



**The Governor's Commission on Rationalizing Health Care Resources
Testimony of J. Richard Goldstein, M.D., President and CEO
New Jersey Council of Teaching Hospitals**

ABOUT NJCTH

The New Jersey Council of Teaching Hospitals (Council) was formed 21 years ago as an organization that initially addressed the needs of UMDNJ and its teaching hospital affiliates. The Council has expanded the mission to include non-UMDNJ affiliates and today count 11 teaching hospitals/systems as members. Collectively, we represent approximately 1200 residents (45%), more than 29,000 health care professionals and 6,900 hospital beds, care for more than 312,000 inpatients, and almost 3,000,000 outpatients every year, and have an aggregate annual budget that exceeds \$4.6 B. Among our members are three Level I trauma centers, four Level II trauma centers, six of the state's designated children's hospitals, and seven of the state's designated cardiac surgery centers.

I am J. Richard Goldstein, M. D. and served as the State Commissioner of Health (1983-86) under Tom Kean. I joined the Council 5 years ago as CEO. The Council has been actively promoting health care reform including: extensive research, publications, and legislative actions focused on insuring the uninsured (2004-2006), chairing the DOBI Commission on the Uninsured (2005), and a comprehensive health reform plan provided Governor Corzine resulting from my work on the Transition Team (2006-07). We have actively participated with Senator Vitale on expanding FamilyCare and reforming Medicaid; and served as The New Jersey node for the IHI Saving 100,000 Lives which resulted in a statistical saving of over 4000 lives in 18 months; and have played a key role on a number of legislative issues affecting New Jersey's health system.

Our members deliberate and outline solutions on many core health care issues through the Academic Affairs Council, the Quality and Patient Safety Collaborative, and the NJCTH Council of Children's Hospitals.

THE COMMISSION'S QUESTIONS

What criteria should the state use to define an “essential” hospital?

One important criterion for defining an essential hospital is one that addresses not only today's needs within New Jersey's communities but the future community needs as well. Because teaching hospitals educate tomorrow's doctors and perform the clinical research to develop new treatments, they are by definition looking to the future and therefore most of the larger training programs (with more than 75 residents) should be deemed essential. Teaching hospitals typically provide a greater breadth and depth of services. These are the largest teaching hospitals in New Jersey:

<u>Name</u>	<u>Medicare Slots</u>
University*	293
Cooper*	186
RWJUH	169
Newark Beth	148
Kennedy	144
St. Barnabas	144
St. Joseph's*	143
Hackensack	129
Morristown	121
Monmouth	94
St. Peter's	90
Jersey City*	89
Cathedral	86
Jersey Shore	84

Teaching hospitals should have an expanded role as the intellectual hub and referral center for the community hospitals in their region. The Institute of Medicine (“Leading Change in the 21st Century”) selected academic medical centers (AMC) to lead the charge for change. For example:

1. AMCs must shift the emphasis from acute care to chronic care (which requires more family practitioners than we produce). New models of care are required (team care, data collection, Preventative-EMR's, emphasis on self-management, promoting the adoption of healthier life-styles, linkages with community programs).
2. AMC's perform clinical research that must be incorporated into practices more quickly than has traditionally occurred.
3. AMCs processes must promote evidence-based medicine.
4. AMCs must involve nursing schools and public health schools and the communities they serve.

* The asterisked teaching hospitals are also classified by the state as “safety net” institutions because of the volume of charity care services they provide and/or the relatively low economic status of the communities they serve. In a sense, they are “double essential.” All major teaching hospitals are providers of last resort for the seriously ill.

It is conceivable that some communities are over-bedded with teaching hospitals and that one or more should close/merge. We would hope that in such situations the residency slots would be preserved and would be transferred to the appropriate institution.

Teaching hospitals should be financially supported for both graduate medical education (GME) as well as the clinical services provided.

Is the state over-bedded?

If one for-profit corporation operated all of the hospitals and wanted to squeeze out every penny of duplication, we would likely have fewer hospitals, fewer beds, and higher occupancies. (Of course, there would be other consequences that are less desirable: from experiences in other states, there would be little to no access for the uninsured and under-insured, including Medicaid, and there would be little to no surge capacity unless the state was willing to pay for it.)

The reality is that the need for hospital services (and their beds) changes seasonally and over time as the population ages (more beds) or the uninsured population increases (more beds) and new care processes are implemented shortening LOS (fewer beds), so hospitals must expand and contract accordingly. Some surge capacity seems desirable in case of influenza or Bird Flu or terrorist acts. Every effort should be made to maintain as few beds as possible and this likely means changing how physicians are reimbursed for inpatient care, the current system incentivizing longer lengths of stay. Ultimately, the issue of how many beds are appropriate relates to their cost within the current inpatient care structures. An empty, non-staffed bed adds no new cost to the system, thus would save little in a revised, “cost savings” oriented health plan. Hospitals provide a central repository for sophisticated, high-tech equipment and a place where physicians from all disciplines can interact. Clearly there is great value and efficiencies in such a centralized environment. However, if through technological advances one can treat a patient at home using monitoring devices just as well and less expensively than admitting the patient to a hospital, then that is what should happen. Investments should be made in IT and other technologies, as well as new care models to optimally manage chronic diseases so as to improve the quality of life and to avoid undue complications that require expensive hospitalization.

If the state is over-bedded, what difference does it make financially if the beds are not operational? Even closing an entire hospital does not save that much money if the patients are underinsured and their caretakers and care costs are shifted to another facility. Most of the fixed overhead remains (debt service, HVAC) and disposing of the closed hospital is a major problem.

This is not to say that consolidation of highly technical services is not useful. It is. Every study on quality points to the higher the volume, the better the outcomes. Wherever possible, consolidation of expensive, underutilized services should be considered.

How about proximity vs. regionalization?

Proximity is a relative term. Ben Franklin once described NJ as a beer keg tapped at both ends by NYC and Philadelphia. The issue of regionalization takes us beyond NJ’s borders. Out-migration has been reduced by the successes of some of NJ’s best hospitals, but it is still an

issue. For example, approximately 10 percent of pediatric inpatient cases are transferred/referred to centers outside NJ, 70 percent going to Philadelphia. While NJ has nine designated children's hospitals, not one has the clinical services and staff to compete with the Philadelphia children's hospitals. Sadly, we will never catch up with only 32 fellowships in pediatric subspecialties compared to 203 in Philadelphia. The state resource plan needs to take a position on how much out-migration, and for which populations, is acceptable. If the out-migration of children, for example, is to be addressed, part of the equation is to gain substantial more state support for fellowship training.

What to do about private ACS?

These facilities are less regulated than their hospital counterparts and we agree with NJHA that the playing field should be level. In particular the law that makes it illegal for physician owners to refer patients directly to entities in which they have financial ties should be strictly enforced and appropriate regulations promulgated that accomplishes this.

The activities of HMOs and other payors, such as Medicaid, have put so much downward pressure on physician's incomes that physicians seek other opportunities beyond just seeing more patients to maintain their income. Management consultants advise physicians to consider these investment opportunities. The problem is that ACS facilities not only siphon off the best-paying patients but the facilities generally do not provide charity care services or accept Medicaid patients. The hospitals have little ability to change the environment; the courts consider removal of staff privileges to be a restraint of trade, so hospitals have no leverage even within their own medical staff. ACSs may be less expensive than inpatient surgeries and may save insurer's money (except PIP) but at what cost to the overall health system? This is a very expensive way to save money.

The root problem is the diminished income for physicians. Charity care pays physicians zero and NJ is dead last in Medicaid fee-for-service rates for physicians. The state should consider innovative ways to support physicians while ensuring quality in the services provided.

Hospitals should help enroll patients in Government programs

There is no central database outlining the status of the patient's application for Medicaid or Family Care. Applications are initiated at a variety of treatment points: MD office, FQHC, hospital ED, and county offices. It would be extremely helpful for the caretakers and the state if a centralized database outlined the status of an application as is done in Pennsylvania (COMPASS Program).

NJHA described the fragmentation of the enrollment process. We believe this can be handled much better if the system were state run rather than county-run. Bear in mind that some obstacles are intentional. Legislators always object when non-qualified persons fraudulently enroll in government programs, hence barriers are always put in place that inevitably result in tens of thousands of eligibles not enrolling. The State Department of Treasury's Division of Taxation could probably devise a better way to automatically enroll and de-enroll beneficiaries.

How can hospitals work better with physicians on issues like length of stay and quality?

On LOS, a smarter MD reimbursement system based on the DRG rather than a per diem charge would resolve most of the problem. As for quality, there are many ways to address this including pay for performance (P4P). All the hospital associations are actively engaged in these demonstration projects.

Key issues with insurance companies?

The principal issues hospitals have with insurance carriers stem from the relative lack of respect/accountability by the carriers. The insurers have an attitude that places them superior to the hospitals. Insurers continually make unilateral changes to the hospital contracts and they are notorious for denying claims, delaying claims and downgrading claims requiring hospitals to go to greater and greater lengths to settle disputes. Much of this stems from the fact that in New Jersey there are a relatively small number of very profitable insurers with a very large market share. Thus they feel that they can do whatever they want when dealing with individual hospitals. There clearly needs to be something done that levels the playing field and forces insurers to deal with hospitals in a respectful business partnership rather than from a superior / subordinate position.

THE COUNCIL'S QUESTIONS

What would be your suggestions to improve the New Jersey Health Care System?

- 1. We Need an Enlightened, Detailed, and Politically-Supportable Seven to Ten Year Plan**
We can all agree that the vision is to have a comprehensive, efficient, affordable health care system that meets the needs of the citizens of New Jersey regardless, of their economic circumstances or cultural identity. We all desire a system that does not overly burden business or government or working people, and one that fosters medical education and innovation.

Our current system falls far short of the vision. We tend to make decisions and pass laws that deal with the inequities of the current system, which was put in place without a clear set of goals. We lumber along, and the system is unraveling. It is time to work on a comprehensive new plan. A physician manpower and ancillary health care professions manpower plan is a critical piece of the puzzle because of the looming physician shortage.

Your commission is charged with developing and publishing a “state resource allocation plan” and NJCTH looks forward to working with you on this important endeavor.

- 2. The Structure of Government Must be Reorganized to Implement the Plan**
State government already has too many silos in different departments (Health, Human Services, DOBI, Justice, and Community Affairs) that impact health care. They are careful to avoid turf issues, but within their silos, they are having significant operational overlaps, yet barely coordinate services. For example, few elements of the IT systems for Medicaid, FamilyCare, Charity Care, or any other program are integrated. Except for the Governor, there is no one in charge of coordinating their actions, and this has lead to no one being

responsible for our health care system—for coordinated services, cost, quality, or access.

Once a strategic health plan is outlined, the government will need to reorganize itself to better implement the Plan. A Health Care Oversight Board, with public, private, and business members, should monitor the entire program, regardless of where the pieces are housed.

3. To end the cycle of cost-shifting, the increases in premiums, and individuals and businesses dropping coverage; government programs need to pay hospitals and physicians close to their actual costs of providing care.

The historical model of business-sponsored health care insurance, in an era of globalization and price competition, is unraveling in many industries. In no small part this is due to the under funding of hospital-based Charity Care, Medicaid, Medicare, graduate medical education (GME), and hospital-related bad debt (due to insurance policies with high deductibles, high co-pays, or services provided to individuals that have opted out of company-sponsored health insurance or who work for companies that do not offer health insurance), which when taken collectively requires hospitals to cost-shift **\$2.2 billion** in underpayments.

Program	Underpayment that Gets Cost-Shifted	Notes
Medicare	\$720M	Medicare pays about 90% of costs. It is also the largest payor hence the impact of any underpayments is disproportionately large. The \$720M is the 10% underpayment.
Medicaid	\$195M	Medicaid pays about 75% of costs. The \$195M is the 25% underpayment.
Charity Care	\$590M	Shortfall after state subsidy of \$693M in 2007
Graduate Medical Education	\$280M	Based on Medicare cost principles
Bad Debt	\$450M	Based on 3% estimate statewide
Total	\$2.235B	

It is not only that the totality of this burden is crushing the system, it is greatly exacerbated because the burden is not shared equally, hammering specific segments of the market much, much more than others. Ironically, it is the large payors – including many that are very profitable – that carry less of the burden because of their market share/purchasing power than do smaller businesses. When Blue Cross negotiates, it reminds providers that it can send its customers somewhere else. That is a powerful incentive to offer them a discount. When NJ’s ill-fated DRG program began, there was the same cost-shifting to pay for Charity Care and GME, but it was equal cost-shifting (and the bill was much less). All parties, including Blue Cross, Medicare, and Medicaid, paid the same for their patients.

When Medicaid and Medicare refused to continue their participation in NJ’s DRG program (the federal government argued it was illegal for them to pay the costs of the uninsured even

though New Jersey proved it was cheaper for them to do so), the cost-shifting on the remaining parties increased from <12 percent to 24 percent on average. The impact on smaller payors was disproportional, as it is today. This increase was too much for small payors, including a few advocacy-savvy labor unions and small businesses, so the complaints became a chorus and the program was challenged legally as a violation of the federal ERISA law but was terminated before the courts reached their decision saying it was not.

But if DRGs had been in effect in 2005, the average cost-shifting mark-up would have been 37 percent. In 2007 cost-shifting is estimated to have risen to 55 percent, a huge increase with profound ramifications: Businesses are abandoning health insurance coverage at an ever accelerating rate. More uninsured will result. Remember the 55 percent is an average; some large payors pay mark-ups of only a few percent while smaller ones can pay in excess of 200 percent over cost.

Unfortunately the ability of a hospital to cost-shift the underpayments depends almost entirely on their geographic location. Poorer communities, especially inner city hospitals, do not have a payor mix that can support massive cost-shifting. These are the institutions that have already fallen: NJ lost 20 hospitals in the past decade. Many additional hospitals are likely to fail if the charity care funding is not improved. As they fail, their patients will utilize the hospitals that remain. This is a zero-sum game. The hospitals they gravitate to will be adversely financially affected. **The improvement in market share that the surviving hospitals realize is only helpful if the new customers can pay more than actual costs, not less.**

4. We need to invest more, not less, in graduate medical education (including fellowship training not supported by GME funding), to address the looming shortage of physicians.

Teaching hospitals are the intellectual centers of gravity for research, clinical care, and medical education. They are responsible for improvements in patient safety, centers of excellence such as Level I trauma care, transplants, cardiac surgery, and children's hospitals. Yet their most critical societal function is to train physicians. Unfortunately, a physician shortage is likely given the following:

1. The population of the US (and New Jersey) is growing: +70 M (1980-2005)
2. The largest growth is those over age 65 – those who consume the most resources. The number >65 will double by 2030.
3. Most illnesses are far more prevalent among the elderly. For males age 40-44, 146 new cancers/yr/100,000. Age 70-74, 2806 new cancers/yr/100,000.
4. Wealthier Americans – baby boomers - will consume more health resources.
5. One third (250,000) of active MDs are 55+ and likely to retire by 2020.
 - a. 9000 retired in 2000; will increase to 22,000/year by 2020
6. Newer MDs work fewer hours/week. 50% are female.

OPTIONS:

1. Improve supply via medical school expansions and more slots
2. Improve supply of other health care professionals (APNs)
3. Import more IMGs (currently 6000/yr) = 25% of MDs in training (>50% in NJ)
 - a. But supply could drop: other countries are working hard to retain their own; other ethical issues; 6000/yr is not enough to meet our future needs.

NJ has always paid its fair share for GME until this year's budget which would effectively reduce state support of GME funding by \$100M, from \$170M to \$70M. **At current resident salary levels, this could reduce the number of residents by 1500 (from 2600 to 1100) which for all practical purposes would set NJ back 30 years. It would lead to decertification of the programs by ACGME and would eventually eliminate all Medicare GME (\$300M) as well. Teaching hospitals could not teach, perform research – including stem-cell research, care for the uninsured, operate Level I trauma centers, or lead the charge in changing care models. (See attached overview of the issue).**

CONCLUSION

Our current health system is unaffordable and unsustainable. As important as these issues are at the moment, merely providing insurance or rationalizing physical assets is shortsighted. The fundamental shift that must take place is to move from reactive to predictive medicine and from one-size-fits-all remedies to patient-centered, evidence-based, personalized medicine. Transitioning from the old model to the new will require investments in IT, new curriculum in our medical schools, and profound change in how we educate our residents. A physician shortage appears likely in the next decade which will require more allied health professionals. The members of the New Jersey Council of Teaching Hospitals look forward to providing leadership towards a healthier future.