The Governor's Commission on Rationalizing Health Care Resources
Testimony of Rev. Joseph Kukura, President
Catholic HealthCare Partnership of New Jersey

Professor Reinhardt, Michelle Guhl and members of the commission. I am Fr. Joe Kukura, President of the Catholic Health Care Partnership. With me is Michael Maron, President & CEO of Holy Name Hospital and Chairman of the partnership.

I am a priest of the Archdiocese of Newark, ordained almost forty years ago. I am a theological ethicist by background and for the last 25 years I have worked in healthcare both in New Jersey and on a national level. For 10 ½ years, I was a vice president of the Catholic Health Association of the United States in St. Louis. I asked Michael, chair of the board of our partnership, to join me because he can bring more of a financial and operational perspective to your questions. Michael has worked in New Jersey health care for 25 years. He has an MBA from Columbia University and was a CFO for the first half of his career.

The Catholic Healthcare Partnership is a statewide coalition established to advance the health-ministry of the Catholic Church. We represent all fifteen acute Catholic Hospitals in NJ. Our mission is to establish a voluntary collaborative environment for the hospitals to share information, unite for advocacy purposes and strengthen the faith based component of healthcare. Our collective history goes back 125 years to the foundation of the first hospitals of our State. Unlike in other areas of the United States, the pride of the Catholic hospitals in New Jersey, is the fact that they have remained in urban areas where health care need is great.

We represent over 4500 staffed beds and employ 20,000 individuals, Last year, our hospitals delivered more than 20,0000 babies, recorded almost 200,000 inpatient admissions, and had 2.3 million outpatient visits. Emergency room visits totaled more than 460,000. Most importantly, our Catholic hospitals provided 23% of the documented charity care that is delivered in New Jersey, which in 2005 amounted to more than $205 million in care.

It is somewhat fitting that we appear last, because our role is to be unifying and to be advocates for the most needy in the state of New Jersey. Sadly, the neediest are not just the individuals we often think about but the institutions and the infrastructure to care for the needs of the individuals as well. Yes, we represent faith based organizations but we are supportive of all efforts by all institutions to care for the people in their communities.

An often quoted phrase, attributed to Catholic Healthcare is "No Margin, No mission" we expand on that premise and complete the circle by saying "No Mission, No Matter". Yes we fully understand that we have a role as stewards of community resources to provide high quality, safe and efficient care. But we also know that when dealing with the human condition mathematical algorithms and the business aspects of running large organizations need to be balanced by the mission of healing. Value in healthcare goes beyond the tangible measures we often reference today. It is our dream that someday we

define outcomes as perpetuation of a healthy body, a healthy mind and a healthy spirit. We cannot dissect and separate the three, because they are the essential elements of life.

We are proud of the fact that New Jersey's Acute care hospital delivery system is dominated by non-profit, mission driven organizations. We believe it is imperative to preserve this aspect of our delivery system, because the governance of non-profits are charged with meeting the needs of the community as there point of departure. In contrast the boards of for profit entities are charged with meeting the needs of shareholders. Many of the problems that inflict the health care system stem from the conflicts that arrive from the contradictory missions and governance mandates of nonprofit and for profit organizations.

Part of the problem in New Jersey and the Nation as a whole, is that the non profit component of the healthcare delivery system is diminishing. We are troubled by a possible future, wherein the healthcare needs of the community become subordinate to the economic needs of shareholder return. In New Jersey the hospitals, the front line of the delivery system, are nonprofit organizations in a complex web of for-profit providers, suppliers and payers.

It troubles us that it is the hospitals who appear to be under attack. We are troubled that non profit hospitals in an effort to survive abandon their missions to the community and begin to adopt and behave more like for profit entities. Can hospitals perform better? Absolutely. Can hospitals be better stewards of the community resources entrusted to them? Absolutely. That said New Jersey Health care is not as inefficient as some would suggest. But we need to create an infrastructure that is much more transparent and that supports real time, accurate sharing of evidence based performance and outcomes. Simultaneously, we need a system that keeps in check the economic forces that will drive shareholder return above the needs of the community.

We are aware that you have received many reports and other testimony from other organizations. It is not our intent to replicate or be redundant, we do agree with the many of the perspectives submitted by NJHA, the Hospital Alliance of New Jersey, and the Council of Teaching Hospitals. It is our hope to compliment those testimonies with additional viewpoints.

What do we know today?

You have seen reports from NJHA: Accenture, Avalere, The Dartmouth Atlas of Health Care, Kaiser Family Foundation Statistics, Robert Wood Johnson State Coverage Initiatives State of the States, The Commonwealth Fund, The New Jersey Health Care Quality Institute and probably many others.

We know that New Jersey has a population of over 8 million people, a low and declining unemployment rate and relatively robust economy. We have one of the highest per capita incomes of any state in the nation. We know that New Jersey is the largest net exporter of

revenue to the Federal government[1]: Ranking 2nd in contributions and 39th in receipts for a net ranking of 50th in the nation.

Other than the net export of federal dollars this should be the foundation for a very healthy infrastructure yet instead we have a State Budget that is in crisis year in and year out and hospital and provider delivery system that is on the brink of financial disaster. There has been enough data reported already to support this fact, but the New Jersey Health Care Facility Financing Authority alone can attest to the magnitude and reality of the hospital financial crisis.

What we don't know

What we don't know for sure is the cause of the hospital financial crisis. We have many symptoms we diagnose and treat those symptoms, but we don't address the underlying causes. For example Charity care, a very real problem but is it a funding problem in isolation or a symptom of a underlying issue. We believe it is a symptom, but very much like treating a patient in severe pain, you can not diagnose or treat the underlying cause until the pain has subsided. It will be impossible to get thought provoking and meaningful diagnostic discussion with the industry until the pain has subsided. The charity care problem is much larger than just 1.4 million people not having insurance. There are significant social and economic forces contributing to both the manner in which care is delivered and paid for (if paid at all). But the immediate problem today is that the volume of charity care continues to rise while funding for charity care remains static or declines and is still significantly below the estimated costs for delivering that care.

Another example, the proliferation of freestanding ambulatory surgery centers. A very real problem, but a symptom. If physicians net operating margins had not declined as drastically as they have, would they still be aggressively pursuing alternative sources of income? Perhaps, but if we also operated in a more efficient market structure those services would be priced appropriately, competed for appropriately and if lost would not have the severe negative impact on the hospitals. The negative impact on the hospitals is real because we have never operated in an efficient market, but instead have cost shifted and cross subsidized services so many ways, that we can no longer keep track or have long forgotten where or how costs and revenues have shifted. That cost and revenue shifting has fueled entry into a new markets where selective profitable services can be cherry picked by for profit entities against the highly regulated non profit providers that deliver care today.

Bad data

Most data that is accumulated, massaged, and presented regarding New Jerseys health care system is in fact bad data. By bad we mean it is either too outdated to be meaningful or just erroneous in how it is gathered and summarized. What is clear is that bad data leads to poor decisions, poor assumptions and poor treatments that don't solve the

[1] Tax Foundation.org

underlying etiology. Example: The Dartmouth Atlas report. Many conclusions / assumptions have been based on the recent report. While some of the data regarding visit rates and utilization is real and probably accurate, it must be noted that this is 2003 data, pertaining to only the Medicare population. Furthermore, in 2003 many New Jersey Hospitals in an effort to survive were manipulating the Medicare system to maximize reimbursement. It is unclear how these practice patterns affected both utilization and cost allocations that led to the reports conclusions. Example 2: Many of the aforementioned reports reference the number of maintained beds versus licensed beds in New Jersey. Surveys are taken periodically, but we suspect with less than accurate results. Why, because in this race to the bottom no one wants to give credence to the gap between their maintained beds and licensed beds to avoid the appearance of downsizing or the beginnings of financial distress.

Hospital Costs

The industry and consultants today cannot tell you with certainty what it costs to treat a certain patient, or diagnosis. Why? Because even the most sophisticated cost accounting systems available today rely on charges to allocate cost. Charges in New Jersey have been meaningless for years. Medicare and Medicaid pay fixed prospective rates and managed care companies most often negotiate per diem rates. Charges have been grossly misstated for years in an attempt to keep the hospitals solvent in an ever changing cost shifting and cross subsidization environment.

Furthermore there are very common and frequently misquoted perceptions about hospital operations and the corresponding costs. Example: Reduce the length of stay in the ICU for a patient and x amount of dollars will be saved. This principle is often untrue on both the revenue and expense side of the equation. If it's a government payer the revenue for the entire stay is fixed based on diagnosis not location of care. Secondly, the majority of costs in a hospital and especially in areas like the ICU are fixed. Any discussion revolving around hospital financial viability must first accurately understand the segmentation of costs in a hospital between fixed, step variable and variable.

As we get into the specific answers to your questions we want to summarize and emphasize certain principle we feel are critical to meaningful and sustainable reform.

1. We cannot continue with a fragmented system where payers observe different methodologies and the massive cost shifting and cross subsidization practices that have occurred historically are continued or worse increased.
2. Transparency of all health care transactions by and amongst all the participants (providers, payer, suppliers, patients) is essential to creating an environment where evidence based improvements can occur.
3. The system needs significant overhauling and short term fixes, while necessary must be part of a longer term reform plan otherwise they are destined becoming more confusing overlays on already outdated complex and dysfunctional system.

What Criteria should the state use to define an "essential" hospital?

Not an easy question. A large part of the answer depends on the time frame to be considered. We've already seen significant closures consolidations and downsizing of the hospital industry in New Jersey. We know that more than half of the hospitals are operating in the red and in severe financial distress. If you take this question in the context of a larger reform package and on a short-term time horizon then we would say every hospital today is essential because we simply do not have the tools or the data to make any other assumption.

That said, it is clearly reasonable to assume that hospitals who are currently providing high volumes of charity care and Medicaid and who by their absence would create a severe access problem are essential. The problem with this equation is the definition of access. Those who provide care to the most vulnerable populations are essential. Availability of services is much less significant on a go forward basis because the ability to duplicate or transfer services from one organization to another will be easier due to technological advance and easy access to medical knowledge bases.

We firmly believe that every patient should have the right to choose their physician and hospital. We do not believe as eluded to in the Avalere report that any significant "system" savings will be achieved by pruning hospitals out of the system so that the remaining branches will grow stronger.

Long-term we believe there are many dynamics that need to be considered in this equation. For instance we believe mission driven faith-based organizations providing a unique and balancing component in a fragile health care ecosystem are essential. An organization whose culture puts patients first, and embraces the principles of stewardship, service, and quality and innovation should be considered essential. We cannot create a monopolistic system, it will only breed inefficiency, corruption, and stagnate the drive for innovation and improvement.

Do you believe the state is over bedded?

We agree with the conclusion of the Accenture report, we are not over bedded. The majority of hospitals in the state does not operate their licensed beds and are reluctant to accurately report the number of maintained beds. It is imperative for a healthy hospital infrastructure to incur standby costs associated with availability of beds and services. It is inefficient from a service standpoint to run a hospital at extremely high occupancy levels. While through put and volume are important availability for the unknown and the unexpected is equally as important. Hence, a segment of hospital costs, in the fixed cost category must be considered "standby" costs so that availability is preserved.

On a longer-term horizon such information as epidemiological data, population patterns, surge capacity in the event of an emergency or pandemic all need to be considered in determining the number of beds and the location of those beds in New Jersey health system. Because we have considerable debt and sunk operating costs in the existing

facilities we feel it is imperative that only the existing facilities be considered in the infrastructure as opposed to building new ones.

How should the commission assess the availability of services to the people of New Jersey including services often regarded as necessarily provided in the near vicinity such as (OB/GYN) as opposed to services that may be appropriately located more regionally (such as transplant).

If we understand the question correctly we would have to conclude that the commission cannot accurately assess the availability of these services. For years New Jersey tried and failed at implementing a controlled planning and policy process. The single biggest problem is the technological advances and evidence-based knowledge changes in medicine that are occurring at an ever-increasing pace. Unfortunately this dynamic conflicts with traditional policy-setting and planning which takes a very static view of the system in the present.

As we mentioned earlier technological advances and easier access to an expanded medical knowledge base will only increase the ability to duplicate or transfer services from one organization to another. It is critical that continuity and efficient coordination of care be considered in the availability equation. There are far greater efficiencies to be gained in the system by improving continuity and familiarity of care.

Futuristic view, an end-stage renal patient who's been going to the same dialysis center for 20 years receiving all his acute episodes of care by the same nurses in the same facility having all of his other chronic conditions managed by the same physician team and nursing team for 20 years becomes eligible for kidney transplant. Is it better patient care to remove that patient from an environment that knows every intricacy of his health conditions to receive a transplant or is it better to bring the experienced transplant team to the patient. It is highly probable that the advances we are seeing today in the healthcare delivery will strongly support the latter model as more efficient. We believe this will be more evident as we continue to preserve people in multiple chronic states for longer periods of time.

In the long run we believe that all health care the most efficient and the highest quality health care is local healthcare.

Given the oft-cited negative financial impact of ambulatory care surgical centers on hospitals what should be done to deal with this perceived problem?

As we mentioned earlier the proliferation of ambulatory surgery centers in New Jersey is a symptom of a greater underlying problem. The physicians in our health systems have been grossly underpaid by managed care and do not get compensated for charity care. Much of their migration into ambulatory care is driven by the need to keep themselves financially whole. It is further driven by the cost shifting of revenues to certain select services thereby making them more profitable than others.

In the short term given the financial crisis that exists within the hospital industry in New Jersey we think it is imperative that the Board of medical examiners and other oversight agencies take a more stringent interpretation of the Cody Law and limit the number of freestanding ambulatory surgery centers.

Long-term it is our hope that reforms will once again compensate physicians adequately for the essential services they deliver to the community and that we have a system that is no longer muddied by excessive cost shifting and cross subsidization facilitating cherry picking up profitable services instead allowing for fair and accurate pricing of services delivered. We believe these two principles will eliminate or restructure the argument surrounding ambulatory surgery centers to one of access and quality.

How can FQHCs best work with acute care hospitals to ensure access for our citizens?

The federally qualified health centers are an excellent concept in getting federal dollars back into New Jersey to support primary care initiatives in the communities. This should not be seen as a panacea for optimal delivery a primary care. Many of the federally qualified health centers are independent of the hospitals do not operate 24 hours a day seven days a week and lack the necessary economic incentives to provide comprehensive coordinated care to the populations they serve. As a result when the needs of that community are not met by the FQHC the hospital emergency room's often become the next stop.

Like many areas in this report we think this is an area where New Jersey should once again step forward and become a demonstration state petitioning the federal government to work with us in a cooperative funding venture to improve upon the existing FQHC model. This is an area where the mission driven nonprofit mindset coordinated properly can add significant value and improve access to care in many communities.

How specifically can hospitals assist with increasing the number of people with health insurance particularly with enrollment into Medicaid and family care?

Clearly and we think unanimously we all agree the goal here is to improve insurance coverage for the underserved. As we're sure you've heard there are many bureaucratic restrictions and obstacles preventing the smooth enrollment of potential applicants into the systems. While we applaud many of the initiatives going on around the country and those being proposed in New Jersey we are somewhat skeptical that the open insurance market is the right place to get this population insured. This is an area where government needs to step in and establish a controlled market administering claims through a single agency to work cooperatively with the providers of care.

Too many other states are already well on their way in implementing Medicaid waiver programs that are geared to creating affordable insurance products for this population to voluntarily participate in. These are very worthy and credible experiments. If we approach this in a collaborative way and believe that we must experiment and we would

suggest New Jersey apply a different hypothesis. The hypothesis in New Jersey we suggest would be just enroll this population and a single-payer nonprofit driven model as opposed to creating low-priced benefit plans in the existing open insurance market.

How can hospitals work more effectively with physician groups to enhance efficiency including length of stay and quality?

First and foremost it must be noted that while we applaud and are very supportive of the physicians who deliver services in our community they are very much part of the for-profit side of the equation which creates conflicting economic incentives.

Physicians in New Jersey again are paid by a different methodology than hospitals. It is imperative that the economic incentives to improve access, quality and efficiency are aligned between all providers of care. To this end and as part of a greater health care reform experiment we fully support projects that explore gain sharing and the alignment of economic incentives. It is also imperative to note that there are many federal and state statutes that impede the collaborative efforts of for-profit physicians and nonprofit hospitals in this regard. If any of these experiments are to succeed waivers from these restrictive statutes will be essential.

In addition if we allow for a system of total transparency so that hospitals, physicians and payers can all see simultaneously the level of activity and the pricing associated with it, then at least we will have more accurate data to be able to drive accelerated evidence-based change in efficiency and quality.

What are the principal issues hospitals have with insurance carriers including contract negotiations and payment problems?

Again this is an area where the conflict between for-profit driven incentives and the needs of the community and the nonprofit providers collide. The economic model established for insurance companies is to collect premiums and payout as little as possible in claims. Years ago when New Jersey was a demonstration state for the all payer DRG system this dynamic did not exist. Many of the principles of that system drove cost-effective high quality affordable care to the communities we serve. The problem and why it was ultimately dismantled was that this system was also based on the flawed principles of cost shifting and cross subsidization.

The main problems we have with the insurance industry today stem from these principles. The absence of transparency and the ability to deny claims or reduce the amount of a claim and then create a bureaucratic gauntlet to impede adjudication are all contributors to the issues we have with the insurers.

If we view the health system in a similar context of an ecosystem three major forces in balancing the system are the providers of care, the recipients of care and those who pay

for the care. The reason why efficient market forces do not exist in health care is because the recipient of the care does not pay for the majority of the care received and there is no efficient market where information can be exchanged There is no incentive for them to proactively participate or even cooperate in the care that is delivered.

The ideal situation for us would be one where hospitals generate bills that actually reflect the services rendered are paid for those bills by the carrier who then settles any co-pays and deductibles directly with their beneficiary and since there would be total transparency if a hospitals bills were out of line with other providers the patient could then complain or choose to seek services elsewhere. But at no time should we have a system where services are rendered first and the question about the amount and whether or not we will get paid at all is secondary.

Summary

We thank you for the opportunity to participate in this very important endeavor. We are concerned as are many of our colleagues about the time frames and the original mandates of the Executive Order may not be realistic. We believe that comprehensive reform must first deal with the short-term crisis that is at hand. But it must also be done in the context of a longer term dynamic view that calls for greater sharing of information and funding by both federal, state, local governments as well as the private sector.

We end with a quote from the Judaic/Christian tradition: ***New Wine Needs to be put in New Skins!***