OUTLINE OF REMARKS

SENATOR BOB DOLE

HOSPITAL PAYMENT REFORM SEMINAR
April 28, 1983
L'Enfant Plaza Hotel

INTRODUCTION

- For years, we've been adjusting this or that element of the medicare program. We've added a regulation here, some monitoring there, but we had never gotten to the heart of the problem--the way we pay for services. The result is that costs have risen unnecessarily for beneficiaries, for hospitals, and for the Federal Government. It was clearly time for a change.

- Prospective payment is the shot in the arm medicare now needs. It's a positive change; good for senior citizens, for doctors, for hospitals, and for taxpayers. And it comes at a time when it is desperately needed.

- 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).

- 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 1982, and hearing 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 the prospective payment legislation.

THE NEW PROSPECTIVE PAYMENT SYSTEM

- Hospitals have lacked incentives to control costs because the current cost-based system allows greater payments for ever-growing costs. Clearly some change was needed, and that change began with the adoption of incentives for the efficient delivery of hospital services in the form of prospective payment.

- Action on H.R. 1900 was more rapid than many expected or wanted. But when it became clear that the House intended to move ahead, I felt it important that the Senate have an opportunity to discuss the proposal and modify it as appropriate before conferring with the House on the bill. And in fact, the Senate Finance Committee and the members of the full Senate did discuss a great many issues and I believe, improved the final bill.

- Let me make it clear from the outset, that there was every desire to construct a bill that would not penalize the hospitals, or put them at risk. Our intention was to really improve the system, making it easier for us and for the hospitals to do their jobs.

- We had been forced in recent years to simply tinker with the 223 limits as a method of reducing program expenditures. This didn't make sense to you or to us. As a result, large numbers of people, including the hospital industry, were supportive of a move away from cost-based reimbursement.

- The provisions contained in H.R. 1900, establishing a prospective system 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.

- There are a number of issues in particular that we are committed to pursuing. Many of them are reflected in the section requiring the Department of Health and Human Services to conduct certain studies. I'd like to spend a few moments reviewing those remaining issues.

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.

- The 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.

- 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 will be paid on the basis of a mix of 75% of their costs, and 25% of the national/rural DRG rate. In addition, during the 3-year transition period, 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 beyond its control. The adjustment would have to fully compensate the hospital for the fixed costs it incurs and for the reasonable cost of maintenance of core staff and services.

- In addition, 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.

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 agreeing to such a change we expect that additional legislation will be enacted by the Congress to deal with capital-related issues before October of 1986. In anticipation of this change, we have directed the Secretary to complete a thorough review of the methods by which capital, including return on equity, can be included in the prospective payment.

- The treatment of capital costs will be very difficult to resolve, but resolve it we must. What we do to encourage hospitals to build or invest in new equipment has an enormous impact on health care costs.

- A teaching adjustment was provided in light of doubts about the ability of the DRG case system to account fully for factors, such as severity of illness, which may require the specialized, and often costly, services of teaching

institutions. This adjustment is only a proxy to account for those factors which may legitimately increase costs. We are hoping to find some better, more accurate method of addressing both the indirect and direct teaching costs in the future.

Severity of Illness

- Probably one of our greatest concerns is the inability of the new system to differentiate between two different patients within the same DRG.

- While the bill does provide for special treatment for the so-called "outlier" cases, it really doesn't address the problem of internal case mix differences.

- We have asked the Secretary to study the advisability and feasibility of providing for the application of some type of severity modification. We believe this will be particularly important to teaching institutions.

OTHER ISSUES OF PARTICULAR CONCERN TO HEALTH CARE PROVIDERS

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-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 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.

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.

- In order to identify medically appropriate patterns of health resources use, the legislation requires a commission of independent experts to collect and assess information on 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 with the Secretary, to assess the safety, efficacy, and cost-effectiveness of new and existing procedures, to collect and assess 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.

- The hospital system is a complex one, which is becoming more and more complex over time. The needs of one provider are often different than those of others. 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.

- But in reviewing the changes made in hospital reimbursement keep in mind that while prospective payment for hospitals is a partial solution to cost growth, it is not by itself a solution to the solvency problem faced by the medicare trust fund. A much larger effort to reform our system, including changes in beneficiary cost sharing and alterations in the way we pay physicians will be necessary. This will also take your assistance and guidance.

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

April 27, 1983

- M E M O R A N D U M -

TO: SENATOR DOLE

FROM: SHEILA BURKE AND ED MIHALSKI

SUBJECT: KEYNOTE ADDRESS BEFORE HOSPITAL PAYMENT REFORM SEMINAR

Attached is a set of talking points for your speech tomorrow morning at the L'Enfant Plaza Hotel. You are scheduled to give the keynote address at 8:30 a.m. before a one-day invitational conference sponsored by the Johns Hopkins Center for Hospital Finance and Management entitled "New Approaches to Hospital Payment Reform: The Unanswered Agenda." The conference is being convened to explore possible options for "the systematic and rational reform of the health care financing systems." It is expected that various speakers at the conference will comment on their thoughts regarding what the future should bring in terms of health payment reform.

Attached are an agenda of speakers and a background summary for the conference.

attachment

NEW APPROACHES TO HOSPITAL PAYMENT REFORM: THE UNANSWERED AGENDA

Washington, D.C.
April 28, 1983

8:15-8:30	Welcome and Introduction Carl Schramm, Ph.D., J.D., The Center for Hospital Finance and Management
8:30-9:15	What the Congress Has Done: Reforming the Hospital Payment System Senator Robert J. Dole
9:15-9:45	The Unanswered Agenda Carl Schramm, Ph.D., J.D., The Center for Hospital Finance and Management
9:45-10:30	Hospital Payment Issues Facing the Congress: Another Perspective Senator Howard M. Metzenbaum
10:30-10:45	Break
10:45-12:00	Panel Discussion: Hospital Prospective Payment and the DRG System Bryan Luce, Ph.D., Health Care Financing Administration Susan Horn, Ph.D., The Center for Hospital Finance and Management Mary Nell Lehnhard, Blue Cross-Blue Shield Associations (Other panel member from the American Hospital Association)
12:00-1:00	Lunch Luncheon Address: 12:10-12:50 "What Should Be Done About Health Care Costs" Representative W. Henson Moore (awaiting confirmation)
1:00-2:00	Panel Discussion: Physician Reimbursement Issues Joseph Boyle, M.D., American Medical Association John Ball, M.D., J.D., American College of Physicians (Panel member to be announced)
2:00-2:45	Toward A Federal Policy for Health Care Assurance Karen Davis, Ph.D., The Johns Hopkins School of Hygiene and Public Health
2:45-3:00	Break

3:00-4:00	Panel Discussion: Hospital Payment Systems and Implications for Special Groups Karen Ignagni, American Federation of Labor Michael Romig, U.S. Chamber of Commerce Vita Ostrander, American Association of Retired Persons
4:00-5:00	Panel Discussion: Future Trends in Hospital Payment Donald Cohodes, Sc.D., Blue Cross-Blue Shield Associations Merlin DuVal, M.D., Associated Hospital Systems Lou Orsini, Health Insurance Association of America Carl Schramm, Ph.D., J.D., The Center for Hospital Finance and Management
5:00	Cocktails

NEW APPROACHES TO HOSPITAL PAYMENT REFORM: THE UNANSWERED AGENDA

The Center for Hospital Finance and Management of the Johns Hopkins Medical Institutions was established to undertake basic research on the finance of hospital care and on the management and organization of the hospital industry. From time to time, the Center sponsors forums for the exchange of ideas on important topics related to this mission.

The conference on the unmet agenda in hospital finance will attempt to explore some of the areas that are being overlooked in the pell-mell rush of Congress to protect the federal budget from hemorrhages caused by the Medicare and Medicaid programs. Issues that have been neglected in recent months include the impact of the newly established federal legislation on the poor, on various types of hospitals, including public and teaching hospitals, and on various insurance carriers, such as Blue Cross, the private carriers and HMOs. Indeed, discussion around these matters has been singularly focused on what the federal legislation portends for various interest groups. Whatever progress might have been made in attempting a comprehensive, fair and equitable system of payment reform in the past has gone by the boards.

We feel that, in view of recent Congressional action on health care financing, now is a good time to convene a select group of influential health leaders for a one-day conference to gather some consensus around the idea of a comprehensive and rational approach to reform, and to set an agenda for what must be done.

The presentations and the invitees have been carefully selected to ensure the highest level of interaction and dialogue. Our day will be spent at the L'Enfant Plaza Hotel, and the attached agenda is structured to minimize the inconvenience to participants' schedules.