH OF HOSPICE CARE IN THE COUNTRY TODAY WOULD SEEM TO INDICATE THAT HEALTH CARE PROFESSIONALS HAVE RECOGNIZED THE HUMANITY AND CONVENIENCE OF THIS TYPE OF CARE AS OPPOSED TO INTENSIVE INSTITUTIONAL TREATMENT.

MEDICARE'S ROLE IN THE HOSPICE MOVEMENT WAS ESTABLISHED WHEN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) CREATED A NEW TYPE OF HOME HEALTH BENEFIT AVAILABLE TO MEDICARE RECIPIENTS--HOSPICE CARE. BASED ON LEGISLATION I INTRODUCED IN LATE 1981, THE PROVISION IN TEFRA PROVIDES HOSPICE COVERAGE FOR PERSONS JUDGED TO BE IN THE LAST SIX MONTHS OF LIFE. A MEDICARE BENEFICIARY CAN ELECT TO RECEIVE HOSPICE CARE INSTEAD OF THE TRADITIONAL MEDICARE BENEFITS AVAILABLE. SOME OF THE TYPES OF SERVICES COVERED UNDER THE BENEFIT INCLUDE NURSING CARE, HOMEMAKER HOME HEALTH AIDE SERVICES, SHORT-TERM INPATIENT CARE, OUTPATIENT DRUGS FOR PAIN RELIEF, BEREAVEMENT COUNSELING, AND RESPITE CARE FOR THE PATIENT'S FAMILY.

THE HOSPICE BENEFIT UNDER MEDICARE WILL BE EFFECTIVE NOVEMBER 1, 1983. THE DELAY WAS INTENDED TO ALLOW CONGRESS AND THE

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ADMINISTRATION AN OPPORTUNITY TO LOOK AT A NUMBER OF STUDIES SCHEDULED TO BE COMPLETED THIS YEAR. I UNDERSTAND THE DRAFT REGULATIONS ON THE HOSPICE BENEFIT ARE EXPECTED TO BE PUBLISHED VERY SHORTLY.

AS YOU KNOW, HOSPICE CARE HAS A VERY RICH HISTORY OF DELIVERING PALLIATIVE CARE TO TERMINALLY ILL PATIENTS, IN BOTH THE U.S. AND EUROPE, AND REPRESENTS A LESS COSTLY ALTERNATIVE TO INSTITUTIONAL CARE. I LOOK FORWARD TO THE IMPLEMENTATION OF THE MEDICARE HOSPICE BENEFIT, AND HOPE THE PROGRAM WILL REALIZE SOME SAVINGS AS A RESULT.

MEDICARE RESPONSE TO CHANGES IN HEALTH CARE TECHNOLOGY

MANY BELIEVE, AND APPROPRIATELY SO, THAT MEDICARE'S PAYMENT PRACTICES RESPOND MUCH TOO SLOWLY TO CHANGES IN THE HEALTH CARE DELIVERY SYSTEM: CHANGES BOTH IN TECHNOLOGY AND IN TREATMENT SYSTEMS. FOR EXAMPLE, WE CAME AROUND TO RECOGNIZING THE VALUE OF FREE-STANDING AMBULATORY SURGICAL CENTERS AND THE VALUE OF NURSE PRACTITIONERS MUCH MORE SLOWLY THAN MANY OTHER PAYERS.

THE RECENTLY-PASSED MEDICARE PROVISIONS IN THE SOCIAL SECURITY REFORM PACKAGE WILL ALSO HELP TO ADDRESS THIS NEED.

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IN ORDER TO IDENTIFY MEDICALLY APPROPRIATE PATTERNS OF HEALTH RESOURCES USE, THE LEGISLATION REQUIRES A COMMISSION OF INDEPENDENT EXPERTS TO COLLECT AND ASSESS INFORMATION, MEDICAL AND SURGICAL PROCEDURES AND SERVICES--INCLUDING INFORMATION ON REGIONAL VARIATIONS OF MEDICAL PRACTICE AND LENGTHS OF HOSPITALIZATION AND ON OTHER PATIENT CARE DATA--GIVING SPECIAL ATTENTION TO TREATMENT PATTERNS FOR CONDITIONS APPEARING TO INVOLVE EXCESSIVELY COSTLY OR INAPPROPRIATE SERVICES NOT ADDING TO THE QUALITY OF CARE PROVIDED.

THE LEGISLATION FURTHER REQUIRES THE COMMISSION, IN COORDINATION TO THE EXTENT POSSIBLE WITH THE SECRETARY, TO ASSESS THE SAFETY, EFFICACY, AND COST-EFFECTIVENESS OF NEW AND EXISTING PROCEDURES, TO COLLECT AND ASSESS FACTUAL INFORMATION, GIVING SPECIAL ATTENTION TO THE NEEDS OF UPDATING THE NEW PAYMENT SYSTEM TO REFLECT APPROPRIATE DIFFERENCES IN RESOURCE CONSUMPTION IN DELIVERING SAFE, EFFICACIOUS, AND COST EFFECTIVE CARE.

CONCLUSION

IN CLOSING, LET ME REITERATE MY INTEREST IN HAVING ALL OF YOU KEEP IN TOUCH WITH ME ON ISSUES OF CONCERN TO YOU WITH RESPECT TO THE FINANCING OF HEALTH CARE SERVICES.

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THE HEALTH CARE DELIVERY SYSTEM IS A COMPLEX ONE, WHICH IS BECOMING MORE AND MORE COMPLEX OVER TIME. THE NEEDS OF RURAL COMMUNITIES ARE OFTEN DIFFERENT THAN THOSE OF URBAN AREAS, EVEN IN STATES LIKE KANSAS. WE NEED HELP IN RECOGNIZING THESE DIFFERENCES AND IN DESIGNING SYSTEMS TO MEET YOUR NEEDS. THE NEW REIMBURSEMENT SYSTEM IS BOUND TO REQUIRE SOME CHANGES AS IT IS PUT INTO PLACE. CLEARLY, WE DON'T HAVE ALL THE ANSWERS. WE LOOK TO YOU TO HELP US FIND THEM.

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