P U B L I C H E A R I N G

before

SENATE INSTITUTIONS HEALTH AND WELFARE COMMITTEE

on

HOSPITAL RATE SETTING LAW

Held:
September 21, 1982
State House Annex
Room 114
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Senator Richard J. Codey (Chairman)
Senator Garrett W. Hagedorn

ALSO PRESENT:

Eleanor H. Seel, Research Associate
Office of Legislative Services
Aide, Senate Institutions Health and Welfare Committee

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SENATOR RICHARD J. CODEY (Chairman): Today's hearing, of course, is on the subject matter of the DRG (Diagnosis Related Group).

Our first witness this morning will be Ms. Dorothy Powers, Chairman of the Hospital Rate Setting Commission. Ms. Powers?

D O R O T H Y P O W E R S: Thank you very much, Senators, and ladies and gentlemen. We are very, very pleased that you are having this hearing today, and I am very, very pleased to be here to testify on behalf of the Commission. You will be hearing from other members of the Commission later, and I am going to give a general statement. The other members of the Commission will add to what I have to say on their particular interests and perspective.

You have my statement before you. I am not going to read it, but I would like to cover some of the highlights. The points I make will be best understood in context of the history of the system, and I just want to mention and go through that briefly.

Chapter 83, when it was passed, mandated a new methodology and process for prospective reimbursement of hospital costs. The overall goals of this legislation were hospital cost containment, while at the same time ensuring that hospitals that are needed, that deliver efficient and effective care, shall remain solvent and that equity among payers be established.

The new methodology that was passed is very complicated to implement, but the concepts are reasonably simple. It is a prospective reimbursement system for all hospitals. Rates are set that the payers will pay. Prospective reimbursement is a strategy for reducing hospital costs by setting an established price for hospital care; that is, the hospital knows in advance what it will receive in terms for providing certain kinds of services.

In New Jersey, the inpatient price, if you will, is established through a classification system called DRG's, and very simply, you can look at DRG's as being a type of illness that already has been decided through data that has been developed. You can reasonably expect the cost of providing treatment for that illness to be comparable among institutions. The DRG rate then that is developed is hospital specific, and it is based both on the hospital costs and the statewide averages of all the care hospitals that they would be compared to.

The advantages of this system are very apparent: It provides incentives for hospitals to cut costs, and perhaps more important, it provides a link between medical practice and hospital management. This is unique to the DRG system.

Management reports can be developed that can involve the medical profession in managing their practices. The new process was set up to have a Commission, which is the adjudicator of the new program, and the responsibilities of the Commission are really to make all final decisions on hospital specifics or generic appeals, and we have the authority to adjust and approve all hospital rates for all payers.

A number of things we consider in making our decisions are to balance the hospital requests versus reasonable costs, to consider delivery of care of services, and we always have to consider access to quality care. I believe that many of the objectives of the program are being met.

Let me just mention solvency of hospitals, and particularly, some of our inner-city institutions which have had severe financial problems and have dramatically improved. Most hospitals that are in the system have found that their bottom line has improved, and I know that you will be hearing from hospitals later today, and

they can testify directly. This is not true for all, but I think in most cases, there has been an improvement and a movement in terms of their bottom line.

Equity among payers is being established. We have equivalent costs for equivalent treatment by and large, and, therefore, the cost shifting among payers that was prevalent before the program came into being has been virtually eliminated. Of course, this is not true in any of the other forty-nine states.

On the issue of cost containment, the data that we have generated is from twenty-six hospitals being in the system for two years. It is not sufficient to make any definitive statement, but I believe the results are worth noting, and in fact, I believe that you have a packet that gives the data of the experience of the first twenty-six.

Just briefly -- for example, in 1981 the national increase in operating expenses was 18.7%. In New Jersey in the twenty-six hospitals in the DRG system for two years, it was 13.8%. Inpatient days nationally rose 1.2% and inpatient days in our New Jersey DRG hospitals went down .6%. Length of stay remained at average; it didn't increase or decrease on the national level. It decreased by .5% in New Jersey.

In conclusion, I would like to say that from my vantage point, the system which was created by bipartisan effort of the Legislature is working reasonably well. It certainly isn't perfection yet, and the areas that we need to strive very hard for are: more timeliness of the schedule of rates coming out; reconciliation of the hospitals in terms of their under or over collection; and, reconciliation for payers. These are issues that we are working on and we must get the time-line down. The system needs to be tightened up in terms of appeal process. Until these issues are dealt with, the system will not be truely prospective, and until the system is prospective, we will not be able to see that bottom line of cost containment.

Let me just conclude by saying that on balance, I believe that the program is serving the citizens of New Jersey very well even in its infant stage now. Thank you very much.

SENATOR CODEY: Ms. Powers, if you would, for those of us who are laymen in regard to the DRG, explain, for example, if someone goes into a gall bladder surgery and how those things are set up. Is there a difference between hospitals? I understand there is a set fee. Would you explain that?

MS. POWERS: There would be, for a particular type of illness -- as you mentioned, the gall bladder surgery -- that a hospital's specific rate is established. They are not 100% comparable because part of the --

SENATOR CODEY: In other words, each hospital has a different rate for a gall bladder operation?

MS. POWERS: Yes. But they have been based partly on historic costs of the hospital and partly on the standard of the average costs of their peer hospitals. And, this incentive is because the standard is in, as well as their costs -- is that if they are more efficient than their peers, they would have additional money that the hospital would keep. If they are inefficient in comparison to their peers, they would lose a certain amount of money.

SENATOR CODEY: Senator Hagedorn?

SENATOR HAGEDORN: Yes. I remember in the testimony when the original bill was considered, there was a great complaint about the time that it took to

determine rates, and I understand that that problem still prevails. My question is: What is the Commission doing about it in order to speed up that process?

MS. POWERS: This year, part of that is growing pains and we are confident that the rates will be out. You can certainly press Joe Morris on this; he will be the next person to testify. This year, because we are using the same cost base for running the rates, they will be out and they will be timely. This, again, is part of the growing pains of having the full complement of hospitals on this year, running it on a different cost base year. There were delays this year, but we are moving forward now, and we hope to have the appeals process virtually finished by the end of the year.

SENATOR HAGEDORN: My next question is the question of custodial patients. What plans has the Commission set out to provide for payment in this area?

MS. POWERS: The custodial patients who stay in the hospital -- and, again, utilization review is involved here -- will receive a rate that is an average of what would be paid if that person was in a nursing home in the area.

SENATOR HAGEDORN: In that fashion then, are we following the Chapter 83 as far as the requirements are concerned?

MS. POWERS: It is my understanding that we are, yes.

SENATOR HAGEDORN: One other question I have had in our area, and that is: What is the Commission doing to alleviate the complaints of patients who receive the DRG bills and they are substantially higher than the actual charges for a hospital stay? There has been a great unrest on the part of patients who cannot understand the variation in cost from the actual cost to what the DRG is charging.

MS. POWERS: All right. First of all, there is an appeal system. Patients who have certain lengths of stay that are longer than average or shorter than average go on direct charges. The patients must understand that the price that they are paying is an average, and sometimes it is over and sometimes it is under. They can appeal if the charges are under. I don't suppose that any of them appeal if the charges are higher than what they are having to pay.

SENATOR HAGEDORN: Can you tell us of any case where the charge has been lower?

MS. POWERS: I can't give you one in mind, but that is how the averages work.

SENATOR HAGEDORN: One other question: You have indicated the differences between 1979 and 1980, for example, and 1980 and 1981. Then I refer to Page 31 of the HRET Report, which in conclusion, says, "There was considerable uncertainty as to the effect of the program on reducing the costs of medical care." This is really to the contrary as to what you are testifying.

MS. POWERS: Again, if I indicated the figures that I am using are rough, gross figures, there has not been an evaluation of this, and there won't be. The HRET is going to evaluate this. The only thing I can give you is the actual percentages without evaluating what that really means. But, in comparison to the national averages, there has been less increase in hospital costs in operating expenses in New Jersey than as a nation as a whole.

SENATOR HAGEDORN: You did indicate that we probably are one or two years behind in setting the actual rates. How did we come up with the 1980 figure then of 13.8%? Where does that figure come from?

MS. POWERS: These are the audited financial statements from the hospitals.

SENATOR HAGEDORN: Final?

MS. POWERS: (continuing) Final -- and the 1981 actuals from national are, again, reported by -- where did those statistics come from? You have them in your package.

MR. WARREN: (responding) They came from the American Hospital Association. The data came from the American Hospital Association Report, and the Commission's data came from audited financial statements from the first twenty-six hospitals.

SENATOR HAGEDORN: For what period?

MS. POWERS: For 1981.

MR. WARREN: Right. For 1981.

MS. POWERS: May I introduce Jeffrey Warren, our Executive Secretary to the Commission, who I might say has been with us from the beginning, and he certainly gets very high marks from the Commission.

SENATOR CODEY: If there are no further questions, thank you very much, Ms. Powers.

MS. POWERS: Thank you.

SENATOR CODEY: Our next witness is Mr. Joseph Morris, Acting Assistant Commissioner of Health.

J O S E P H M O R R I S: Thank you, Senator Codey. It is a pleasure to be before your Committee today. I must apologize for Commissioner Mayer's inability to attend. She had commitments that she made some months back, and she does send her apologies to the Committee.

I am the Acting Assistant Commissioner for Health Planning and Resource Development. Within my division, we have health planning, certificate of need, and rate setting responsibilities. I think it would be helpful for the Committee if I separated two major pieces, I think, that will be discussed before you today. Looking at your list of witnesses, you are going to run the full gambit on these issues.

The first that I would like to distinguish between is the statute itself, Chapter 83; and then the other situation which causes a lot of interest is the diagnosis related group patient classification system and reimbursement system. I will also note that right now, at this point, I think there is a television broadcast in thirty-five cities where Jack Owen of the American Hospital Association is explaining the Federal government's intentions to implement this type of reimbursement system for all hospitals throughout the United States.

What we are doing in New Jersey truely is on the first cutting edge of anything done with DRG's, and I think that explains some of the growing pains that Chairwoman Powers explained to you.

First of all, on the statute, Chapter 83: It was actually an amendment to the Health Facilities Planning Act of 1971. That is when the Department of Health and Insurance first were given, among other broad responsibilities, in regulating hospitals out of rate regulation. The Department of Health didn't really initiate its own review; instead it relied upon Hospital Research and Educational Trust until about 1974 because there had been a prior system of voluntary budget reviews initiated by the Hospital Association dating back to 1968. The department instituted a Budget Review Hospital Program in 1975. Again, the statute was implemented in 1978, and Rate Setting Commission, which was an important new feature -- the Commission members were named during 1979. Regulations were promulgated to implement the system in 1980.

First of all, in terms of the broad overview of the statute, I see that it has within it a number of competing and conflicting needs and requirements to the various participants. I look at it, and I see that what is being stressed is access of care, quality of care, and financial solvency, and ability for financial access for those portions of our population who do not have adequate resources to pay for care. I think that when you have testimony today, you will see that Chapter 83 seems to mean many different things to alter many different parties involved. I see that Chapter 83 really meant to be a beginning for a partnership of all the parties involved -- the providers, the payers, the regulators. Although I must confess to the times that I feel quite schizophrenic because on one hand, the hospitals charge that we do not have enough money in the rates, the payers counter-charge that we are causing them to pay out too much money, and somehow I know that I am not taking it home with me. So, there must be a balance throughout all of this that I think is explained probably by the high cost increases in health care that have been going on for the last fifteen years. I think that is one of the biggest problems we have in regulating hospitals, that there has been unprecedented growth during the last fifteen years. And now, with resources dwindling, there is a need to turn that around and to be able to provide quality care at an affordable price.

The goal of this statute was to provide for the full financial elements or needs of a hospital. Of course, what that had to be balanced against was that the hospitals were to be efficient, effective, appropriately and properly utilized.

One of the major ingredients in meeting full financial needs to the hospital was a provision for uncompensated care-- the payment for services to those patients who did not have medical insurance and did not qualify for Medicaid, the local, State and Federal supported program.

The other, of course, big problem is that Medicare, which is a totally Federal program, contols almost 50% of all the patients. That will be increasing as the population of New Jersey over age 65 grows, and a greater and greater emphasis will be based on the hospitals receiving payment for provision of services from the Federal government.

Therein lies the situation of trying to implement a system that would meet all the needs and goals of this statute. In order to measure who is efficient, effective, appropriate and properly utilized, the Department of Health felt it necessary to go to a system that would really measure the care that was delivered, the true outcomes of what a hospital delivers each and everyday. It is not really a patient day, but it is the different types of patients treated. That is why we chose the Diagnosis Related Group System -- because it is a patient classification system, and it seeks to take patients on the basis of their diagnosis or illness and the procedures or treatments that they receive and classify them into groups that make sense.

Before such an approach, most cost based reimbursement systems lumped all patient days together. A patient day was a patient day, and it was considered to be equal. Of course, it is very obvious that the care of an open-heart surgery patient on any given day is much more intensive than a tonsillectomy patient or a newborn.

Also, we needed to have all payers participate, and our State statute has a constitutional problem that we cannot get the Federal government to particpate

unless they so choose. For that reason, the Department of Health sought and obtained from the Federal government a waiver of its reimbursement principles. In getting this waiver, the basis was that we felt we had a system that could meet the financial needs of hospitals. It would show hospitals how to manage differently, how to be able to work with the physicians, to review how care is being rendered, improve it and make even greater demands, and deliver care in a much more cost-effective manner.

We were able to obtain from Medicare not only the waiver, but significant concessions on what Medicare would pay that it doesn't pay in the other states. There is only one other state that has a waiver that is similar to New Jersey, and that is Maryland.

The very important thing is that hospitals will be paid for their uncompensated care. Estimates are that this amount was running between $60 million and $90 million back in 1978. The amount is much larger today because we have seen a high degree of unemployment, more people without medical coverage because of being out of work, and any number of funding programs on the State and Federal level eliminated because of lack of funds. For that reason, the services that were originally reimbursed by it, any number of mechanisms are now coming up short, and the hospital is responding by asking the Rate Setting Commission to approve additional funds into the rates.

All of this is something I believe the Legislature can understand as you wrestle with the State budget. There seems to be a never-ending demand and needs to be met and fewer and fewer resources. That is just an ongoing problem that the system will have, and again, we hope that the Diagnosis Related Group -- that patient classification system -- the ability for the hospitals to work with it and to work with the physicians, because this system is based on the language of the phsysicans -- the diagnoses; that is what the physicians write. They describe your illness by their diagnosis.

I think that the system is not without its problems. We have had startup problems; the rates have been late on occasion. My comment would be that although we are late by our own timetable, we are well four years ahead of the rest of the country. I think, considering the undertaking, we are making progress; we are not content to stand where we are. I have had many discussions with Ms. Powers, and we are attempting to make the rates more prospective. We have a new set of regulations for 1983, which will come before the Health Care Administration Board for approval during the month of October. In that set of regulations, we make a commitment to have the rates for most hospitals out before the first of the year. This is an important step in meeting the more prospective natures as Ms. Powers indicated.

There are problems with the system, and some questions have already been raised by the panel. I'll just briefly respond to the general nature of the problems, and I'll be available for questioning.

First of all, with individual patient problems: There are those instances where patients will receive a bill, which has an average case amount, which is higher than what his actual charges appear to be from the hospital. This is an undue hardship. We try to work with the patients through the patient appeals mechanism and with the hospital so that there isn't any due harm to either the hospital or the patient.

I think the major improvement we have made in that area is the regrouping of the Diagnosis Related Groups. That regrouping took effect and made in 1982. To date, we have seen a slight decline in the number of patient appeals or situations that have been described.

The other problem is trying to, for the first time, take this new system and the new reporting requirments because in order to be paid for a case -- the right amount, whether it be an appendectomy or gall bladder -- the hospitals were required to submit, along with their bill, the patient information on diagnosis, procedures, age, and other variables that pertained to what case the patient would in.

The first year, in 1980, seemed to be the year that we had the most problem. The hospitals did not have to implement at the same time this requirement for reporting the clinical data with the financial data. As a result, when the hospitals reconstructed the data to submit to the Department of Health during 1981, there was a problem of making the data as clean as it would have been if it had been collected concurrently.

Of the twenty-six hospitals, three hospitals were independent processors. The other twenty-three depended on some time-share type of billing system where some other company does their billing and then was going to match the clinical information. We were able to clean up the three independent processed hospitals almost a year ago. We have been working with the other data from the twenty-three hospitals to clean it up. We are significantly through that process, and we expect that we will have the final results for 1980 for all twenty-six hospitals available before the end of this calendar year.

I think that in trying to meet the full intent of the legislation, we have been, for the most part, successful. There are problems. I don't believe they are being ignored; it is just that what we are dealing with is a very complex situation. The treatment at hospitals is complex, and anytime you try to determine what is a fair and equitable price to pay a hospital, you are going to get into a complex issue. We are trying to make sure that we don't have any additional complexities that are not required, but if we are ever going to communicate with the physician, we have to move off of just simple answers. I think we are working toward something that will work for the hospital industry and the payers, but more importantly, for the citizens of New Jersey.

SENATOR CODEY: Thanks, Mr. Morris. Senator Hagedorn?

SENATOR HAGEDORN: Mr. Morris, how many of the hospitals have gone through their final reconcilation?

MR. MORRIS: For 1980, Senator, three hospitals have gone out of the first twenty-six. The other twenty-three -- we are in the process of finaling off and finalizing the amounts due to them.

SENATOR HAGEDORN: How long is that going to take?

MR. MORRIS: We estimate that we will have that completed before the end of this calendar year, Senator.

SENATOR HAGEDORN: The DRG system, which provides sufficient money to hospitals to ensure that they do stay abreast of current technology -- have they? Has the system provided that?

MR. MORRIS: You will receive two views, I'm sure, on this, Senator.

SENATOR HAGEDORN: I would like your view.

MR. MORRIS: I'll give you my view, and then I'll give you the opposing view.

My view is that we have provided enough for any new technology. There is , within even the statute, a provision that ensures that the maintenance and replacement of capital and equipment -- and we have what is called "price level depreciation." We pay the hospital more money than they actually paid for their present equipment so that they can replace the equipment. Also, through the overall general incentive nature of the program, by trying to get the hospitals to deliver more effectively -- we feel that there are additional monies there. Each year the hospitals indicate that this is something which they fight with the department on -- the regulations -- to try to get additional amounts built in. The other side of that is the payers, of course, fight with the department not to give anything additional because they think that the financial elements are rich enough already.

SENATOR HAGEDORN: Of all the acute hospitals in this State, how many have not been brought into the DRG system?

MR. MORRIS: At this point in time, there are seventeen, Senator.

SENATOR HAGEDORN: Out of a total of how many?

MR. MORRIS: Ninety-nine. And those seventeen were hospitals that did not have the financial billing information on each patient in a computer-readable form. We had to do something different for them and wait until 1981 when they did have the billing information for each type of patient, be it an appendectomy or a gall bladder. That information we received probably in mid-1982. We had some difficulties in processing it. We are going to implement rates for these hospitals during the latter part of this year, and it will be based on their 1981 information.

At this point, our concern is to try to get those seventeen hospitals up and on the system with what is an average rate, the statewide rate for peer hospitals.

SENATOR HAGEDORN: What is the current prospect for the "cap" being pierced? And I'm talking about now, the Medicaid cap.

MR. MORRIS: There is, for both Medicare and Medicaid, this overall "cap." What it relates to is that the Federal government, in agreeing to the waiver, had to, under their Social Security amendments, protect the Social Security Trust Fund. In order to comply with that, the Federal officials said that, "Under a waiver, the Medicare and the Medicaid programs would pay the rates determined by the Department of Health." Yet, at a point in time, if it was determined that, under this new system, Medicare and Medicaid were paying more than they would have under the old system, the waiver could be dropped and even a potential for pay back by the hospitals of the excess amount.

The final "cap" projections, unfortunately, cannot be made until we do the reconcilation for 1980 and 1981 for the hospitals, so we are awaiting that. My sense is that in the first few years, it was projected that we would be above the "cap." The reason for that was we were including additional financial elements. We were paying the hospital for items that Medicare had never paid before -- like uncompensated care. And we expected it to be a number of years before the hospitals could implement management actions to respond and actually start spending less than more. So, given that, during 1981, we also experienced an increase in the amount of

uncompensated care due to certain counties lessening their support for the grants on behalf of the medically indigent.

I would say that we are still above the "cap," and it is necessary that for 1982 and 1983, that we have sufficient savings from the program to ensure that we maintain the waiver.

SENATOR HAGEDORN: In other words, you are projecting that you will increase over the "caps." Who is going to pay that cost under the DRG system?

MR. MORRIS: The Medicare waiver indicates that there would be a pay back by the hospital. Our experience on this is that the only other state that had a waiver was the State of Maryland. They had similar financial elements to New Jersey, and although they were initially over the "cap" during the first few years, Medicare allows that they had passed a test because in the later years of the experiment in Maryland, they came under the "cap."

I would say that if the hospitals and the payers can move during 1982 and 1983, to have less expenditures than was happening in 1980 and 1981, there may not be a pay back. But if there is a pay back, it would have to come from the hospitals.

SENATOR HAGEDORN: In other words, who is going to pay the hospitals?

MR. MORRIS: In the absence of a Medicare waiver, I am going to have to act like an attorney now. In the absence of a Medicare waiver, I think trying to enforce the provisions of Chapter 83 are difficult because the Blue Cross payers who said that unless there is full participation that the 1978 amendments do not apply. If that is the case, I would imagine that we would go back to the situation that exists in 48 other states. Medicare and Medicaid would pay their amounts under their cost based reimbursement. Blue Cross would revert back to a cost based reimbursement system, and the only charge paying patients would be commercial carriers and self-pay in union-type programs. So, the hospitals would have to get the money from those types of payers.

SENATOR HAGEDORN: In other words, there is going to be an increase more than likely for the premiums to subscribers on insurance coverage. For example, right now, you've got, as I remember it, Blue Cross has had a 40% increase since this thing was started.

MR. MORRIS: That is correct, Senator.

SENATOR HAGEDORN: I just wonder how far we can go in tapping the third-party payers to make the system work.

MR. MORRIS: One of the biggest increases in this system, Senator, is the burden of uncompensated care. That is what is being picked up by the payers. That is the one major financial element that has resulted in the increase in Blue Cross premiums, in my estimation.

SENATOR HAGEDORN: In other words, under the DRG system, we are asking the third-party payers to be the welfare collecting agency instead of using another area to do it.

MR. MORRIS: That is one way of characterizing it, Senator.

SENATOR HAGEDORN: I have one other question. Are you familiar with unbundling?

MR. MORRIS: Yes, I am, Senator.

SENATOR HAGEDORN: Has the DRG influenced that procedure where doctors form under the employ of hospitals, radiologists, and others -- are now self-

employed, and we don't know how far that trend is going to go. Have those costs been indicated in the cost analysis that we have been looking at -- the cost comparison? Do you consider the fact that a hospital no longer pays the doctor; it is a separate cost? Has that been figured in these figures?

MR. MORRIS: With your indulgence, Senator, I would like to provide a fuller answer.

First of all, unbundling is an expression for when the hospital spins off or takes, as you said, services which were provided in a hospital setting; then they are provided by some other private organization, resulting in an additional bill or cost to the consumer. What would seem through the figures that you are looking at in 1980 and 1981 -- the only unbundling that was occurring at that point in time was that radiologists who were formally salaried or fee-paid by the hospital went fee-for-service. There was then an arrangment where Blue Cross pays slightly different than they normally would under their hospital contract, and all other patients would get a separate bill from the radiologist.

What is happening today in terms of unbundling -- it is much more prevalent in other states. I think the reason for that is that in other states, they still have the burden of uncompensated care, and under the burden of uncompensated care, they have to find ways to take certain high income producing programs, such as radiology -- take it outside of the hospital cost based mechanisms, run it as a private business, and in effect, charge every patient who uses services a premium to offset the losses being experienced -- the other services of the hospital.

In essence, it is doing the same thing that the Chapter 83 and the DRG system does. It is being used as a welfare collection device, if you will. I don't think that the DRG system and the Chapter 83 reimbursement system is primarily motivating this trend toward unbundling. I believe that the provisions for uncompensated care protects New Jersey hospitals to a greater extent.

The other reason why hospitals do unbundling is to have greater access to the capital market. Again, I don't think it is really that vital in New Jersey since the hospitals have access to capital very readily through the Rate Setting System, which will pay whatever the debt service is, and the ability of the hospitals to finance the New Jersey Health Care Financing Authority, which issues tax-exempt issues.

I think the real issue in unbundling is that there is now competition being directed against the hospital, and the hospitals are trying to respond to that competition. The competition is coming in the form of physicians who are now competing directly with the hospital. The radiologists are setting up radiological services across the street from the hospital. They are taking the patients who can pay and leaving the hospital with the burden of those patients who cannot pay for their services.

I think the real issue here is: Does the health planning process have the capacity of addressing these new services that are being set off across the street from hospitals? Hosepitals have to go through a certificate of need process, but under the current statute, I believe that private practice of physicians allows these physicians to set up a practice -- start radiology services -- and compete with the hospital by taking the paying patients and leaving, perhaps the medically indigent, to go through the doors of the hospital.

SENATOR HAGEDORN: In other words, if we allow this trend to continue, will the Rate Setting program be effective? Are we going to be able to contain costs?

MR. MORRIS: It is a very serious leak in the whole health planning and control of hospitals, Senator.

SENATOR HAGEDORN: Does the department have any recommendations on how to overcome it?

MR. MORRIS: We are working on recommendations. I have a feeling that I had better talk to my Commissioner first because I think that the recommendations are going to be in terms of legislation to determine when physicians, in a group practice, are actually a health care facility. That is what is happening right now. Physicians are not considered a health care facility, and they do not have to go through any certificate of need process, and at a drop of a dime, can compete with the hospital.

SENATOR HAGEDORN: Okay, I have one other question and that is -- I think that maybe I have alluded to it to some degree -- and that is the letter of July 2 to Carolyn Davis at the Health Care Financing Administration in Washington -- where you asked that the private payers be eliminated from the DRG system, and subsequently, also possibly the self-insured. Many industries and small corporations are self-insured. Can you tell me the reason for that?

MR. MORRIS: Yes, I can, Senator. One of the first problems that Dr. Mayer encountered when she came to the department was the issue that you, yourself raised, about some of the patients that received bills that are in excess of their seeing a charge for actual services.

Oftentimes, these patients -- in fact, 99% of the time -- they are self-paid patients. What Dr. Mayer felt was that these patients, for the most part, since they have limited insurance or co-pay provisions -- They know that they don't have the first and full-dollar coverage, so they are much more concerned about their consumption of resources than a patient who knows that his bill will be paid in entirety. We felt that in many of the appeal cases that we saw that the patient had sought to be as efficient as he possibly could in his utilization of services. A typical case would be a maternity patient who, in less than 24-hours after delivery, checked herself out of the hospital to save money, only then to be given the full cost per case.

It should be emphasized that Medicare, Medicaid and Blue Cross, which, for the most part, provide almost total dollar coverage, account for 75% of the admissions to New Jersey hospitals. So, in trying to control a system where one problem we felt was that the consumer doesn't have a direct role in determining the resources consumed in how much his hospital bill will be. We feel if they have total dollar coverage as is the case with 75% of the patients, you have to focus your attention on the provider as a true resource consumer, who are the physician and the hospital.

The DRG system works very well toward putting incentives for the provider because right now, if you have total dollar coverage, you don't have the incentive to be efficient in your utilization. As long as it is not going to cost you anything, there is a tendency to forget about the broad public paying an issue.

Dr. Mayer felt that these small, commercial, self-payers had a different interest, a different incentive to be careful about their resource consumption,

which was not addressed by this DRG per case amount. She wanted to explore the issue with Dr. Davis of HFCA. We have received no response to date. We felt that those patients had a similar or a dissimilar incentive to get out of the hospitals than other patients, and we thought that they should have been treated differently because they are different.

SENATOR HAGEDORN: Are you saying then that the 75% or the third-party payers have no interest in keeping the cost at a minimum?

MR. MORRIS: No, Senator, I am saying that individual patients who have third-party coverage are not as concerned as the patient who may be paying 20% to 50% of the bill himself, as opposed to the patient with third-party coverage who will be covered in entirety.

SENATOR HAGEDORN: Well, in other words, if we are concerned about cutting costs, shouldn't we be considering the 75% that pay and find out how we can also get them to maintain or have that same interest in cutting costs?

MR. MORRIS: Yes, I would agree with you, Senator.

SENATOR HAGEDORN: And what are we doing about it?

MR. MORRIS: First of all, in terms of the utilization review, we have been working with the eight existing bodies, which are made up of physicians, and this is peer review. It is intended to work with the attending physicians who admit patients to the hospital to make sure that their care is appropriate and effective and properly utilized.

We have been trying to make sure that the utilization review bodies are responsive to the needs of the payers because the payers eventually are the ones who have to pay the bill for that.

We have seen a renewed interest by certain payers, specifically, Medicaid and Blue Cross in New Jersey, to try to institute better utilization review programs.

SENATOR HAGEDORN: Okay. Who pays the difference then between the actual cost that a private payer pays and the rate that has been established by the Rate Setting Commission for a certain diagnosis?

MR. MORRIS: Your question is if the Health Care Financing Administration expresses willingness to go along with the proposal that Dr. Mayer laid out, who would pay the difference?

First of all, all patients would bill their actual charges. There are any number of commercial self-pay patients who actually have a cost in excess of the average amount. What we have tried to do is make sure that entire class of patients would balance out. In other words, you would take all patients in that category and make sure that the total amount that they paid added up to the average cost per case, if it had been applied to each and every patient.

SENATOR HAGEDORN: In that particular hospital?

MR. MORRIS: In that particular hospital, and we do it for all hospitals.

SENATOR HAGEDORN: I have nothing further, Mr. Chairman.

MR. MORRIS: Senator Codey, there is one question that Senator Hagedorn had asked of Ms. Powers that I would like to clarify.

SENATOR CODEY: Wait a second, sir.

MR. MORRIS: Okay, Senator.

SENATOR CODEY: You mentioned before about the Medicare/Medicaid waiver. That expires in 1983.

MR. MORRIS: That is correct.

SENATOR CODEY: Correct? December of 1983. What happens to the DRG system after the waiver expires?

MR. MORRIS: Of course, we are going to explore that the waiver would continue during the evaluation period. There were some attempts in the Federal Legislature to ensure that waivers such as Maryland and New Jersey would be given more permanent status. That is what will be required. The Department of Health will have to seek approval for the waiver to continue.

SENATOR HAGEDORN: Mr. Chairman?

SENATOR CODEY: Just a second. Let me continue.

In regard to the DRG, the bottom line, has it resulted in lower hospital costs or not?

MR. MORRIS: The figures that Ms. Powers was able to cite show that there have been some positive indications. The expenditure levels of a New Jersey hospital -- hospitals are lower than national. Now, this has been true for a number of years, especially when I was running the Budget Review Program in New Jersey out of the Department of Health.

I think what is more important is that we still have that differential. We are lower than the national average, when you consider that there were hospitals that were in very serious financial trouble, and for the first time, they received funds. There were many programs that the hospitals had been holding back on, and they were able to initiate. The fact that these new services were implemented -- new, in some cases, benefits to employees who were stalled for a long time.

SENATOR CODEY: So, the bottom line?

MR. MORRIS: The bottom line is there are still cost decreases, not as much as we expect the system can produce.

SENATOR CODEY: Okay. Senator Hagedorn?

SENATOR HAGEDORN: I would just like to follow up on the question that I thought was very pertinent of Senator Codey. That is the question of the DRG expiring possibly in 1983 and knowing the trend of policies in Washington. Has the Rate Setting Commission or the Department of Health set up a contingency plan if that should happen? Should they be thinking about it?

MR. MORRIS: We are thinking about it, Senator. Our foremost interest is trying to preserve the waiver. We have had ongoing discussions with the Health Care Financing Administration to ensure that the waiver will be maintained. But, that is predicated, and the Federal government assures us that as long as we are saving money and the demonstration looks successful, they will continue with the waiver.

The real important part is that we have to be saving money, so the bottom line is whether hospitals can manage to deliver quality care with less money by being more efficient during the next two years.

SENATOR CODEY: Okay. Thank you very much.

MR. MORRIS: Thank you, Senator.

SENATOR CODEY: Our next witness will be Mr. Louis Scibetta, President of the New Jersey Hospital Association.

L O U I S P. S C I B E T T A: Thank you very much, Mr. Chairman, Senator Hagedorn. I am Lou Scibetta from the New Jersey Hospital Association. With me today is Dom Camisi, Senior Vice President from the Association, whose primary expertise is in the area of financial management.

I would like to say on behalf of NJHA, we very seriously appreciate the opportunity to talk to you on this very important subject, the Chapter 83 provisions. I hope you will bear with me. I have a rather lengthy statement on an extremely complex and crucial subject.

I have been asked to note too that most of our membership has asked us to allow our testimony exclusively today to represent their statements to your committee in your interest because of the fact that otherwise you would be listening to 120 testimonies rather than about 4 or 5.

SENATOR CODEY: Just one question, Mr. Scibetta. Does your statement represent the unanimous backing of all hospitals in New Jersey?

MR. SCIBETTA: In general, our statement represents the unanimous backing of the hospitals.

SENATOR CODEY: Okay, thank you.

MR. SCIBETTA: There may be some institutions that feel more strongly on one or other points relative to it.

I'd like to point out that our comments represent years of detailed, intimate knowledge with Chapter 83 legislative changes including negotiation and development stages, the DRG system since its inception, and with the innumerable changes that have been made in this system since it began.

I personally serve as the co-chairperson, along with our Health Commissioner, Dr. Mayer, of the formal evaluation process being conducted through the Health Research and Educational Trust of New Jersey. I am confident that our professional staff at NJHA represents expertise in terms of knowledge of this system that is as knowledgeable as any parties in this State. My comments then represent these three years of the real world of DRG's in our hospitals.

When the legislature passed Chapter 83, the Board of our Association went on record supporting it. We supported it then and we continue to support it now. We believe that you have passed a good law.

To implement Chapter 83, as you know, the Department developed the DRG method of reimbursement. We supported the DRG system as an experiment and we continue to support the DRG system as an experiment.

I am here today to testify on what our Association feels are some of the promises or goals of Chapter 83 and the degree to which the DRG system has succeeded or failed in meeting these goals. That is extremely important because under Chapter 83, all of the hospitals' income available for operations is predetermined by government and approved in advance. If they are paid more, or if they charge more, they must pay a substantial interest penalty while also losing revenue. They can only be paid what their approved costs are. If they receive less than what they are approved because of a problem with the system, they have no other means of receiving money to meet these deficits since all rates that they charge to all payers are controlled by government. This includes money received from all sources and from all payers.

Also, if they are not paid according to the items required in the law, they will receive less than their approved costs. Finally, if they are not paid until months or years later, they have no way to generate income to pay their bills.

I would like to review some of the goals now of Chapter 83 as we would define them. In brief, the legislation demanded cost containment. First, I

would say that you can be assured that for over a decade now, New Jersey hospitals have operated well below the rate of increase for the rest of the country. We have incurred lower cost increases, spent less money, and both delayed and reduced our expansion requirements. I would also note paranthetically that you cannot expect this performance indefinitely, as eventually the quality of care may suffer or the deterioration of the physical plant may be in serious evidence.

Secondly, solvency of hospitals was mandated. There is no question that many inner-city hospitals, which were nearly bankrupt in 1978, are now healthier because the law requires that the system pay hospitals for services to the many indigent patients that they serve and also for the bad debts that they incur. I would caution that the DRG system may be tightening to a point now where we are coming to see similar problems in all types of hospitals in the next year or so. On a short term, at least, Chapter 83 has certainly provided relief.

Third, equalized payments for all payers have brought about a reduction in the differential among payers, as well as the sharing of costs by all payers for indigent care and bad debts.

Fourth, the system was designed to be prospective; that is, costs and rates are to be determined in advance so that payers could anticipate outlays and hospitals could plan on approved revenues. This is a major failure to date, which I will address a little bit later.

Fifth, the reimbursement methodology required in the law was to assure fairness and to guarantee for the first time that a hospital would be paid for its approved costs. This is the second major prblem which I will address further.

In summary, the above noted goals of Chapter 83 regarding cost containment and equalized payments for payers have been served well, we believe. With respect to guaranteed long-range hospital solvency, prospectivity, and the methodological fairness, these goals have yet to be realized and this presents the hospitals with some serious problems. Simultaneously, as Senator Hagedorn has suggested, we have developed many public relations problems.

Attached to our testimony is a copy of our formal comments which we have submitted to the Department of Health in response to the proposed DRG regulations, which the NJHA will entertain at the October meeting. I don't intend to review those with you in detail. They are summarized to some degree in this testimony.

As you know, the process that we have been through is that we have assimilated and documented problems and solutions for the DRG system for the past three years. In effect, this is all culminating once again in October for what will be required to do beginning in 1983. Our staff recently met with the department staff to make sure that we had no misunderstanding about our comments. This afternoon I have the privilege of meeting with Commission Mayer to review our comments in more detail and then present our testimony to the Health Care Administration Board relative to our statements. Naturally, we hope that you will enable us to keep you totally advised, and we may need to ask your assistance if the majority of what we consider to be serious problems with the system are not considered by the actions taken at the Health Care Administration Board.

Some of the serious problems -- I don't want to sound entirely negative, but I think it is important for you to know what these serious problems are. So,

I have tried to identify them as we see them:

First, prospectivity or timeliness of the system; inequitable factors built into the reimbursement formula; elements of financial reimbursement provided for in the law, but not in the regulations or in the system; and P.R. problems and finally solvency.

First the issue of prospective payment: Chapter 83, as you know, envisioned a prospective system. This was one of the main problems which Chapter 83 sought to correct and which the DRG system should. It has not. Rates of payment which hospitals can receive are not issued prior to the beginning of the rate year. You have heard testimony to substantiate that point. In fact, there are 20 to 25 hospitals that do not yet have their initial 1982 rates which are supposed to apply to services provided from January of this year.

After a hospital receives the initial rate, it appears before the Rate Setting Commission. The first hospital for 1982 did not appear before the Rate Commission until August, 1982 to have its "prospective" 1982 rates established. Once again, this is obviously a retrospective system. This makes management virtually guesswork in many instances without knowing what a hospital's approved income will be.

In addition to these delays, it is important to note that a hospital's budget is not truly finalized until after the year when, as you have discussed, the final reconcilation is supposed to take place. As we have heard today, only three hospitals had their 1980 reconcilations performed -- 23 for 1980 still have to be undertaken. For 1981, there are over 60 hospitals that haven't yet been reconciled. Almost all of these hospitals have received less in terms of revenue than what is due them. We estimate their underpayment totals approximately $50 million. The payers will eventually have to pay interest when this amount becomes due, which means a estimated $6 million to $8 million in additional interest payments.

Obviously, this system is not prospective, and the Association recommends that initial rates be submitted in accordance with a timetable, which will allow hospitals to receive a decision from the Commission prior to the beginning of each rate year. And further, that the final reconcilation be completed within at least six months following the end of that rate year. If the department cannot cope with the system within six months afterwards, then it is our recommendation that 100% of the agreed audited monies due should be approved and paid at that point.

The second issue I would like to address is the inequitable factors built into the reimbursement formula.

One such factor is what they call the Capital Facilities Allowance (CFA). Let me divert from my testimony and just go through this briefly. It does mean as a proposed change from the department approximately $12 million for the system There are two bases upon which to assure that the capital of the hospital it is building has sufficient dollars in the reserve funds. One provides them with the opportunity to receive interest and depreciation, and the other one is a formula that includes principal interest and what is called a "Capital Facilities Allowance." At the expiration of the life of the facility, either of those methods of reimbursement provide the hospital with sufficient income. However, the proposal now by the department is to eliminate the provision, the option of depreciation and

interest. For the next perhaps fifteen years, hospitalswill receive approximately $12 million less per year if that option is not available for the hospitals to utilize. That is a serious problem because as we have discussed, the Medicare waiver is an extremely important contingency to this whole system, and we don't know what the future of the Medicare waiver is. We do hope that in our discussions, we think it is extremely imperative that this provision to allow the hospitals to receive both depreciation and interest as the option to continue. It has been the case up to this point, and we see absolutely no reason to change it. Let me stress one more time that under either option, hospitals will not be paid more money, and therefore, the equity of the system suggests we maintain what is there.

To the bottom of Page 8, another matter of concern is the inflation adjustment technically called the "economic factor." This factor measures the allowable impact of inflation on hospital labor costs and supplies. Each year, a hospital's income is adjusted by this figure. The projected factor is later adjusted to the actual inflation rate and hospitals' payment rates are adjusted accordingly. About 60% of this economic factor or inflation rate is comprised of labor cost changes.

To determine labor cost changes, an index for the northeastern portion of the country is used. This index covers all private and non-farm workers. The increase in this index determines the amount of dollars approved for hospital salary increments. The labor index or proxy, as it is called, does not reflect what is happening in hospitals' markets, particularly in the case of registered nurses and other professional and technical positions. The index does not provide for increases due to merit or seniority, even though pay raises for these reasons are common. Also because of the growth and demand of registered nurses relative to the supply, the 1979 base-year salaries are really not representative of comparable 1983 salaries. Many hospitals are having great difficulty attracting professional nurses and other professional and technical people. We think this is one of the major reasons. We recommend that an additional amount be added to this index for merit, for seniority, and to allow for the fact that the index does not reflect hospital labor market conditions.

On a related subject, hospitals grant wage and salary increases based on the department's projected inflation index. At the end of the year, adjustments are then made to hospitals rates to reflect actual inflation, as I mentioned earlier. The problem is that annual pay increases can't wait until after each year is over. When adjustments by the department are retroactively applied, the hospitals' fiscal position is undermined. You can't rescind salary increases already given or already negotiated. In 1982, the actual wage component is 2% below that which was actually projected. These wages have been granted by our hospitals. And, if the actual wage component is applied to hospitals retroactively, it will mean about $30 million in lost income, which will be necessary for hospitals to pay for wage and salary commitment.

We have recommended that no retroactive change to the initial approved wage increase be made. Rather we feel it is fair for prospective adjustments to be made. By this we mean that 1982 adjustments would be made in 1984 and so forth. If a significant misprojection should arise during the year, we have recommended that the matter be brought to the Health Care Administration Board's attention by the department for action. This prospective adjustment would allow hospitals to

be paid nor more than the actual inflation factor over a period of years. If this is followed, hospitals would then not be placed in the untenable position of having to take back approved wage increases.

The third major problem I would like to address is missing financial elements in the reimbursement methodology.

The law states that hospitals will be reimbursed for, among other things, uncompensated care such as indigent care and bad debts, and interest on debt. Yet the regulations do not allow the cost of uncompensated care related to custodial patients. I would like to comment because the question -- divert for a second -- the question was raised earlier. When we speak of custodial care patients, we are talking about patients who are not nursing home patients. They are not acute care patients. They don't fall in the category of either skilled nursing care, intermediate nursing care or acute care. They are custodial patients. Somebody is responsible for their custody, and that is a very serious problem for our hospitals. These are patients, ready for discharge from the hospital, who cannot be discharged simply because they have no place to go except onto the street. Hospitals have assumed responsibility for the custodial care of these people and should be paid a reasonable amount for the associated costs for caring for them. The relevance of that, obviously, is that all costs are 100% reimbursed through the system.

The regulations also do not allow interest to be received on short-term borrowing or interest on loans to finance major movable equipment.

We believe that the regulations are in direct conflict with the law, and we recommend that the missing financial elements be incorporated into the reimbursement formula.

Another problem in implementing the system is the mandate to bill all patients at the average cost per case, probably the best known problem that exists in the system today. This average, in many instances, differs substantially from the actual costs and charges of treating individual patients. The individual patient is subject to inequities when the actual charges fall below the DRG rate.

The patient is allowed to appeal under this system. That was a stop-gap measure at the time and it continues to be, in our judgment. But, the appeal process is a time-consuming one and a costly one. For three years now, this Association has recommended the concept of billing patients based on what we call "controlled charges," and then making adjustments necessary to assure that hospitals receive neither too little nor too much revenue at final reconcilation.

We recommend that billing patients on the basis of charges rather than the DRG rate be implemented as soon as possible. I am heartened to note and happy to point out to you , as Senator Hagedorn did through the July communications, that this Health Commissioner, Dr. Mayer, has initiated this action for essentially private paying patients, requesting approval from the Federal government to go to controlled charges.

The final issue I would like to address is hospital solvency. The law requires solvency for efficiently run and effectively utilized hospitals. The Hospital Rate Setting Commission has been mindful of this when approving rates. However, there is one item that could affect the solvency of all hospitals in New Jersey, which has not been brought to their attention, and that item is the one that both of you have raised earlier. That is the Medicare Cap.

When New Jersey received a waiver from the Federal government, the Health Care Financing authorities stated that the waiver would be subject to this cap. Any excess over the cap would not be paid by either Medicare or Medicaid. To date, three years into a four-year waiver, the Department of Health has not provided any reports as to the status of the cap. We believe that this is a crucial issue which has been overlooked and which could affect the solvency of our hospitals. The former Department of Health staff negotiated this agreement with the Federal government whereby Medicare and Medicaid payments above the cap would be paid by our hospitals. Since the hospitals alone are not liable, as you well know, we feel we deserve a least a reliable update on the status of the cap.

In summary, I would like to reiterate that while we support Chapter 83 and that while we also support DRG as an experiment, the Hospital Association feels that the items that I have just enumerated and all of the items listed in our reommendations to improve Chapter 83 are significant, which must be implemented in order to improve the system, and possibly to enable us to go to a permanent system from an experimental system.

You should know that the time spent and the cooperation received from this Department of Health, and especially from Commissioner Mayer to date, has been very heartwarming. Most of today's problems are a lengthy accumulation since day one, exacerbated by historical inaction from the Department.

I should point out that, in general, this system is excessively complex for the payers, for the hospitals and the Department of Health as their managers. Few people understand the basic because of its needless, expensive complexity. Its goals are relatively sound. The philosophy, however, to average all factors and reduce payments to our hospitals could easily result in having average capabilities, average service, and, ultimately, average health among our seven million residents. Our hospitals are struggling to cooperate and perform in spite of what we think are excessive and expensive rules.

The challenge today is really whether or not the complex system can be managed. Delays of months and years in final audit and adjustments to hospitals are unacceptable. The State must act in the same responsible fashion we feel that it required from the $2 billion State-regulated hospital industry. As you know, the bottom line is the health care of our seven million New Jersey residents, the health of the 1.5 million patients who are resident in our hospitals each year, the service to our over 6 million outpatients who we serve, and frankly, the status of 100,000 people who represent the workforce of our hospitals.

Gentlemen, that concludes my formal comments. I sincerely appreciate your indulgence in this lengthy statement, and I would be very happy to try to respond to any questions that you may have that I may not have covered or those pertaining to my statement.

SENATOR CODEY: Do you have any questions, Senator Hagedorn?

SENATOR HAGEDORN: I have none.

SENATOR CODEY: Mr. Scibetta, you mentioned in your testimony about nurses. I have been told -- I don't know whether it is the result of the DRG or what the problem is, but it is very hard to have good nursing care. Say that I owed someone from what is called the "graveyard shift," from 11 P.M. to 7 A.M. -- that is you are in the hospital, "don't get sick during that time period, that

not only aren't their many doctors around, but the nursing care is not at a level that it should be." What is the problem there?

MR. SCIBETTA: I think the problem there, Senator, is similar to other problems that hospitals face, and that is, there is a certain amount of funds with which the hospitals can utilize to pay for services, to pay for salaries, to pay for wages, supplies and equipment. We are, as I mentioned -- our economic factor or our inflation rate really is the basis upon which increments can be made to pay people in hospitals. If that rate is in any way deficient, and if other sources of revenue should be forthcoming on a timely basis, and the financial elements that are to be included in the reimbursement system are not, there simply are not enough dollars to grant additional increases for services provided.

Nursing is a very serious problem in many of our hospitals. We have a great deal of competition from our neighboring states, but it is not the only problem. It is representative probably of the personnel and salary required adjustments that our industry had better be making on a regular basis, or we are going to find ourselves without the qualified people to deliver health care.

SENATOR CODEY: In other words, you feel that the Hospital Rate Setting can be a little more realistic?

MR. SCIBETTA: We would hope that both the Health Care Administration Board and the Rate Setting Commission would come to grips and agree with us -- that an increment or a merit in seniority be provided in the economic factor and the other adjustments that we have recommended in here. That would at least enable institutions to make these kinds of adjustments with funds that would be available for that.

SENATOR CODEY: So that your testimony today -- overall the DRG has been a step forward in the State of New Jersey and for the people of the State?

MR. SCIBETTA: Senator, that is a very difficult question to answer "yes" or "no" to. I believe that the system of case-mix management is one that is with us nationally, and that we are on the forefront of that direction. I believe that the system that we have in this State is probably unquestionably more complex than it needs to be. I believe that the goals of the case-mix system are admirable goals. I have no doubt in my mind that all parties are equally interested in pursuing them to the satisfaction. My concern is the inequities in the system and the ability to continue to cope with it based on its complexities.

SENATOR CODEY: Okay, thank you very much, Mr. Scibetta.

Our next witness is Monsignor Murray, member of the New Jersey Rate Setting Commission.

M O N S I G N O R H A R R O L D M U R R A Y: Senator Codey, members of the Committee, my name is Monsignor Harrold Murray, and I am Vice Chairman of the Hospital Rate Setting Commission. I appreciate the opportunity to briefly chat with you this afternoon on the Commission and the history of the past years. I have asked our Executive Secretary, Jeff Warren, to sit with me.

The DRG system has really turned hospital management in our State almost completely around. The changes hospitals have had to respond to, while difficult to undertake under this system, do have both their positive and their negative aspects.

On the positive or plus side, this system has provided hospitals with increased financial security through a reimbursement mechanism of the financial

elements allowed by the DRG system. Hospitals now receive, built into their rates, dollars for many areas not previously funded. The establishment of a capital facilities allowance has enabled hospitals to make more reliable predictions of future growth and to count on collection funds now for those future plans.

Another benefit of the financial elements has been the provision of a working cash infusion for those hospitals with a very difficult cash flow situation. In fact, this allowance has turned the accounts payable experience around in some hospitals that were in financial trouble to the extent that they can now start taking advantage of certain accounts payable discounts. Further, many of our inner-city hospitals, most in need of the working cash infusion, were probably in that position due to a large burden of uncompensated care. This problem has also been addressed by the financial elements, which now spread the costs of uncompensated care across all payers of our State. Our Chairwoman, Ms. Powers has mentioned this as has Mr. Scibetta -- that really most of the inner-city health care facilities now find themselves in a more favorable financial position, which certainly enables the hospitals and the physicians and all the health care facilities to give a continuing care to all people.

I would like to mention the benefits to hospitals which result from the new prospective in management informations systems provided by this DRG system. Hospital administrators now have, almost at their fingertips, a system which allows them to trace an inefficiency to its source, be it a specific department, supply-oriented, or ancillary service usage. Standards have been established which allow comparison and performance measurement that should lead to greater efficiencies. Hospital planning, staffing, and budgeting are made easier through analysis of patient mix and the ability to more accurately forecast future revenues. Hospital administrators and physicians can work together with information that compares the way a specific physician or hospital may treat a particular case to the costs and treatments across the State for similar situations and patients. The financial impact of clinical decisions is illustrated in such a way that physicials can take an active role in restraining increases in unnecessary costs.

But all this has not been heaven or purgatory. Some would say that it has been "a little bit of hell on earth." Nevertheless, I do not want to imply that all the industry's problems have been solved. There are some legitimate concerns with this system that can, I believe, be rectified.

There are tremendous demands on hospitals in terms of data requirements and the complexity of the regulations which have been referred to on a number of occasions this morning. We realize that the payers also have their problems. We realize the hospitals have necessities, and occasionally, they apply to us for relief. The Hospital Rate Setting Commission has endeavored to do this, to give them a willing ear, especially in one case.

So, the demands are there on the Rate Setting Commission, on the hospitals, and on the payers. And the system also has a long way to go before it can be truly called prospective. I expect that over time, the system will be able to respond to various hospital and health care concerns with the end result being an improved system of health care for the citizens of our State.

I would just like to end my testimony today by acknowledging the superb leadership -- an objective leadership -- that Ms. Powers has given our Commission,

as well as the magnificent staff backup of Jeffrey Warren, our Executive Secretary, and Pamela Dixon, our analyst. I am pleased to be part of the development of the system. Thank you.

SENATOR CODEY: Thank you, Monsignor. Senator Hagedorn?

SENATOR HAGEDORN: I have nothing.

SENATOR CODEY: Monsignor, do you work in the industry itself?

MONSIGNOR MURRAY: Pardon?

SENATOR CODEY: Do you work --

MONSIGNOR MURRAY: In a variety of capacities, yes. I am on a few Boards, I am in health related activities, and I also visit the patients. So, I am in a rather unique situation where I hear the gripes sometimes that the Senator has referred to.

SENATOR CODEY: Where are the hospitals that you work with located?

MONSIGNOR MURRAY: One was in Elizabeth and one was in Summit, New Jersey. They are non-Catholic facilities, I might add.

SENATOR CODEY: It doesn't matter. But, overall do they seem to be satisfied with the system?

MONSIGNOR MURRAY: Yes. Some hospital administrators whom I have talked with, especially from the inner-cities, are pleased with the system. They find themselves in a situation where now they can meet their fiscal obligations to their payers, their employees, and the bottom line is, they would really like to give quality care. Now they feel they can do this.

SENATOR CODEY: Thank you very much, Monsignor.

SENATOR HAGEDORN: Can I just ask one question?

SENATOR CODEY: Sure, Senator.

SENATOR HAGEDORN: Monsignor, do you share the concerns that were expressed by the New Jersey Hospital Association with respect to the system as it is presently operating?

MONSIGNOR MURRAY: As a Commission member, I try to relate to the hospitals of the State. I do informally talk with the hospital officials, but I have not reviewed their testimony before this morning. I try to keep an objectivity as a Commission member. It is fair to say that just before this system went in, I was not a great supporter. I saw the value of a reimbursement system, which would address the needs of the inner-city hospitals, the consumers and also the payers. This is like looking for Utopia, as you well know. How do you solve these tremendous problems?

I was asked to serve, and I consulted a number of people. I said, "Well, fine, let's try it and see if we can do it." So, I am pleased and my last remark was that I do have some concerns. I do think we can get boggled down in computer printouts and analyses of all sorts. I think we can have the complexity of regulations that I don't know where it is going to end. If you don't keep up with these regulations everyday, you can miss something. I plead with the Legislature , if possible, that we can simplify these regulations so that we can all understand them -- including the Commission.

SENATOR CODEY: Okay, thank you very much, Monsignor.

Our next witness is Herman Hanssler, Assistant Commission of the Department of Insurance.

H E R M A N H A N S S L E R: Thank you, Senator. Good afternoon, Senator

Hagedorn, Eleanor. I am here representing Commissioner Joseph F. Murphy who was unable to attend. He is in Tennessee attending an NIIC convention. If it hadn't been for that, he would have been here. So, I will read a statement that was prepared for him with your indulgence.

I have had the privilege of sitting in for the Insurance Commissioner on the Hospital Rate Setting Commission and the Health Care Administration Board virtually since the inception of the operational phase of the program. It has been a great experience for me as an individual, and I appreciated working with the members on both committees, who I feel have done an outstanding job. I also would like to pay my respects to the staff of the Department of Health for the many hours they have put into the system trying to make it work for the benefit of the public of New Jersey. Without any further ado, I will read the statement for the Commissioner.

As Commissioner of Insurance, I have taken an interest in the way that the captioned legislation is being implemented for a number of reasons, including my direct involvement on the Health Care Administration Board (HCAB), Hospital Rate Setting Commission (HRSC), and the Health Care Facilities Financial Authority (HCFFA) as an ex officio member. I am not only concerned that Health insurance remain available to policyholders of this State and that equity exist among authorized insurers and other third-party payors in the implementation of the Health Care Facilities Planning Act (HCFPA), but I am equally concerned that the system bring about a containment of health care costs.

It pleases me to say that the Hospital Rate Setting Commission has gone a long way in promoting equity among insurance carriers in the treatment, they are accorded as payers. The statutory requirement that "All payment rates shall be equitable for each payer of class of payers without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole" has substantially reduced unjustified cost shifting among the insurance carriers.

As to the availability of health insurance in New Jersey, at the current time Blue Cross and Blue Shield take care of the residual health insurance market through their Open Enrollment programs. The residual market is composed of those individuals and family units that are unable to obtain health insurance elsewhere. Much of the Blue Cross Open Enrollment program is subsidized internally through surcharges on group accounts and the absorption of excess losses through the company's overall financial structure.

When these losses can no longer be borne by Blue Cross's group accounts, it is incumbent upon me as the Commissioner of Insurance to approve rate increases on individual policies. These increases may be such that the coverage will become less affordable or unaffordable to the residents of this State. By making Blue Cross's Open Enrollment policies less affordable, we drift from one of the goals of the HCFPA. More specifically, it is my concern that the policies offered by Blue Cross under its Open Enrollment program not be priced so high as to impair the program's effectiveness. Every person who requires hospital treatment and is and is not able to pay the Diagnosis Related Group (DRG) per case rate because of the lack of insurance or other resources represents increased indigency costs which much now be spread among all payers. It would seem to me that it is better to make insurance affordable for as many people as possible than to force them to become

medically indigent. It is important to the people of this State that there always be a viable market for health insurance. By encouraging insurers to assume this responsibility through a fair payer differential, we equitably distribute the cost of providing a residual health insurance mechanism to all payers.

One of the weak areas of the DRG reimbursement method involves the manner in which services are contracted out and, thereby, elude hospital rate regulations. Services such as radiology, anesthesiology and other anciallary services are "unbundled" to groups of physicians who then bill the patient directly. This practice, if not properly controlled, constitutes a circumvention of the HCFPA, and should be studied tor the purpose of introduc ing legislation to bring these arrangements under the control the the HRSC in order to effectively control hospital costs and rates.

During my short term in office, my theme as Commissioner of Insurance has been cost containment commensurate with the provision of quality health care services. Unregulated hospital rates and costs for medical services not only impact on health insurance, but on automobile and workers' compensation insurance as well. Efforts to "...contain the rising costs of health care services...." as expressed in the statute should have a salutary effect on premiums charged the insuring public in New Jersey. In requiring hospitals to maintain a uniform system of cost accounting, the current law offers hope that the goal of hospital cost containment can be reached without sacrificing quality of care. I whole-heartedly support your efforts and those of the Legislature to contain the costs of health care services in New Jersey. Signed by Commissioner Joseph F. Murphy.

SENATOR CODEY: Thank you very much, Commissioner.

Our next witness is John Kopicki, Vice President of the Elizabeth General Medical Center.

J O H N K O P E C K I: Chairman Codey, Senator Hagedorn, I appreciate the opportunity to be heard today.

I begin my testimony by stating that our institution supported the passage of Chapter 83, PL 1978. We were encouraged by the fact that the new law provided that hospitals would receive all the financial elements of cost necessary to operate, including the cost of uncompensated care.

The major problem we have experienced with the new system has been one of timeliness of rate implementation. We were one of 40 hospitals mandated by the Commissioner of Health to enter the DRG system effective January 1, 1981. However, the Department did not issue our DRG rates until May 1st. Consequently, in 1981, we had to cope with two reimbursement systems: the former "Share" system, from January through April 30, 1981, and the DRG system from May 1, 1981 through the balance of the year -- although the final reconcilation of our approved revenue for 1981 would be based on the DRG system for the entire year.

The difficulty we encountered immediately was that the "share" per diem rate issued by the Department of Health was too low and did not cover our costs. As a result, at the end of the first quarter of 1981, we were in an under-collection position and experiencing cash flow problems.

Effective May 1, 1981, we began billing under the new DRG rates approved by the Department of Health. Due to the complexity of the DRG system, we engaged Peat, Marwick, Mitchell & Company, our auditors, to orient hospital staff to the new regulations. I am proud to say that our staff did an outstanding job in this regard, although it required extraordinary effort.

Under DRG regulations, we were afforded the opportunity to appeal for approval of expenses which were not included in the rates issued by the Department of Health. We did so, and in accordance with the appeal process timetable, a desk review was held by the Department of Health on July 24, 1981. By now, half the year had gone by and the dollars in our appeal had not yet been approved nor included in our rates.

The culmination of the appeal process was the hearing before the Rate Setting Commission of the Department of Health, which took place October 30, 1981. At that hearing,the Rate Setting Commission approved an increase in our 1981 revenue budget. This increase was made effective through new rates authorized by the Department of Health on December 1,1981. We were now eleven months into the year. We received little benefit of the December 1st increase until January, 1982, since there is a lag between the time an increase in rates is effective and the cash is received.

The long, drawn out rate determination process in 1981 was not prospective, and it impaired management's ability to manage effectively. Accounts with our vendors were stretched out excessively. We appreciate our vendors' patience.. We borrowed heavily on our line of credit to meet current obligations, the interest on which, by the way, is not reimbursable under the DRG system.

When we completed out internal reconcilation of our 1981 experience, the extreme seriousness of our cash flow problem was apparent. The reconcilation showed we had under-collected the revenue due us by $4,200,000. The reconciliation prepared by hospital staff was confirmed by our auditor. Based on this evidence, we urgently appealed to the Department of Health for relief. They responded promptly and on June 20, 1982, the Rate Setting Commission authorized an adjustment in the amount of $2 million to flow through our rates commencing July 15th. We appreciate the Department's response to our need. However, this is only a partial adjustment in the amount due us for our services in 1981.

We urgently need an additional adjustment to our rates to offset the remainder of the 1981 under-collection due us. We understand that under the regulations, the Department of Health does not initiate adjustments until it completes its own reconcilation. We are concerned whether the Department of Health can accomplish this reconcilation before the end of 1981. We understand that the final reconciliations for many hospitals in the system since 1980 have not yet been completed. We need the $2.2 million remaining due for services to our patients in 1981 so that we can meet our past obligations. Therefore, we recommend that the Department of Health make a further interim adjustment to improve our cash flow and complete our 1981 reconcilation as soon as possible.

In 1982, timeliness of rate implementation continues to be a problem. We submitted all our required reports to the Department of Health in a timely way. Yet, it will not be until September 22nd that we will appear before the Rate Setting Commission to appeal for needed adjustments to our 1982 rates.

We are a busy hospital. We provide all the major services of a general hospital, and many specialty services not available at other hospitals in our area. We provide the largest share of indigent care in eastern Union County.

We are an efficient hospital. This is evidenced by the fact that the Department of Health awarded us incentives for efficiency under the DRG system both in 1981 and in 1982. Yet, the timetable of rate implementation has placed

us in the position of always awaiting future adjustment in order to meet past and current obligations. This is not fair to us or those who depend upon us.

In the words of the enabling legislation, "It is ... the public policy of the State that hospital services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health."

We are looking to the State to assist us in supporting our high quality, efficiently provided, needed services by enabling us to earn the revenue due us under the system in a timely way.

Our second problem with the system has to do with establishing rates for new services.

Currently, the certificate of need and the Rate Setting activities within the Department of Health are completely separate. Should a hospital receive a certificate of need, it is often not possible at that time to determine whether or not and what level of reimbursement will be approved for that service through the Rate Setting system. Thus, reimbursement for needed, yet costly, new services in unknown until the DRG rate hearing process is completed, which can be months after the service is started.

Elizabeth General and its patients have experienced this situation in the vital area of CT scanning. We anticipate a similar problem in our effort to establish, with the support of the Department of Human Services, a Tri-County Consolidated Inpatient Pediatric Psychiatry program for Essex, Union and Hudson counties. We are fairly confident of receiving a certificate of need. However, in order to operate this intensive program, we must ask that the Rate Setting system work with us to establish in advance, suitable rates for our services.

We contend that the certificate of need and Rate Setting processes should be coordinated so it is possible for hospitals to manage effectively the development of new health care services.

Thank you.

SENATOR CODEY: Do you have any questions, Senator? (no response) Thank you very much, Mr. Kopicki.

Our next witness is Mr. Donald Payne, member of the Hospital Rate Setting Commission.

D O N A L D P A Y N E: Unfortunately, I was hospitalized in New York State, so I can't testify --

SENATOR CODEY: You weren't under the benefit of the DRG.

MR. PAYNE: That's right, but to Chairman Codey, Senator Hagedorn, Committee Aide, other health and hospital-interested persons here, my name is Donald Payne and I am happy to be here today as a member of the Hospital Rate Setting Commission.

The DRG system that you are evaluating today must be considered in the framework of the economic climate affecting all of us. In that respect, the system responds to a condition which can only be exacerbated by our economic woes -- inadequate provision of health care services to the medically indigent.

In the not too distant past, New Jersey's hospitals were placed in an extremely difficult position by the health care needs of this group. Obviously, hospitals cannot deny service to those without adequate financial resources. Hospitals are morally, ethically, and legally obligated to serve all those in

need, regardless of economic status.

In providing this service, however, hospitals experience a revenue shortfall that must be made up with other funds. The two traditional sources of funds have been philanthropy and increases to those patients covered by commercial insurance.

This traditional system can work, but only in hospitals where the number of medically indigent patients is small relative to the number of commercially insured patients. It helps, too, if the surrounding community makes generous donations to the hospital.

In other words, the traditional system breaks down in the very situation where care is needed most - the poor, inner-city neighborhoods where medical need is high, commercial insurance is rare, and excess funds for charity simply do not exist.

Within this setting, the hospital may struggle to maintain both solvency and progressive methods of care. Quality or variety of services may be limited by large proportions of uncompensated care in a hospital's revenue base. In 1979, for example, some of our largest hospitals serving inner-city populations were operating in the red. Newark Beth Israel Medical Center, which is several blocks from my home, lost over $2 million from operations, as did Saint Michael's Medical Center, which, as you know, serves a great number of medically indigent persons in the City of Newark. Indeed, such losses were widespread and inevitable among urban hospitals serving the medically indigent, and are certainly not unique to New Jersey's institutions.

What is unique to New Jersey, however, is the establishment of a progressive and equitable solution to the problem of uncompensated care, as part of Public Law 1978, Chapter 83. Briefly, this solution recognizes that the burden of uncompensated care should not fall on the hospital, nor on a single type of payer. Rather, the care of the medically indigent is being treated in a more equitable fashion by being shared by all payers.

This solution has had the intended effect of promoting financial solvency among inner-city hospitals. For example, both Newark Beth Israel and Saint Michael's are now operating with revenues sufficient to meet their expenses, as are most other hospitals which provide care that was largely heretofore uncompensated.

It is obvious that this provision of the law is a great asset to the financial viability of New Jersey hospitals.

However, hospitals cannot remain immune from the effects of the current economic climate. Basic solvency requirements are assured for efficient hospitals under this system. The opposite side of the coin is that this system will not be effective at containing costs unless hospitals learn to live within the constraints imposed by recent unfavorable economic conditions, as the private and governmental sectors have been forced to cut. Thus, the Commission must look carefully at hospital requests for new funds. New programs should only be developed and approved within reasonable budgetary limitations. In this way, we can assure that this system meets the goals of Chapter 83 of cost containment, as well as the assurance of access to quality care for all New Jersey citizens.

Thank you.

SENATOR CODEY: Commissioner, you would say then that the inner-city

hospitals themselves are satisfied with the new system?

MR. PAYNE: Yes, I think that without this new legislation, we would have the kinds of problems that we have seen through the last two decades with the infrastructure in inner-city areas. I think that this new system, although you have certainly heard of some of the problems of retrospective rather than prospective and some of the other wrinkles in the system -- I think by and large, for looking at New Jersey as a totality, and the health of the State, if one part is very unhealthy, then the whole State is unhealthy, and eventually someone is going to pick up the cost in some way or another. So, I strongly feel that it has helped the inner-city hospitals. I do feel it is equitable, and I think it is a system that should remain in place. We all recognize there are some shortcomings.

SENATOR CODEY: Thank you very much, Commissioner.

Our next witness is Dr. Howard Slabodien, President of the New Jersey Medical Society.

D O C T O R H O W A R D S L O B O D I E N: Good afternoon. I shall be brief, and I hope that you will not consider me too pejorative .

I am Howard Slobodien and I am President of the Medical Society of New Jersey.

In a few weeks I shall be privileged to appear on New Jersey television on the subject, "Quackery." In organizing my thoughts on that topic, I tried to identify the common denominator present in all forms of quackery. And there it was -- the avoidance by the promoters of allowing the products or methods to be subjected to scientific analysis by impartial investigators.

And then I began to consider what I might say to this distinguished Assembly.

Now, I am not suggesting that those who oppose a critical evaluation of DRG are quacks. They may be merely well-intentioned, but misled. But I do feel that they are acting neither in the best interest of the citizens of this State, nor in the tried and true traditions of the scientist.

As a practicing surgeon, I had great hopes for DRG. After all, I have been reimbursed along DRG lines since entering private practice. My charge to the patient in the vast majority of cases includes the fee for both the operation and for the total hospital care, regardless of the variation of the number of days involved. And this method has worked well through the years. So, I looked forward to the DRG experiment when it was first proposed.

But now I have great reservations about its applicability in paying hospital costs or charges. I am far from convinced that there has been a saving in cost to the State. And I am particularly concerned that the quality of care may be deteriorating, that patients are being forced out of the hospital setting still hurting, still in trouble, and still in need of acute care, merely because the system rewards those institutions with rapid turnover of patients.

The DRG program has been criticized adversely in outstanding publications by extremely well-qualified individuals located in areas stretching from the Atlantic to the Pacific. And this criticism covers many areas in the application of the program. It should be noted that among these criticisms is the fact that the medical profession has been invited only minimally or marginally to participate in the program.

Yet, the only rebuttal to these critics, as far as I know, has come from those responsible for initiating or expanding the DRG concept in New Jersey. And these individuals who have MD's, PhD's and MPH's, etc. among their scientific accomplishments continue to oppose the application of scientific inquiry despite their backgrounds in the scientific method and despite their avowal at the onset of DRG, that it was to be a so-called "pilot program" involving approximately two dozen hospitals. To make matters worse, and you have heard this in previous testimony, the Congress of the United States is being proselytized most actively to approve DRG for Federal programs, despite the lack of proof of its merits.

The medical profession has been given a bum rap - that it is primarily responsible for much of the rise in health care costs, despite the fact that physicians do not receive even one cent of every five spent on health care. If for no other reason, and there are many others, doctors should be interested in containing these costs, and we are. We shall continue our efforts both to control costs and to assure the maintenance of quality care under whatever reimbursement mechanism you may choose.

I don't know whether DRG has been good for New Jersey either in whole or in part. But no one else does either. If it has merit, let us utilize its positive aspects as effectively as possible. If it is garbage and we continue its expansion, there won't be enough landfills in the country to contain it. Isn't it about time we found out the truth? That is why we urge support of a legislative resolution to conduct a thorough and long overdue evaluation.

Thank you very much for listening. I will be glad to answer any questions I can.

SENATOR CODEY: Doctor, what has DRG done for physicians financially? Has it hurt?

DR. SLOBODIEN: DRG has done nothing for physicians one way or the other.

SENATOR CODEY: Financially I mean.

DR. SLOBODIEN: Financially. We have no financial stake in it at present.

SENATOR CODEY: In other words, playing the "devil's advocate," if someone is released -- people are released, patients are released earlier than they had previously -- would it be harder to bill a patient more because you are not going in in the morning to visit him since he is now at home?

DR. SLOBODIEN: Theoretically, there could be some consideration in a non-operating medical practicioner. Certainly, not from my point of view, where everything is an all-inclusive package. Part of the problem here relates more to, at least as far as I am concerned -- if an individual is being hit with unauthorized days because of pressure upon the system, that the patient may be the one to pay extra.

SENATOR CODEY: Okay, thank you very much, Doctor.

SENATOR HAGEDORN: I have a question.

SENATOR CODEY: Sure, Senator.

SENATOR HAGEDORN: Doctor, I observe that you are the President of the New Jersey Medical Society, and we can assume that the sentiments that you have expressed here today reflect the sentiments pretty much of the Medical Society?

DR. SLOBODIEN: Yes, indeed.

SENATOR HAGEDORN: Are you aware also of one of the problems that I feel

we have, and that is the long period of time that it is going to take to determine whether or not this is an effective system? I think it is projected for about five years. Should we wait that long in order to determine if it is effective and what affect will it have on the quality of care?

DR. SLOBODIEN: I think the evaluation in process is long overdue. It should have been done a long time before. As you are aware, and I have heard it this morning and early this afternoon, they don't even have the evaluation on the original hospitals in the program. In the age of computers, I find this somewhat difficult to understand.

SENATOR HAGEDORN: Thank you.

SENATOR CODEY: Thank you very much, Senator.

Our next witness is Liz Wilson from the Speech and Hearing Association.

L I Z W I L S O N: Senator Hagedorn, Senator Codey, thank you very much for inviting us here this afternoon.

As a member of the New Jersey Speech, Language and Hearing Association and Chair of the Committee for Directors of Speech and Audiology Clinics in Hospitals and Independent settings, I do welcome the opportunity to appear before this Committee.

Two issues are of primary concern to our profession: (1) Have the DRG's succeeded in reducing or containing health care costs? (2) Has the DRG system helped to improve the quality of health care services?

While some hospital clinics report fees have been reduced initially, most clinic directors stated that fees for services have risen, sometimes dramatically. There are reports of broad fluctuations of fees on a month-to-month basis. Our information indicates that this phenomenon may be occurring at least in part because of a system for department grouping. Speech pathology and audiology services are grouped with a variety of services for billing such as occupational therapy, recreational therapy, physical therapy and even shock treatment. These groupings vary from hospital to hospital. In many cases, total revenue in relationship to total cost of the department group is such that speech and hearing fees must be lowered or raised to account for the revenue produced or not produced by other departments in that group. There seems to be no opportunity for fees to reflect the actual cost of the speech or hearing services because of the grouping procedure which obscures true charge/cost relationships.

One obvious disadvantage is that where fees have risen, often disproportionately to either the service provided or to the population served, the inflation costs must be passed on to the private outpatient consumer.

We also question the manner in which a target DRG reimburses two hospitals for a service when, in fact, only one hospital may have provided that service. For example, the reimbursement for care of a stroke patient would be the same for two hospitals within a peer group, yet only one of those hospitals may have provided speech therapy services to the stroke patient. Thus, the DRG rate is too high for the hospital not providing speech therapy services. As a consequence, there seems to be little incentive for that hospital currently without the service to develop the capability for comprehensive quality patient care.

Reportedly, the DRG rates are based upon historical cost figures with a built-in inflationary factor. This assumes a status quo in terms of program size, space, staff, equipment and need for services. Such an assumption, we feel,

discourages program growth and development an utilization of recent technology, which, in turn, negatively impacts upon quality of our patient care.

The nature and scope of the population which the Speech-Language Pathologist and Audiologist serve has expanded in complexity over the last decade. To expect a status quo in the nature and scope of our potential case load is not realistic. There is a high level of expertise now required in the treatment of the laryngectomized patient, the gerontology patient or the high-risk infant, to cite a few examples. We are concerned that while the DRG system is supposed to be a prospective system, it functions, in fact, as a retrospective system.

We are concerned that the system designed for cost containment of health care will, in fact, result in elimination of services vital to the rehabilitation of our patients. In our experience, DRG has not successfully resulted in cost containment of speech and hearing services, but has resulted in fluctuation or even soaring fees for our services.

Thank you very much.

SENATOR CODEY: Thank you very much, Ms. Wilson.

We are now going to recess, and we are going to convene in exactly one hour.

L U N C H R E C E S S

SENATOR CODEY: We would like to re-convene, please.

Our first witness this afternoon will be Mr. Richard Mellman, Vice President in Actuary, Prudential Insurance.

SENATOR CODEY: May I please have quiet?

R I C H A R D J. M E L L M A N: Good afternoon, Senator. As you know, Prudential has taken a close interest in the development and implementation of both Chapter 83, the State Rate Setting law, and also the operation of the DRG program. As a matter of fact, Joe Frankel and I attended all the mark-up sessions of this Committee five years, which produced the law that established this innovative program.

In the interest of brevity, I would like to cover some of the points in my prepared statement and turn the entire statement in because many of them have been covered this morning.

The most important point we would like to leave with the Committee is we ask you to recognize that the DRG system, while admittedly not perfect, is a good system and good for the public. Both the Federal and the State governments and the American people are concerned about the steeply rising cost of hospital care. New Jersey's DRG program is an innovative program that shows promise of providing many of the answers. We see the positive features of this system as far outweighing any of the problems encountered thus far. Many of the start-up problems that we saw in 1980 have already been corrected by 1982.

If we could just back off for a minute and discuss the environment that produced this law. First of all, hospital care is extremely expensive. Last year in the United States, the cost of hospital care went up by approximately 19%, and today American people are spending somewhere between $400 and $500 per capita on hospital care. So, there is a great concern on the part of both the Federal and the State governments and the public about this. It is generally felt that the reason that hospital costs have inflated so rapidly is not only due to the great

advances that have been made in medical care, all the new technologies that we didn't even know about years ago, like open heart surgery and kidney dialysis, and so forth -- but basically, we don't have a strong market system in which the buyer shops from the cellar. People have insurance, medical care is complicated, and people do not know how to shop for doctors or hospitals, nor do they know how to question whether it is worthwhile, etc. We have a system in effect in most of the states in the country underwhich the incentives are reversed. It is essentially retrospective cost, plus reimbursement -- the more the hospital does for you, the longer they keep you, the bigger the bill is, and the patient is protected by insurance and cannot ask questions.

In New Jersey we have a program that reverses these incentives. It is prospective and it is based on case-mix rather than itemized cost, plus, and it encourages the hospital and the physician to be more cost-aware in their treatment, to do testing on a pre-admission basis, not to prolong care, etc.

We are confident, although there is an absence of hard figures as has been mentioned this morning -- We are confident that when those hard figures start coming in, that the system will prove itself to be cost effective.

The second point I would like to mention is the implications of the cost-shift, and the importance of the waiver. Last year in the United States, the Federal government underpaid on the treatment of Medicare patients by approximately $5 billion. This year that number is, no doubt, $6 billion or $7 billion. Congress last week put through a budget and tax act which will make that number $8 billion for next year, and the Reagan administration is talking about saving another $30 billion during the next three years.

Those savings are savings to the Federal budget. Unless hospitals and doctors stop providing care to sick, elderly people, these costs are still going to be incurred. They are going to be passed through to the private sector patient, which in about half the states, means all the private sector patients. And then in the other half of the states, it means just those who don't have Blue Cross coverage, as was the situation in New Jersey prior to the passage of this law.

In New Jersey we have the waiver, and we also have a waiver in Maryland as has been mentioned. Last week a waiver came through for Massachusetts, and currently New York is applying for a waiver. So, the citizens of New Jersey escape, so long as this waiver is in effect -- escape the hidden taxation that results when those costs are passed to the private sector. We estimate that in states without waivers, that our premiums are running approximately 25% higher than they would otherwise run because of the hidden taxation that is imposed to make up for the Medicare shortfall.

We see that the DRG program is providing the following benefits in New Jersey: First, by paying hospitals on a pre-admission basis, the system alters the incentives. Secondly, the DRG represents a significant improvement over other management tools in terms of defining hospital resources. We think it gives hospital administrators and hospital full-time medical staff a powerful management tool in monitoring the patterns of attending physician treatment. Thirdly, as has been mentioned this morning, the program has restored the solvency of our inner-city hospitals. And, finally, by providing for equity of charges to all payers, we now have more meaningful competition between Blue Cross, commercial insurance, and employer self-insured plans. So that the public, employers and individuals,

now have a choice which they didn't have before in deciding how they shall protect themselves against these costs.

In considering the merits of the program, I believe it is important to consider four questions:

1. Is it good for the public? There are indications that the public really has an incomplete understanding of the program. We have heard this morning from the providers, but we haven't heard from many citizens yet. To the extent that it offers a slowdown in some of these inflationary forces, that is good.

2. Is it a system that is fair to the hospitals and a system with which hospitals can live? I think it would be too much on your part to hope that hospitals will all like the program. I don't think it is really necessary that every hospital like the program as long as the system is essentially fair, one with which the hospitals can live and one which assures continuance of high quality treatment to the patients.

3. Is the system administrable? I believe the system meets this test also. We have learned how to administer our part of the program, and I think the hospitals and the State have also.

4. Is the system fair? I believe the answer to this questions is also basically "yes."

My prepared statement goes into a number of complaints that have been made against the system, and in the interest of time, I would like to mention just one of them, and that is: The complaint is sometimes made that the system is too complicated. I believe that is a certain amount of "sour grapes." I think we live in a computer age. Hospitals know how to implant atomic powered pacemakers in patients, and I think by comparison, to charge those patients by the diagnosis or by admission instead of itemizing the number of pills and tests and minutes spent in the operating room is not an insurmountable task.

It is true that there are implementation problems in connection with this program. We have certainly experienced some of them, and we are well aware that they exist. We think that they are problems that lend themselves to fine-tuning the system and improving it rather than questioning the ethicacy of the system. As the Department of Health completes the three-year phase into the program this year with all hospitals on line, we hope that some of these time delays that have been mentioned this morning can be reduced and the system made proper.

We do believe, however, that for these problems to be handled better and improved, that it is essential that the Department of Health be adequately staffed with competent technicians. To the extent that this Committee has jurisdiction over the budget of the Department of Health, we urge that the budget be made adequate to fill a number of the key jobs that have been vacant for the last year. This year, New Jersey's hospitals will incur expenses and receive revenues in the neighborhood of approximately $3 billion, which is approximately $400 per person in the State of New Jersey.

What we are talking about in connection with these vacant jobs in the Department of Health, I think, is probably on the order of -- I don't really know, but I would guess it is on the order of perhaps $250 thousand a year in salaries. So, we are talking about less than 100 of 1% in terms of the hospital cost, an extremely small fraction of 1% and a very modest price to pay for a cost effective system in the State of New Jersey.

In summary, we urge the Committee to take a judicious view of any problems that may have been brought to your attention, remembering that any major change in a system as complex as the health care system is bound to cause ripples to begin with. The Department of Health is well into the cleanup phase in which they are debugging and fine-tuning the system. We strongly urge you to consider the benefits of this system in terms of lowering costs, improving hospital efficiency and keeping inner-city hospitals solvent. If there is any question whether this system is a model for the rest of the country, I would point to the comments that have been made this morning that Secretary of Health and Human Services, Richard Schweiker, has instructed his department to start developing a nationwide system, which is based on the New Jersey system.

Thank you.

SENATOR CODEY: Are there any questions, Senator? (no response)

Mr. Mellman, in regard to the system, you mentioned that it made you more competitive. I'm assuming that you are relating to the discount that Blue Cross/Blue Shield had.

MR. MELLMAN: Yes, sir.

SENATOR CODEY: Roughly, what was that discount percentage-wise?

MR. MELLMAN: We estimate that prior to the establishment of the program, that Blue Cross statewide was paying approximately 70% of what was being charged to people who were being billed on the charges basis. Of course, that varies from hospital to hospital. As Donald Payne brought out this morning, an inner-city hospital which has relatively few charges patients and many medically indigent, there would be a larger percentage there. It would be smaller out in the suburbs. Typically it ran perhaps as much as $100 per day per patient.

SENATOR CODEY: Up until then, you were really unable to compete realistically in the field. I mean, it would seem hard to compete with.

MR. MELLMAN: To any question, there is usually a simple answer, which is generally right. I would say, in general, we were non-competitive. It was possible for a good underwriter to kind of "pick his shots." For example, Blue Cross, at that time, on groups of less than 100 lives, had community rating, and so it was possible for an insurance company to look around for young groups or groups located in low-cost areas or something like that. But, in general, we were not competitive.

SENATOR CODEY: Okay. Thank you very much.

SENATOR HAGEDORN: I have some questions.

SENATOR CODEY: Sure, Senator.

SENATOR HAGEDORN: Are Prudential rates controlled by the Department of Insurance?

MR. MELLMAN: We file our rates for approval with the Department of Insurance. The system is not identical with the procedure that applies to Blue Cross. For example, there is no public hearing required, but we do inform the State of our rates, and they have the right to disapprove.

SENATOR HAGEDORN: They do have the right? They have the right to disapprove?

MR. MELLMAN: Yes, sir.

SENATOR CODEY: Thank you very much, Mr. Mellman.

Our next witness is Mr. David Trespacz, Associate Chief Underwriter Analyst with Travelers Insurance?

D A V I D T R E S P A C Z: Thank you, Senator Codey. My name is David Trespacz, and I am here from Hartford, Connecticut, representing the Travelers Insurance Companies.

We insure many large employers with employees utilizing hospitals in New Jersey. During 1981, our insured accounted for approximately 12,000 admissions to New Jersey hospitals.

I would like to make a brief statement concerning our experiences with the DRG program. We have been involved with the DRG system since its installation in January of 1980. As with any new program, we had some administrative problems encountered by our claim payment locations handling New Jersey hospital claims. Examples of some of these were questionable assignment of the DRG codes, patients who were billed for the prompt payment discounts taken by the insurer, and frequent changes by the hospitals in their allowances for capital needs and payer factors, which hampered our ability to monitor the assignment of the DRG price per case. However, as the system gained in time, we feel that most of these problems have been resolved as the hospitals became more familiar with the DRG system.

During 1980, with twenty-six hospitals participating in the system, we calculated that our dollar savings in those hospitals amounted to about 12% to 15% over what we had been paying. This savings was due, in part, to the establishment of payer equality under the system, as Mr. Mellman just referred to.

Because the hospitals phased and approached the DRG system, it has been difficult to determine the precise effect of the DRG system on Taveler's policyholders since 1980. In order to measure the cost savings, a comparison should be made between claims experience before and after implementation of the DRG system, or between the DRG and non-DRG hospitals.

As a major insurer, the Travelers has a commitment to cost containment efforts. Since hospital expense is the largest portion of the insured plan, we support the DRG method of containing hospital costs. The system encourages the hospitals to search for more efficient ways to provide care, and the system has introduced competition to the hospital industry by providing incentives to control for unnecessarily long stays and encouraging shifts to ambulatory or outpatient care.

These steps, we believe, can also help to improve the financial well-being of the hospitals. The system also encourages hospitals to enlist the aid of the attending physician to control the use of hospital resources to contain costs while maintaining quality care. Thus, the system could eventually improve the financial well-being of the hospitals while also helping to control the costs for our insurance.

The use of a complete and accurate medical record has become essential for the proper assignment of the DRG code. Assignment of questionable DRG's or DRG's which maximized reimbursement did exist under the initial DRG coding system. However, steps have been taken to correct these practices under the new DRG system, which became effective in June. In addition, the need for a complete and accurate medical record has resulted in the establishment of the uniform bill required in all hospitals as of January, 1982. This uniform bill has assured our claim processors that all the necessary information is available to promptly process claims.

In conclusion, the hospitals and the Department of Health, we feel, should

begin to undertake stronger efforts to educate their respective communities about the DRG system. The stories which have made the headlines in the past involved primarily the bad experiences with the system, but in today's atmosphere of spiraling health care cost inflation, it is imperative that future efforts be aimed at promoting the DRG system as a method of cost control that works.

Thank you very much.

SENATOR CODEY: Do you have any questions? (no response)

You stated that the DRG system saved roughly $10 million to $15 million in claims?

MR. TRESPACZ: No, 12% to 15%.

SENATOR CODEY: Oh, 15%. I'm sorry. What has happened to your rates then?

MR. TRESPACZ: Our rates have at least been able to be more stable, I think, than they would have been in the absence of the DRG system.

SENATOR CODEY: Okay. So, then at least from your point of view, it has contained costs.

MR. TRESPACZ: That is right.

SENATOR CODEY: Even in your rates. Okay, thank you, sir.

Mr. Jeffrey Wasserman from the Health Research and Educational Trust of New Jersey?

J E F F R E Y W A S S E R M A N: Good afternoon. My name is Jeffrey Wasserman, and I am Vice President for Research for the Health Research and Educational Trust of New Jersey.

For the last two and a half years, our organization has been involved in an extensive evaulation of the DRG system. Although our study is still being completed, I am here today to share with you some of the observations and insights we have gained during the course of our work. Because I know that there are many people who wish to testify today, I will try to be brief. My office will be happy to provide more detailed information to those of you who would like it.

The first basic question we sought to investigate was: Is the DRG system well designed, and does it work as anticipated? Three specific points are of interest here:

1. Roughly 10% of the DRG's used in 1980 contained patients whose assignments failed to recognize true differences in clinical status. For example, patients with the same illness, but with widely varying degress of severity, were placed in the same DRG. However, the classification system has subsequently been changed, and it is my understanding that many of the problems we identified have been remedied already.

2. Using statistical techniques, we found that the current practice of computing DEG rates separately for teaching and non-teaching hospitals is indeed appropriate. We also concluded that no additional variables that describe hospital characteristics should be taken into account when computing DRG rates.

3. When we examined the accounting aspects of the system, we concluded that with a few relatively minor exceptions, the cost accumulation, cost finding and cost allocation processes used are consistent with traditional cost accounting definitions and concepts.

The second major area studied was how the DRG system has affected hospital operations. Here, significant effects were observed as a result of the system's implementation.

For instance, the medical staffs in DRG hospitals are more directly involved in hospital operations than are their counterparts in non-DRG hospitals. Furthermore, the importance of the medical records department, in relation to other hospital departments, has increased dramatically in DRG hospitals. In addition, the quantity and type of information collected in DRG hospitals has expanded, which, in turn, allows for the development of more sophisticated management and information systems. And, finally, DRG hospitals appear, as one would expect, to be more outcome or product oriented, whereas non-DRG hospitals are more process oriented.

Another concern regarding hospital operations centers on the quality and timeliness of the data generated to meet the system's requirements.

In general, we found that the data that resulted once the system was in place was more accurate than previously. On the other hand, it took considerably more time to produce those data. This, of course, had an adverse effect on hospital billing.

More precisely, in the eight DRG hospitals studied, the number of incomplete face sheets being turned in dropped considerably, but at the same time, it took the Medical Records Department almost a day longer to complete the abstracting process and submit the data to Patient Accounting for billing. It then took them an average of two more days to release the bills. It is likely, however, that as hospitals become more experienced with the system, the time required to process all of the needed data will decrease.

It is critical to bear in mind that there are indeed costs associated with meeting the new demands of the system. Our analysis has shown, for example, that the average cost of creating an inpatient bill has risen by more than $7.00 per discharge. This is nearly $8 million on a system-wide basis, though only one-third of one percent of all expenditures made for hospital care in New Jersey. But these and other costs of operating the system have not resulted in an acceleration of the increase in hospital costs. In fact, in contrast to an 18.7% increase in operating costs for hospitals nationwide in 1980, the 26 DRG hospitals experienced an increase of only 13.5%.

Additionally, though we cannot yet be sure, it appears that between 1979 and 1980, the financial positions of the DRG hospitals improved considerably while the financial standings of the non-DRG hospitals remained roughly the same.

However, several other factors relating to the hospitals' financial positions need to be considered as well. For instance, despite the fact that the DRG hospitals had more money on the books than their counterparts who were still being reimbursed on a per diem basis, the liquidity of the DRG hospitals has been reduced. Much of this reduced liquidity can be attributed to the fact that the DRG hospitals' accounts receivable increased. These increases are primarily due to delays in generating bills and the longer time taken by payers to pay and process claims. Again, these delays can be expected to dissipate as hospitals and payers become better acquainted with the intricacies of the system. At present, it is uncertain as to whether or not the system has achieved reductions in the costs of providing care that are large enough to offset the added costs of implementation.

We do feel that, in time, we will be able to confidently make such a determination. In the meantime, it is our view that the system has led, and will continue to lead, to the adoption of better management practices on the part of

hospitals, increased communication between physicians and hospital administrators, greater accuracy in the data, and a heightened awareness of the costs of providing patient care. We are optimistic that over time, such improvements will reduce hospital costs and,hence,expenditures on the part of consumers of hospital care.

Thank you.

SENATOR CODEY: Thank you very much, Mr. Wasserman.

Our next witness is James Carroll, Vice President for Finance of Morristown Memorial Hospital.

J A M E S H. C A R R O L L: Thank you for allowing me to appear before you today. Much of what I am going to say you have heard before, so I'll be very, very brief. You have a copy of my comments.

Morristown Memorial feels that Chapter 83 has had a desirable effect on New Jersey Hospitals for the following reasons:

Payment by the case (or DRG) is more equitable than payment per day. That change took place under the DRG system. The DRG payment responds to the cost differences in a hospital's patient mix.

There is an incentive and an disincentive included in the system to reflect recognition of hospital cost comparisons when compared to cost screens, and we think that is a desirable thing.

As you have heard before, indigent and bad debts are paid by all patients, not just self-pay and commercial insurance companies. We think that that broadening of that base to cover these indigent costs, again, is a very desirable thing.

This was eluded to briefly earlier today, but the system rewards hospitals for expanding their outpatient efforts. We think that is good medicine, and we think that by giving a financial incentive to hospitals to do that, it is desirable and beneficial to the community.

The system provides additional cash to hospitals which have large vendor accounts payable, and we think that is desirable.

The costs screens used to set rates are sensitive to major differences among hospitals, such as teaching versus non-teaching, urban, suburban and rural. We think that sensitivity in the system helps more accurately define the costs that are allowed the various hospitals.

However, as in any new complex system, there are improvements that can be made. Morristown believes that billing a DRG rate versus billing controlled charges creates substantial procedural and public relations conditions. These have all been eluded to by people who proceded me, and we agree with their comments. We would like to see the system bill control charges and use the DRG process as a way to develop reasonable costs on which those charges are based.

The system adjust retrospectively for inflation factors and volume differences, and that has also been mentioned this morning. We believe that that is something that should be changed. We think, at the very least, the inflation factor for the labor rate should be truly prospective, so a hospital is given the labor factor in its rates before the year starts so it can plan its salary and management programs during the year, and not have to guess the wage rate inflation factor, and then know that as the year is over, that factor may change, and find themselves in a position of having committed salary increases and then not be paid for those salary increases. We think that is intenable.

We do feel that the inflation factor for supplies' cost could be done retrospectively. They tend to react as the year progresses.

We also feel that hospital operating costs necessary to operate the certificate of need approved equipment are approved only with difficulty. We heard that discussion at some great length from Mr. Scibetta, and we think there should be some recognition of allowed equipment in a hospital and the cost necessary to operate that equipment.

As I pointed out, we have listed only a few of the positive and negative comments, but I think much of these you have heard before.

Thank you. Are there any questions?

SENATOR CODEY: Mr. Carroll, overall and despite that there are obviously some bugs in the system, do you feel that it has been a step forward then?

MR. CARROLL: Yes, we do.

SENATOR CODEY: Okay. Thank you very much.

SENATOR HAGEDORN: I'd like to ask a few questions.

SENATOR CODEY: Sure.

SENATOR HAGEDORN: Has Morristown been able to reduce the number of patient days under the DRG?

MR. CARROLL: Yes, our length of stay has been dropping. It has been dropping since 1980 when we went into the system.

SENATOR HAGEDORN: Do you have radiologists on your payroll?

MR. CARROLL: We are one of those hospitals that unbundled before the DRG system came into New Jersey. Our radiologists were billing fee-for-service prior to DRG.

SENATOR HAGEDORN: In effect, that would help to reduce your costs, wouldn't it?

MR. CARROLL: The costs we are comparing it to would be the base year, and they were not in that base year, so we have reduced our costs in spite of this fact.

SENATOR HAGEDORN: Do they use your equipment?

MR. CARROLL: They do.

SENATOR HAGEDORN: Does your hospital get paid for it?

MR. CARROLL: They do.

SENATOR CODEY: Thank you, Mr. Carroll.

Our next witness is Mr. Joseph Walsh, Vice President of Blue Cross/Blue Shield.

J O S E P H W A L S H: Senator Codey, Senator Hagedorn, I appreciate being given the opportunity to speak today. As you can imagine, Blue Cross has been involved with the DRG process and Chapter 83 for a number of years, which pre-existed the implementation of the system.

Central among the concerns we expressed during the developmental stages of the Rate Setting system was the significant and immediate increase in the cost of health care for Blue Cross new subscribers which would result. In addition to incorporating provisions, which greatly reduced Blue Cross' differential, and thereby, our ability to continue our past level of subsidy for individual and community related coverages, the new law provided for a number of additional elements of cost, which were herefore not a part of Blue Cross' hospital reimbursement formula, one of the most significant of these costs related to uncompensated care.

This morning Mr. Morris mentioned that in 1978, he estimated that the total uncompensated care bad debts and indigents for New Jersey was approximately $60 million to $90 million. According to the cost reports filed by the 59 hospitals, which came under Chapter 83 in 1980 and 1981, bad debts and uncompensated care, in general, amounted to $144 million. Therefore, in addition to paying for hospital services for our own subscribers, Blue Cross will pay approximately $36 million for care rendered to those who could not or did not choose to pay their bills.

All during this morning's discussion, one thing was stated over and over again, and that was there is lack of data concerning this system. In an attempt to arrive at some estimate as to the magnitude of the increase in Blue Cross payments attributed to Chapter 83, we examined the experience with the original 15 DRG hospitals, which entered the system in May of 1980. We found that our average daily payment to these hospitals increased by 31.8% for 1980 when compared to the 1979 level of payment. This contrasted to an 11.5% increase for the same period of time for non-DRG hospitals. In 1981, payments to these same DRG hospitals increased by an additional 17% as contrasted with, and again, an approximate 11.5% for non-DRG hospitals. This meant that in the first twenty months under Chapter 83, the compounded rate of increase to hospitals on the system was approximately 54%.

Our preliminary data would indicate the similar cost increases are being experienced in other hospitals as they are phased under Chapter 83. The plans overriding concern at this point in time regarding Chapter 83 and the DRG experiment is the general lack of hard data as to the true impact of the system on statewide costs. While it would appear that Chapter 83 has done much to improve the financial position of many hospitals, particularly those with traditionally high levels of uncompensated care, Blue Cross data indicates that this has only been accomplished through significant increases in the amount paid for hospital services.

Of additional concern is the fact that we have seen little movement to date by the regulators to bring into play those elements of Chapter 83 which are intended to increase the incentives for hospitals to control costs.

These are several issues that I would like to mention that are of concern to as many of which we have heard about this morning. So, I'll deviate from notes a little bit.

One of those issues is the "cap" that was discussed on Medicare and Medicaid payments, which was a condition to receiving the waiver. We are greatly concerned that the "cap" will be exceeded, as was stated by the New Jersey Hospital Association. We know of no study which has been performed or is in process to show where Medicare and Medicaid stand in regard to the "cap."

The additional elements of cost and other provisions of Chapter 83 that caused increases in Blue Cross payments are also applicable to government payers. It would appear to us, therefore, that there exists a strong possibility that the "cap" will be exceeded. This prospect could have a severe financial implication for the plan and other non-governmental payers, and it would be directly contrary to the basic tenant Chapter 83 that, "all payment rates shall be equitable for each payer."

A second area of concern to us is the general concept of uncompensated care. Senator Hagedorn, who was present for the initial deliberations, concerning

how we would finance uncompensated care in the State -- I think you will recall that the alternative sought was the last alternative. The reason we even called these costs "uncompensated care" was because we could not separate truly indigent costs from bad debt costs. The original discussions were for bad debts.

Blue Cross, as have others, does feel and has expressed our opinion that these costs are more properly a social responsibility to be financed from public sources of revenue, as opposed to a surcharge on those already paying their hospital bills. By guaranteeing uncompensated care costs, Chapter 83 may have somewhat reduced the incentive for hospitals to seek other sources of funding or to agressively pursue collections.

There has been a decrease in the level of county and other public and private support since the implementation of Chapter 83. In 1979, the initital twenty-six DRG hospitals, which came under Chapter 83 in 1980, listed grants and contributions totaling $3 million. In 1980, grants and contributions to these hospitals was reduced to $2.1 million, and in 1981, it dwindled to $700 thousand.

In 1979, these same twenty-six hospitals had uncompensated care liability reported at $41.4 million. In 1980, after being under Chapter 83 for only a portion of the year, uncompensated care increased by 18% to $49.2 million.

As a third point, Blue Cross would also support the recommendations of others that the interim charge mechanism for interim reimbursement for the control charge mechanism be adopted. We believe this mechanism would reduce confusion, lower administrative costs, and eliminate the inequities which are an inescapable bi-product of an average per case payment method. We do not believe the adoption of a control charge interim payment mechanism would compromise the cost containment concept of per case reimbursement, since hospitals would be fully subject to the incentives and disincentives of such a system at the time of final reconciliation. We do believe that control charges should be applicable to all payers, and not to just a segment of the payers under Chapter 83.

The final issues which I would like to address has also been touched on today, and that is the issue of unbundling. While the most significant impact of unbundling has been felt in the area of radiology, where radiologists at 81 of the 93 acute care hospitals have now unbundled and are billing patients directly for their services, we understand that their other specialties have already unbundled or are considering unbundling. While we are not suggesting that Chapter 83 is solely responsible for unbundling, which in fact, again, sometime prior to the law, we do believe that increased regulation may have created an environment conducive to the acceleration of unbundling. We are fearful that unless some attention be given to this phenomena, the emerging trend will inevitably spread to encompass an increased range of specialties and services.

Under Chapter 83, there is little or no incentive for a hospital to retain the cost of professional services, while a strong incentive exists for physicians and other professionals to free themselves of regulatory restraints. Although unbundling may have a favorable impact on a hospital's cost, it is most definitely having an adverse impact on the overall cost of patients being treated at New Jersey hospitals.

In summary, while we believe that Chapter 83 and the price per case concept may embody the elements necessary to effectively contain hospital costs,

to date Blue Cross' experience has been a substantial increase in costs. Although some front-end increases were anticipated, it was also anticipated that during the latter months of the experiment, we would experience a dramatic reduction in the rate at which hospital costs increased. As of this date, that has not occurred, and we have no indication that it will occur within the near future.

Thank you very much.

SENATOR CODEY: Are there any questions?

SENATOR HAGEDORN: I would just like to get one thing clear. Has there been a substantial increase in the compensated cost under DRG? Did you make that statement?

MR. WALSH: Yes. Do you mean what we are paying for hospitals?

SENATOR HAGEDORN: For increase in compensated costs. In other words, has the practice of not paying bills been expanded under the DRG, and what are the problems for hospitals or for you?

MR. WALSH: We have seen in the initial hospitals that went on the system in 1980 an 18% increase in their rate of uncompensated care. It is difficult to evaluate the impact statewide.

SENATOR HAGEDORN: Okay.

SENATOR CODEY: Thank you very much, Mr. Walsh.

Our next witness is Mr. Stanley Peck from the Health Insurance Association of America. Is Mr. Peck here? You don't look like Mr. Peck.

A N N E C. G R A B O I S: My name is Anne Grabois and I am an Assistant Director with the Consumer and Professional Relations Division of the Health Insurance Association of America. In the interest of time, I have submitted my written statement to you, but I just briefly want to tell you that the Health Insurance Association of America represents approximately 332 insurance companies that are responsible for about 80% of the health insurance written by insurance companies in the United States today. Over 140 of these HIAA member companies are licensed to do accident and health business in the State of New Jersey. According to our most recent annual survey, private health insurers have paid over $750 million in accident and health benefits on behalf of 2.5 million private insureds in New Jersey.

I would just like to add at this point that our member companies generally support the statements made by the Prudential and Travelers this morning, and the HIAA has supported and continues to support the DRG reimbursement system.

Thank you.

SENATOR CODEY: Okay, so you would say that it has made you more equitable in terms of competing in the market. Am I right?

MS. GRABOIS: Definitely.

SENATOR CODEY: Okay, thank you very much.

Dr. Frank Primich?

D O C T O R F R A N K P R I M I C H: Mr. Chairman, members of the Committee, interested parties, and innocent bystanders, I could be here representing the Association of American Physicians and Surgeons, an organization dedicated to the preservation of private practice of medicine. I could be here as President of the Medical Staff of Riverside General Hospital, the sole surviving proprietory hospital in New Jersey. I could be here to present the position of the Medical Society of New Jersey, which I have been instrumental in converting from scientific

observation to active opposition. I could be here on behalf of the Libertarian Party, which is striving to return this country to the limited government responsible for its past growth and success. I could be here to represent the National Taxpayers' Union. Instead, I propose to speak on behalf of those who have no one else to represent them: the insurance premium payers, the rugged individualists, and the hospital patients.

To any individual who prides himself in being open-minded, it is frustrating to hear repeatedly from supposedly authoritative sources, that the DRG's have good and bad features. This implies that a final judgment of their merits must await some retrospective evaluation in the distant future, hopefully beyond the statute of limitations which might hold those responsible who initiated this stepping-stone on the road to socialized medicine. The non-judgmental approach implies a balance between good and evil. When the good accrues to relatively few, and damage is spread over all the rest, the scales of justice tip precipitously. In a Socialistic or Totalitarian society such actions are commonplace. If they are tolerated in this State, our other cherished liberties will be further endangered.

Let us first look at the supposed good features. No one can deny that it is a boon to the computer industry. It would appear to help alleviate the unemployment problem, since more people become necessary in the business offices of hospitals, not to mention the additional bureaucrats needed to play out the charade. It offers the statisticians on both sides of the discussion an almost infinite supply of numbers to play with, so varied and abstract as to permit any conclusions imaginable. It should absolutely identify those providers who grossly over-utilize hospital facilities. It is hoped to have an educational impact upon those physicians who practice bad medicine. It is projected as the only regulatory vehicle which meets the bizarre requirements for the Medicare/Medicaid waiver without which S-446 would be doomed. It, therefore, would permit the equalization of hospital billing intended by the Legislature, and eliminate cost shifting. It is one approach to asssuring survival of inner-city hospitals and those institutions who inept management has placed them in jeopardy.

Now, let's examine these suppositions in reverse order:

Subsidization of ineptitude can only lead to its perpetuation.

Inner-city hospitals have arrived at their deplorable state, in large part, because of the false promise of high quality care for all projected by politicians who had little appreciation or concern for the ultimate cost. To bail them out by increasing taxes would be very unpopular and politically hazardous.

Cost shifting, the problem supposedly addressed by S-446, turns out to be replaced by a more onerous cost shift.

Discounted rates for Blue Cross, Medicare, and Medicaid has made it necessary for hospitals to raise their rates to commercial insurers and self-pay patients in order to break even. Though the theory overlooks some significant factors, it would appear fair that all payers pay the same amount for the same service. This loses its element of fairness when the factor of an annual $100 million in uncompensated costs is brought into the equation. These costs, which "big brother" had benevolently proposed to underwrite, were to now be prorated amoung the various payers.

Blue Cross, with over 2,000,000 subscribers in New Jersey, has been forced to raise its premiums by over 40%, with the threat of more to come. The taxpayer is being spared by paying out of his other pocket as an insurance subscriber. This is not merely a cost shift. It turns out to be a "blame shift" as well. The hostility of the victims of this shell game is focused upon the insurance companies and the health care providers who are charging such"unconscionable fees."

While the above relates more directly to S-446 than DRG's, it is an absolute essential to understanding the overall issue.

The Medicare/Medicaid waiver deserves condemnation in passing. It permits the Federal government to pay a little more than prior rates, but stipulates that if it turns out that costs are higher than under the old system, the hospitals will be responsible for return of the difference. There is no such protection available to the insurance subscribers or the self-payers. Withdrawal of the waiver is probably the best hope for scuttling this whole travesty.

Gross over-utilizers and bad practitioners are well known and easily recognized in any institution. Fortunately, they are few in number. If there were a genuine desire to weed them out, there are far simpler ways of doing it than mandating "cookbook" medicine for all physicians and patients.

Increased employment and computer utilization may have sounded as if I were being facetious. Any humorous overtone fades when you realize that simple economy dictates that more clerical personnel be reflected in less employees directly involved in patient care. Computerization means that you, as an individual, will be converted into a number, not even your Social Security number, but the DRG disease designation.

Faced with the need for expert medical treatment, wouldn't you prefer the doctor of your choice and the assurance that your care would be determined by his, or her, best judgment?

Testimony can be expected from individuals and groups favoring DRG's whose personal prejudice should be evident. Hopefully, there will be others who will share my admittedly prejudicial opposition.

My main concern today is that too much weight will be given to the presumably unbiased findings of Volume 1 of the HRET DRG Evaluation. My contention is that the Policy Committee and the Evaluation Task Advisory Group are woefully lacking in representation of insurance subscribers, practicing physicians or hospital patients.

Speaking of weight, the report is heavy enough to require $2.24 for first class postage. This will discourage many from studying its content. It isn't as overwhelming as it appears. Indeed, it may be characterized as underwhelming. Thirty-three of the eighty pages are devoted to the bibliography. Fourteen additional pages are tables which report on three serial surveys of participating hospitals. Failures of response and high "no opinion" percentages make the statistical validity suspect. My favorite is the question as to whether the DRG method of allocating costs was reasonable. Twenty-three 1981 entries into the system answered: 30.4% "yes," 30.4% "no," and 39.1% "no opinion." If that had been an election, "none of the above" would have won.

The double-spaced text is an easily readable 31 pages. The conclusions, half of Page 31, are all that is really significant. It is a shame that they are

"inconclusive." A vital question is raised as to whether the costs of compliance and implementation may not be greater than projected claims of cost savings. It is my belief that this will eventually be proven true. During the interminable wait for absolute confirmation of that fact, irreparable damage will have been done to the traditional concepts of health care.

DRG's were introduced as an "experiment" or pilot study. I like to refer to tham as the "kamikase pilot study," and claim they do not meet the scientific nor ethical criteria of an experiment.

Even prisoners cannot be experimented upon without their consent. The original "voluntary" aspects of the program were a farce. Only ten of the initial twenty-six hospitals were volunteers. The subsequent mandatory inclusion of all our other hospitals was a blatant unconstitutional usurpation of power by the State Department of Health.

The Legislature was sold a "pig in the poke." They surrendered unwarranted authority to the Commissioner of Health, which I claim has been arbitrarily and capriciously abused. Repeal of the awesome power to do harm is vital to the future health and welfare of your constituents.

Paying patients, either as direct payers or insurance subscribers, will find themselves paying more and more for care of poorer quality of abysmal impersonality and subject to de facto rationing.

Doctors are in the precarious position of being next to bear the brunt of blame. When this ill-conceived program sputters and stalls, the groundwork has already been advanced that "control" of physicians is inadequate for success of the program.

As far as the national aspects of this issue are concerned, and these are very important, we are morally obligated to point out the shortcomings and fallacies of the concept. The delusion that further regulations will correct the flaws and inequities of DRG's should not be encouraged. We should not, in a mistaken sense of State pride, cover up the tragic mistake we have made. New Jersey has enough blemishes on its image without once more boastfully being "first with the worst."

Thank you.

SENATOR CODEY: I take it you are opposed. (laughter)

Do you have any questions, Senator?

SENATOR HAGEDORN: I have one question. I was wondering if the Doctor could enlarge and explain to us what he means by "de facto rationing."

DR. PRIMICH: Yes, sir. One of the ominous future implications of this whole program is that the way it is structured, it is to the hospitals' advantage to under-treat a patient, either in time or services. There are many types of medical problems which in and of themselves sound an alarm that says, "Oh, this patient is going to be a problem. We're going to have difficulties in treating the patient; we're going to have difficulties in eventually being able to discharge this patient to some type of service." This primarily relates to the elderly because with so many of these people, once they are admitted into the hospital, it becomes a problem as to when and how they can be discharged.

What will happen ultimately -- what has already happened in many instances -- I am very disturbed by the fact that many efficient hospitals where I have counted on support from them on the basis of the ominous regulations that are here and

the threats that are posed two, three or four years down the road when the rachet effect of this regulation closes in on them -- But, they have felt by and large that since they are efficient and the system isn't, that they can work within the system and, in effect, "rip it off" and come out with a better bottom line for the time being than they had before. Anyone who reasons that way very readily will set up an admission policy which will deny admission to those patients who look like they are going to be bad risks. We will selectively pick those patients who we can treat fastest, cheapest, for the highest price, and the other poor souls will be really relegated to some type of third-class care.

SENATOR HAGEDORN: Doctor, is it possible or conceivable that hospitals would be inclined to over-treat or over-diagnose a patient to expand the cost or the income to the hospital?

DR. PRIMICH: Yes, sir. There has been a lot said about education, and my big concern that was mentioned by one of the more recent witnesses is the fact that the public has very little idea of what is going on.

What is more ominous to me is that the doctors have very little idea of what is going on. I have been trying to conduct a one-man educational program, not only within the State, but nationally through the Private Practice Magazine, and what I find is that the educational side of this thing occurs where the hospital administration will call a meeting and try to explain to the doctors how the system works. Rather simply, they will give examples taken from the rating printouts which say, "Now, Doctor, if you mistakenly diagnose this person as having a chronic heart disease and an acute coronary, or if you diagnose this patient as having an acute coronary with chronic heart disease, there is a $1000 difference between which way you write this on the chart." This has absolutely nothing to do with the improvement of health care. It wastes a hell of a lot of my time and that of other physicians, but the hospital and those with better record rooms -- I heard somebody say that hospital record rooms are increasing.

I have a charge to make there, not only against the program, not only against the people who innovated it, but against my fellow physicians. Hospital charts have gotten so extensive in order to conform with regulation that there is not one iota of beneficial information there for any statistical purposes. People write whatever it seems that they think someone else wants to read. It does not relate to that patient's particular condition at the time. It has relatively little value in the future, which is what hospital records are supposed to be for, so that we can fall back on someone else's record from two years ago. That record is totally disguished so that it will meet the criteria of the regulators.

SENATOR CODEY: Thank you very much, Doctor.

Our next witness is Nancy Meyerowitz, Director of Management Systems for Overlook Hospital.

N A N C Y M E Y E R O W I T Z:Mr. Chairman, Senator Hagedorn, my name is Nancy Meyerowitz, and I am the Director of Management Systems at Overlook. I am the responsible person for implementing the DRG system at the hospital. I am speaking on behalf of Mr. Thomas Foley, the President and Director of the hospital.

I want to thank you for the opportunity to offer my comments on our experiences with Chapter 83 reimbursement. I have shortened my prepared text so

as not to be repetitive from some of the comments made this morning.

We were one of the first 26 hospitals to enter the system in 1980. We are now completing our third year under this innovative reimbursement system. Despite the numerous problems incurred in the implementation of the program, we believe it can be a viable tool for reimbursement in New Jersey, and perhaps a model for the rest of the country.

We are in full support of the reimbursement concepts introduced by Chapter 83. The system recognizes, for the first time, the impact of case-mix on hospital costs. Althought not perfect, the system attempts to tie payments to hospitals to the mix of patients treated. In addition, severity and age of our patients is taken into consideration. I think this simple concept is very often overlooked, and it is an important part of Chapter 83.

As has already been discussed, the New Jersey system is designed to be a prospective one. This should enable us to improve our budgeting, financial management, and planning efforts. The retrospective or per diem system, which was in place prior to DRG, actually rewarded those hospitals whose costs increased. This system, which allows hospitals to keep any excess of revenue over costs, is an incentive to contain costs. We, at Overlook Hospital, recognize the need to contain the rising costs of health care while maintaining a high standard of care.

Chapter 83 stipulates, as it should, that hospitals should be paid for all reasonable costs of doing business. All payers are now required to pay their fair share of bad debts and uncompensated care. A greater degree of equity is also realized under this system as payment rates are established for all payers.

Finally, the DRG system has provided the basis for a potentially valuable management tool. The data allows us to measure the actual costs of treating a given type of illness, as well as a comparison of these costs to those of similar institutions. The reports we receive provide an additional tool for our medical staff to use in the evaluation of quality of care and resource use, something that they have been doing for many years. The information has also proved as a useful planning tool in the analysis of current services and the review of the impact of proposed new services or an increased level of service.

Overlook has maintained its sound financial standing while under Chapter 83. The hospital has continued to be able to provide a high quality care to our patients despite the many difficulties we have encountered during the implementation of the system.

We have not experienced any need to discharge our patients prematurely. Physicians at our hospital are the ones who control discharge and admission to the hospital, not the hospital administrator.

We have, however, several major concerns with the DRG system. You have heard about many this morning, and I would like to emphasize those that we feel are important.

First, the system has not proved to be a truly prospective system. In such a system, there would be minimal year-end adjustments. Unfortunately, this has not been the case in New Jersey. Mid-year changes have been introduced each year. This year we switched to a completely new set of DRG's in June. It was almost like a new ball game.

The methodology for reimbursement of certain costs, such as utilization review, has just been finalized. Significant revisions to other methodologies, such as that for reimbursement for nursing costs and teaching status, have been

proposed to take effect within the next two years.

In addition, far too many issues are deferred to the year-end reconciliation process. We have the same concerns expressed earlier regarding the economic factor and its retrospective implementation.

The second major concern we have is the failure of the system to address changes in medical practice and new technologies. Our 1982 revenue is based on our 1979 costs, which have been increased only by an inflation factor. This assumes that our medical and professional staffs are providing the same level of service as in 1979. As you know, medical practice has changed significantly in many areas and many new technologies are available. Tremendous advances have been made in the treatment of cancer patients, which are very costly, but save lives.

The system fails to recognize the costs associated with these changes in medical practice and the purchase of new equipment. The appeal process, we feel, has not worked in these areas, and there is no integration with the planning process. We have identified needs of our patients and community which we do not feel we are currently meeting. It will be difficult to meet our responsiblity and provide these services without adequate reimbursement. Unfortunately, we anticipate that this problem will only increase as time goes on. Our patients are getting older and are living longer, and they are demanding the highest quality of care regardless of cost.

Another problem which concerns us is the billing of patients without insurance. As has been said earlier, it is not fair to the self-pay patient who is paying only one bill, and it has no incentive to keep resource use down in these cases. We recommend that certainly patients without insurance be exempt from paying the average rate. The average rates could be used for final reconciliation to ensure the integrity of the system.

The last major concern that I would like to mention relates to several proposed changes in the definition of reimburseable costs. These are proposals that are for 1983. Currently, interest expense on major movable equipment is not an allowable element of cost, but can be appealed. This appeal option is to be removed in 1983. Secondly, in 1983 hospitals will no longer receive reimbursement for depreciation expense associated with fixed capital. Only principal and interest will be guaranteed. This, we feel, places hospitals in an extremely precarious position, particularly if the reimbursement methodology were to change in the future.

In conclusion, I would like to offer our support for the innovative concepts introduced by the legislation in Chapter 83. The program has rectified many of the inadequacies and inequities of the previous system. We do have serious concerns regarding the implementation of the system in New Jersey with regard to some of the proposed changes as I mentioned in my earlier remarks. The system needs to function in a consistent manner for several years in order to evaluate its success in containing costs and the impact on the quality of care.

Because of the many changes that have been introduced our ability to respond has been limited. Hospitals cannot be squeezed too tightly without it affecting the quality of care we provide or our ability to deliver needed services.

Thank you.

SENATOR CODEY: Thank you very much, Ms. Meyerowitz.

Our next witness is Mr. Michael Wax, Budget Director of East Orange General Hospital.

M I C H A E L W A X: I would like to bring to your attention one potential serious issue with the 1983 regulations that our hospital is concerned about.

The Department of Health has proposed the tightening the cross-subsidization corridor in the third year to plus or minus 5%, from the existing plus or minus 25%. We have been informed that because the Department of Health received so many comments on this issue, the Department of Health is revising its corridor to plus or minus 10% as a concession to the industry. We consider this plus or minus 10% as not a reasonable compromise and will cause considerable harm to the health care industry throughout the State.

This regulation will force hospital outpatient charges -- clinic, emergency room, hemodialysis -- to rise approximately 30% in 1983 over 1982 levels. This is compared to a normal 10% increase due to inflation.

The huge increase is because hospitals have traditionally kept outpatient charges comparatively low, due to competitive reasons and to encourage the use of outpatient services. This regulation makes for very poor health planning policy on a State level. It discourages the use of cheaper outpatient services and will lead to the use of more expensive inpatient care. More people will postpone efficient outpatient treatment because of the substantial price increase, and will need to be treated for more serious complications later in an inpatient setting.

The Department of Health has stated that a hospital has the right to appeal before the Rate Setting Commission for permission to cross-subsidize their outpatient areas with inpatient revenues. However, all hospitals will have to appeal to prevent the 30% price rise.

We propose that the current corridor for third-year hospitals be kept at the current plus or minus 25% limit, or at the very least, an exception be granted for the outpatient cost centers -- clinic, emergency and hemodialysis. Any distortions to the DRG reimbursement system will have to be tolerated because no system can be made 100% perfect.

In addition, the mechanics for calculating the cross-subsidization corridors are monstrous and involve about two man-weeks of work. It is too easy to make a misprojection of annual expenses, revenues, recoveries, depreciation or statistics with such a tight corridor.

We are enclosing a copy of a cross-subsidization calculation to give you an idea of the complexities involved in this calculation. This regulation will force a hospital to constantly change charges throughout the year. An average hospital has hundred of charges.

Due to these severe problems, we propose a cross-subsidization corridor be left at 25% for the third and future years. The Department of Health can allow cross-subsidization on appeal, but so far, it is denying our request for 1982. Due to this one issue, we project our hospital will lose $500 thousand to $1 million in reimbursements in 1983.

I have spoken to Jim Hub, the representative from the Department of Health this morning on this particular issue, and he has indicated to me that the Department would be willing to listen to an exception for the outpatient areas. In addition, they may be willing to phase in a different corridor limit of maybe 20%

the first year and 15% the following year. Whether this will follow an action before the Health Care Administration Board remains to be seen.

SENATOR CODEY: Do you want to leave your card with me? Thank you, Mr. Wax.

Mr. Steven Latimer from Legal Services of New Jersey?

S T E V E N L A T I M E R: Senator, members of the Committee, I bring a slightly different perspective, I think, to the hearing. Legal Services of New Jersey is the coordinating arm for all the Legal Services programsof this State, and as the Committee may know, Legal Services program is mandated to provide legal representation in civil matters to indigents in the State.

We have been concerned for a number of years in Legal Services about the provision of uncompensated care to poor people, people who cannot afford to pay for these services, and my comments will focus on how Chapter 83 has affected our clients, many of whom are in urban centers.

For some background, prior to the enactment of Chapter 83, our clients -- low-income women, children, low-income elderly people -- were dumped on hospitals that were willing to accept poor people. Those were hospitals that, for the large part, had an obligation to accept uncompensated care under the Hill-Burton Act; care, if they weren't a Hill-Burton case, had to be provided through some of the welfare programs. Many times, at the admission stage in the hospital, which is critical for this purpose, the people were not told about the availability of uncompensated or low-cost care for Hill-Burton. They were not told of the availability of general assistance. What happened was, a person would come into the hospital, get treated, be discharged, and be billed for care which, under the law -- there was no need to bill him, and the hospitals were not really entitled to bill the people. These had severe impact on people; they caused distress and physical problems to elderly people. I know of instances over the years before Chapter 83 was implemented where poor, elderly people had foreclosure actions instituted for payment of hospital debts, which under the law, they were entitled to at low cost or no cost.

For us, for the people in Legal Services, it meant unnecessary time and energy to litigate or resolve the issues without litigation. It meant devoting resources, Legal Service, which, even in the best times, were scarce for clients where there was really no need to litigate, had these people been properly advised at the admissions stage of that to which they were entitled.

With this background in mind, recent polls of Legal Services programs in the State as to the hospital collection cases that were involved indicate that there has been a substantial climb in the number of collection cases that we have had to handle; people have come into our office. We believe that this decline is a direct result of the reimbursement provisions of Chapter 83. We believe that the reimbursement provisions have helped eliminate some of the financial inequities which keep our clients from obtaining very much needed medical services, and we think that for these reasons, that Chapter 83 has helped our clients considerably.

We also think that the hospitals in the inner cities are now able to serve our clients without going into the "red," without being in debt because of the reimbursement, and I think Saint Joseph's Hospital in Paterson has stated recently in the newspaper that the reimbursement scheme of Chapter 83 had placed them in the "black" after they had been in the "red" for much of their existence.

The experience in Camden is that Cooper Hospital's financial picture has improved to a great extent as a result of the reimbursement program. In fact, Camden, which at one time had a substantial number of hospital collection cases -- Camden Legal Services has very few. There are problems, just as there are problems with anything.

From our perspective, it appears that some of the collection cases that have been brought have been the result of poor admissions practices, that proper eligibility determinations have not been made, or that the admissions staff does not understand how the mechanism of Chapter 83 is supposed to work. Part of that can be solved by promulgation of eligibility guidelines that are a little bit simpler and easier to deal with.

The asset and liability test for inpatient services is cumbersome. It confused our clients who are the not the most well-educated people. It probably confuses the hospital. We think that an income test similar to the income test used to determine eligibility under the Hill-Burton Act would be more effective. The low-income eligibility level, we would suggest, would be about $414 per month or $6624 per year for a family of four. That is 133% of the A.F.D.C, the Federal welfare program elibility requirements.

The emergency services under outpatient care require poor people to pay for care except under exceptional financial circumstances. I would submit that most of the clients who Legal Services serves are under exceptional financial circumstances. $414 per month for a family of four, for instance, certainly is not a substantial amount of money to meet families' needs, and in fact, the eligibility level of Chapter 83 is less than the national poverty guidelines would mandate. The national poverty guidelines say a person is virtually destitute if the income for a family of four is under $9300 a year.

Finally, we think that the data resulting from the DRG methodology reporting system would be very helpful to analyze the kinds of health problems that poor people in the inner cities, particularly, where the minorities suffer. South Jersey has a large migrant population with its own health problems. Accurate reporting broken down by income, race, and ethnic categories can give a good profile of the kind of health problems facing poor people and enable the State to adequately deal with those issues.

With that, I thank the Committee for the opportunity to testify.

SENATOR CODEY: Senator? Thank you very much, Mr. Latimer.

The next witness is Lucille Joel of the New Jersey State Nurses Association. She is not here?

Okay, we then stand adjourned. Thank you.

(Hearing concluded)

POWERS: STATEMENT TO SENATE SUBCOMMITTEE

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS DOROTHY POWERS AND I AM THE CHAIRMAN OF THE HOSPITAL RATE SETTING COMMISSION. ALSO HERE FROM THE COMMISSION IS MONSIGNOR HARROLD MURRAY, OUR VICE-CHAIRMAN, AND DONALD PAYNE, A CONSUMER MEMBER. OTHER MEMBERS OF THE COMMISSION ARE DR. SHIRLEY MAYER, COMMISSIONER OF HEALTH AND JOSEPH MURPHY, COMMISSIONER OF INSURANCE. JEFF WARREN IS THE COMMISSION'S EXECUTIVE SECRETARY.

I AM PLEASED TO BE HERE TODAY TO SHARE WITH YOU MY PERSPECTIVE ON THE NEW JERSEY HOSPITAL REIMBURSEMENT SYSTEM AND PARTICULARLY THE USE OF DRGs. THESE VIEWS CAN BE BEST UNDERSTOOD IN THE CONTEXT OF THE HISTORY OF THE SYSTEM. THE PASSAGE OF PUBLIC LAW 1978, CHAPTER 83, MANDATED A NUMBER OF BROAD AND SWEEPING CHANGES IN THE FINANCING OF HEALTH CARE SERVICES. CHAPTER 83 STRESSES BOTH THE IMPORTANCE OF PROVIDING HIGH QUALITY HEALTH SERVICES TO THE RESIDENTS OF NEW JERSEY AND THE NEED TO PROMOTE THE FINANCIAL SOLVENCY OF HOSPITALS DELIVERING THIS CARE. AT THE SAME TIME, THERE IS RECOGNITION THAT THE SPIRALING COST OF HEALTH SERVICES MUST BE CONTAINED AND FURTHER, THAT THE COST OF SUCH SERVICES SHOULD BE REASONABLE AND EQUITABLE FOR ALL PAYORS. IN ORDER TO PROVIDE A PUBLIC FORUM FOR REVIEWING AND APPROVING REIMBURSEMENT RATES FOR NEW JERSEY'S HOSPITALS, THIS LAW ALSO MANDATED THE ESTABLISHMENT OF THE HOSPITAL RATE SETTING COMMISSION.

AS THE ADJUDICATOR OF THE DRG SYSTEM, THE COMMISSION IS PRIMARILY RESPONSIBLE FOR THE FINAL DECISION ON ALL HOSPITAL-SPECIFIC AND GENERIC APPEALS. AS PART OF THE REVIEW PROCESS, THE COMMISSION HEARS FROM DEPARTMENT OF HEALTH STAFF MEMBERS, HOSPITAL AND PAYOR REPRESENTATIVES, AND THE PUBLIC, THROUGH THE PUBLIC ADVOCATE'S OFFICE.

THE DIFFICULT TASK FACING THE COMMISSION AS IT APPROVES HOSPITAL RATES IS THAT OF BALANCING THE NEED FOR CERTAIN PROGRAMS AND SERVICES AGAINST THEIR ASSOCIATED COSTS. FURTHER, THESE COSTS MUST BE REVIEWED IN THE CONTEXT OF WHETHER A HOSPITAL IS EFFICIENT OR INEFFICIENT IN DELIVERING ITS SERVICES. WE MUST ALSO ADDRESS CONCERNS ABOUT ACCESS TO QUALITY CARE IN TODAY'S ECONOMIC ENVIRONMENT OF HIGH EXPECTATIONS AND EVER-DIMINISHING RESOURCES.

THE COMMISSION MUST CAREFULLY WEIGH THE NEEDS OF THE HOSPITALS AGAINST THE ENSUING BURDENS ON THOSE WHO MUST PAY. FOR EXAMPLE, WE ARE OFTEN ASKED TO DECIDE WHETHER A NEW PROGRAM, TECHNOLOGY OR FACILITY CONFERS SUFFICIENT BENEFITS TO JUSTIFY ALL OR PART OF ITS COSTS TO THE PUBLIC AND UNDER WHAT CIRCUMSTANCES SHOULD SUCH COSTS BE ALLOWED OR DISALLOWED.

I BELIEVE THAT THIS REIMBURSEMENT SYSTEM MEETS AND TO SOME EXTENT EXCEEDS THE STATED OBJECTIVES OF CHAPTER 83. THIS IS PARTICULARLY TRUE IN FOUR DISTINCT AREAS WHICH INCLUDE: FINANCIAL SALVATION OF OUR INNER CITY HOSPITALS, THE FINANCIAL SOLVENCY OF EFFICIENT AND EFFECTIVE INSTITUTIONS, EQUITY AMONG PAYORS, AND THE CONTAINMENT OF HOSPITAL COSTS.

WITH RESPECT TO OUR INNER CITY HOSPITALS, IT IS CLEAR THAT THEY HAVE BEEN DRAMATICALLY AND FAVORABLY AFFECTED BY THIS SYSTEM. HOSPITALS THAT PROVIDE VITAL SERVICES TO URBAN POPULATIONS WERE A FEW YEARS AGO ON THE BRINK OF BANKRUPTCY. TODAY THEIR BOTTOMLINES ARE SHOWING VAST IMPROVEMENTS. AS A RESULT, IMPROVED TECHNIQUES OF CARE, AND ACCESS TO MODERNIZED EQUIPMENT ARE NOW BEING PROVIDED TO WHAT HAS TRADITIONALLY BEEN AN UNDERSERVED POPULATION. WITHOUT QUESTION, THE PROVISION OF UNCOMPENSATED CARE GOES BEYOND THE REACH OF DOLLARS AND CENTS.

IT IS SIGNIFICANT TO NOTE THAT, DESPITE SOME CRIES OF DOOM AND GLOOM, MANY HOSPITALS ARE ENJOYING THEIR BEST FINANCIAL YEARS UNDER THE DRG SYSTEM.

THIS IS NOT TRUE FOR ALL, BUT IS AN ACHIEVABLE GOAL, GIVEN THE INCENTIVES BUILT INTO THE SYSTEM.

AS FOR EQUITY, IT IS CLEARLY EVIDENT THAT THE DESIGN OF THE DRG SYSTEM ALLOCATES EQUIVALENT COSTS FOR EQUIVALENT TREATMENT TO EACH PAYOR WITH THE EXCEPTION OF PAYOR DIFFERENTIALS. ANY PERSON REQUIRING A CERTAIN LEVEL OF HOSPITAL CARE WILL INCUR BASICALLY THE SAME HOSPITAL CHARGES REGARDLESS OF HIS/HER INSURANCE COVERAGE. AS A RESULT, COST SHIFTING WITH ITS ASSOCIATED INEQUITIES, A FACT OF LIFE IN 49 OTHER STATES, DOES NOT EXIST IN NEW JERSEY.

FINALLY, THE MAJOR THRUST OF THIS PROGRAM IS COST CONTAINMENT. IN THIS REGARD THE RESULTS THUS FAR ARE WORTH NOTING. IN 1981, TOTAL OPERATING EXPENSES FOR ACUTE CARE HOSPITALS IN THE UNITED STATES WERE UP 18.7%, WHILE IN NEW JERSEY OPERATING EXPENSES WERE UP ONLY 13.8%. AS FOR EXPENSE PER ADJUSTMENT ADMISSION, NATIONWIDE IT WAS UP 17.4% WHILE IN NEW JERSEY EXPENSES PER ADJUSTED ADMISSION INCREASED 13.7% INPATIENT DAYS WERE UP 1.2% NATIONWIDE AND IN NEW JERSEY DOWN .6%. TOTAL ADMISSIONS NATIONWIDE WERE UP .9% AND IN NEW JERSEY DOWN .4%. AND IN LENGTH OF STAY THERE WAS NO CHANGE NATIONALLY WHILE IN NEW JERSEY IT WAS DOWN .5%. IN MY MIND, THIS DATA POINTS TO THE CONCLUSION THAT, DESPITE ITS IMPERFECTIONS, THE REIMBURSEMENT SYSTEM CREATED BY A BIPARTISAN EFFORT OF THE NEW JERSEY LEGISLATURE IS WORKING TO BENEFIT THE CITIZENS OF THIS STATE. THIS IS NOT TO SAY THAT IT IS WITHOUT FLAWS. IT IS OBVIOUS THAT THE SYSTEM IS NOT PROSPECTIVE ENOUGH. THE PROCESS HAS ALSO FAILED THUS FAR IN GETTING HOSPITALS THE RECONCILIATION DOLLARS THAT ARE DUE THEM. TOO, THE APPEALS PROCESS HAS BEEN TOO LENGTHY FOR ALL PARTIES. NONETHELESS, IT IS A GOOD SYSTEM, ONE THAT IS BEING LOOKED AT AS A MODEL FOR REIMBURSEMENT ON THE NATIONAL LEVEL. IN FACT, LEGISLATION HAS BEEN INTRODUCED

IN CONGRESS THAT WOULD MANDATE PROSPECTIVE RATE SETTING THROUGH THE USE OF A DRG TYPE METHODOLOGY.

WE ARE ANXIOUS TO SEE IF WASHINGTON FOLLOWS NEW JERSEY'S LEAD IN THIS MOST CRITICAL AREA.

THANK YOU.

NJHA NEW JERSEY HOSPITAL ASSOCIATION

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Louis P. Scibetta FACHA
President

TESTIMONY OF

LOUIS P. SCIBETTA
PRESIDENT
NEW JERSEY HOSPITAL ASSOCIATION

BEFORE THE

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE
NEW JERSEY STATE SENATE

ON

IMPLEMENTATION OF THE NEW JERSEY
HOSPITAL RATE SETTING LAW
P.L. 1978, CHAPTER 83

SEPTEMBER 21, 1982
TRENTON

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM LOUIS P. SCIBETTA, PRESIDENT OF THE NEW JERSEY HOSPITAL ASSOCIATION. WITH ME TODAY IS DOMENICK J. CAMISI, CPA, SENIOR VICE PRESIDENT, WHOSE PRIME EXPERTISE IS IN THE SYSTEM OF FINANCIAL INPUT AFFECTING OUR HOSPITALS. THE ASSOCIATION, WHICH REPRESENTS ALL THE HOSPITALS IN NEW JERSEY, WISHES TO THANK YOU FOR THIS OPPORTUNITY TO APPEAR TODAY AND PRESENT TESTIMONY ON THE IMPLEMENTATION OF NEW JERSEY'S HOSPITAL RATE SETTING LAW, P.L. 1978, CHAPTER 83.

I HAVE BEEN ASKED TO NOTE THAT MOST OF OUR MEMBERSHIP HAVE DETERMINED TO ALLOW OUR TESTIMONY TODAY TO REPRESENT THEIR STATEMENTS TO THIS COMMITTEE. OUR COMMENTS REPRESENT YEARS OF DETAILED AND INTIMATE INVOLVEMENT WITH CHAPTER 83 - THE LEGISLATIVE CHANGES - INCLUDING THE NEGOTIATING AND DEVELOPMENT STAGES; WITH THE DRG SYSTEM SINCE BEFORE ITS INCEPTION; AND WITH THE INNUMBERABLE CHANGES THAT HAVE BEEN MADE IN THIS SYSTEM SINCE IT BEGAN. I PERSONALLY SERVE AS CO-CHAIRPERSON ALONG WITH OUR NEW COMMISSIONER, DR. MAYER, OF THE FORMAL EVALUATION PROCESS BEING CONDUCTED BY THE HEALTH RESEARCH AND EDUCATIONAL TRUST OF N.J. I AM CONFIDENT THAT THE NJHA PROFESSIONAL STAFF OF FINANCIAL EXPERTS, ACCOUNTANTS, MANAGERS, PLANNERS AND ECONOMISTS ARE AS VERSED IN THE DRG SYSTEM IN NEW JERSEY AS ANYONE IN THIS STATE OR ELSEWHERE. MY COMMENTS REPRESENT THREE YEARS OF THE REAL WORLD OF DRGS IN OUR HOSPITALS, WHICH IS THE ONLY PLACE IN NEW JERSEY THAT DRGS ARE OPERATIONAL.

WHEN THE LEGISLATURE PASSED CHAPTER 83, THE BOARD OF TRUSTEES OF THE NEW JERSEY HOSPITAL ASSOCIATION WENT ON RECORD SUPPORTING IT. WE SUPPORTED IT THEN AND CONTINUE TO SUPPORT IT NOW. WE BELIEVE IT IS A GOOD LAW.

TO IMPLEMENT CHAPTER 83, THE DEPARTMENT OF HEALTH DEVELOPED THE DRG METHOD OF REIMBURSEMENT. IT WAS REPORTED BY THE DEPARTMENT THAT DRGS WERE EXPERIMENTAL AND THAT THE SYSTEM WOULD BE PERIODICALLY EVALUATED. WE SUPPORTED DRGS AS AN EXPERIMENT. WE CONTINUE TO SUPPORT DRGS AS AN EXPERIMENT.

I AM HERE TODAY TO TESTIFY ON WHAT THE ASSOCIATION FEELS ARE SOME OF THE PROMISES OR GOALS OF CHAPTER 83 AND THE DEGREE TO WHICH THE DRG SYSTEM HAS SUCCEEDED OR FAILED IN MEETING THOSE GOALS.

I BELIEVE THAT IS IMPORTANT BECAUSE THE LAW DID NOT MANDATE DRGS. AS YOU KNOW THE DIAGNOSIS RELATED GROUPS (DRGS) ARE MANDATED BY THE DEPARTMENT OF HEALTH THROUGH REGULATION.

IT IS ESPECIALLY IMPORTANT TO NOTE THAT UNDER CHAPTER 83 AND DRGS, ALL OF A HOSPITAL'S INCOME AVAILABLE FOR OPERATIONS IS PREDETERMINED BY GOVERNMENT AND APPROVED IN ADVANCE. THEY CAN BE PAID ONLY WHAT THEIR APPROVED COSTS ARE. IF THEY ARE PAID OR CHARGE MORE, THEY MUST PAY A SUBSTANTIAL INTEREST PENALTY WHILE ALSO LOSING THE REVENUE. IF THEY RECEIVE LESS THAN WHAT THEY ARE APPROVED (BECAUSE OF A PROBLEM WITH "THE SYSTEM"), THEY HAVE NO OTHER MEANS OF RECEIVING MONEY TO MEET THESE DEFICITS SINCE ALL THE RATES THEY CHARGE TO ALL PAYORS ARE CONTROLLED BY GOVERNMENT.

THIS INCLUDES MONEY RECEIVED FROM ALL SOURCES INCLUDING BLUE CROSS, COMMERCIAL INSURANCE COMPANIES, MEDICARE, MEDICAID AND PRIVATE PAYING PATIENTS. ALSO IF THEY ARE NOT PAID ACCORDING TO ITEMS REQUIRED IN THE LAW, THEY WILL RECEIVE LESS THAN THEIR COSTS. FINALLY IF THEY ARE NOT PAID UNTIL MONTHS OR YEARS LATER, THEY STILL HAVE NO WAY TO GENERATE INCOME TO PAY BILLS.

SOME GOALS OF CHAPTER 83

I'D LIKE TO REVIEW SOME OF THE GOALS OF CHAPTER 83, AS WE WOULD DEFINE THEM. IN BRIEF, THE LEGISLATION MANDATED COST CONTAINMENT. FIRST, YOU CAN BE ASSURED THAT FOR OVER A DECADE NOW, NEW JERSEY HOSPITALS HAVE OPERATED WELL BELOW THE RATE OF INCREASE FOR THE REST OF THE COUNTRY. WE HAVE INCURRED LOWER COST INCREASES, SPENT LESS MONEY, AND BOTH DELAYED AND REDUCED EXPANSION REQUIREMENTS. (I WOULD ALSO NOTE THAT YOU CANNOT EXPECT THIS PERFORMANCE INDEFINITELY, AS EVENTUALLY THE QUALITY OF CARE AND/OR DETERIORATION OF THE PHYSICAL PLANT WILL RESULT.)

SECOND, SOLVENCY OF HOSPITALS WAS MANDATED. THERE IS NO QUESTION THAT MANY INNER CITY HOSPITALS WHICH WERE NEARLY BANKRUPT IN 1978, ARE NOW HEALTHIER BECAUSE THE LAW REQUIRES THAT THE SYSTEM PAY HOSPITALS FOR SERVICES TO THE MANY INDIGENT PATIENTS THEY SERVE AND ALSO FOR THE BAD DEBTS THEY INCUR. (I WOULD CAUTION THAT THE DRG SYSTEM MAY BE TIGHTENING TO A POINT NOW WHERE WE ARE COMING TO SEE SIMILAR PROBLEMS IN ALL TYPES OF HOSPITALS IN THE NEXT YEAR.) ON A SHORT TERM, AT LEAST, CHAPTER 83 HAS PROVIDED RELIEF.

THIRD, EQUALIZED PAYMENTS FOR ALL PAYORS HAVE BROUGHT ABOUT A REDUCTION IN THE DIFFERENTIAL AMONG PAYORS, AS WELL AS THE SHARING OF COSTS BY ALL PAYORS FOR INDIGENT CARE AND BAD DEBTS.

FOURTH, THE SYSTEM WAS DESIGNED TO BE PROSPECTIVE: I.E., COSTS AND RATES ARE TO BE DETERMINED IN ADVANCE SO THAT PAYORS COULD ANTICIPATE OUTLAYS AND HOSPITALS COULD PLAN ON APPROVED REVENUES. THIS IS A MAJOR FAILURE TO DATE WHICH I WILL ADDRESS LATER.

FIFTH, THE REIMBURSEMENT METHODOLOGY REQUIRED IN THE LAW WAS TO ASSURE FAIRNESS AND GUARANTEE THAT FOR THE FIRST TIME A HOSPITAL WOULD BE PAID FOR ITS APPROVED COSTS. THIS IS THE SECOND MAJOR PROBLEM WHICH I WILL ADDRESS FURTHER.

IN SUMMARY, THE ABOVE NOTED GOALS OF CHAPTER 83 REGARDING COST CONTAINMENT AND EQUALIZED PAYMENTS FOR PAYORS HAVE BEEN SERVED WELL. WITH RESPECT TO GUARANTEED LONG RANGE HOSPITAL SOLVENCY, PROSPECTIVITY, AND THE METHODOLOGICAL FAIRNESS, THESE GOALS HAVE YET TO BE REALIZED AND PRESENT THE HOSPITALS WITH SOME SERIOUS PROBLEMS. SIMULTANEOUSLY WE HAVE DEVELOPED MANY PUBLIC RELATIONS PROBLEMS.

PROCESS FOR DRG REGULATIONS

ATTACHED TO THIS TESTIMONY IS A COPY OF OUR FORMAL COMMENTS WHICH WERE SUBMITTED TO THE DEPARTMENT OF HEALTH IN RESPONSE TO THE PROPOSED 1983 DRG REGULATIONS. THESE REGULATIONS HAVE BEEN PROPOSED BY THE DEPARTMENT OF HEALTH AND THEY WILL BE ACTED UPON ON OCTOBER 7, 1982 BY THE HEALTH CARE ADMINISTRATION BOARD.

LET ME REVIEW THE PROCESS:

FOR THREE YEARS NOW NJHA HAS BEEN ASSIMILATING AND DOCUMENTING PROBLEMS AND SOLUTIONS FOR THE DRG SYSTEM. THESE MAY BE IMPLEMENTED OR IGNORED IN OCTOBER. OUR STAFF HAS MET WITH DEPARTMENT OF HEALTH STAFF TO ASSURE NO MISUNDERSTANDING EXISTS ABOUT OUR CONCERNS AND OUR RECOMMENDATIONS.

THIS AFTERNOON I MEET WITH COMMISSIONER MAYER TO REVIEW AND HOPEFULLY TO COME TO AGREEMENT ON OUR COMMENTS.

IF WE DO NOT SUCCEED WE WILL FURTHER PRESENT OUR POINTS TO THE HCAB MEMBERS. AT THAT STAGE SENATORS, WE COULD DESPERATELY NEED YOUR HELP. TIME WILL TELL, AND WE WILL KEEP YOU ADVISED. OUR GOAL IS TO IMPROVE THE SYSTEM THAT THE HOSPITALS MUST IMPLEMENT.

SERIOUS PROBLEMS

THE PROBLEMS FALL INTO FIVE GENERAL AREAS: PROSPECTIVENESS OR TIMELINESS OF THE SYSTEM; INEQUITABLE FACTORS BUILT INTO THE REIMBURSEMENT FORMULA; ELEMENTS OF FINANCIAL REQUIREMENTS PROVIDED FOR IN THE LAW -- BUT NOT PROVIDED FOR IN THE REGULATIONS; PUBLIC RELATIONS PROBLEMS AND SOLVENCY FOR HOSPITALS.

PROSPECTIVENESS

I'D LIKE TO DEAL WITH THE ISSUE OF PROSPECTIVE PAYMENT FIRST. CHAPTER 83 ENVISIONED A PROSPECTIVE REIMBURSEMENT SYSTEM; THIS WAS ONE OF THE MAIN PROBLEMS WHICH CHAPTER 83 SOUGHT TO CORRECT

AND WHICH THE DRG SYSTEM SHOULD. IT HAS NOT. RATES OF PAYMENT WHICH HOSPITALS CAN RECEIVE ARE NOT ISSUED PRIOR TO THE BEGINNING OF THE RATE YEAR. IN FACT, THERE ARE APPROXIMATELY 20 TO 25 HOSPITALS THAT DO NOT YET HAVE THEIR INITIAL 1982 RATES WHICH APPLY TO SERVICES PROVIDED FROM JANUARY 1982 THRU DECEMBER.

AFTER A HOSPITAL RECEIVES THE INITIAL RATE, IT APPEARS BEFORE THE HOSPITAL RATE SETTING COMMISSION. THE FIRST HOSPITAL FOR 1982 DID NOT APPEAR BEFORE THE COMMISSION UNTIL AUGUST 1982 TO HAVE ITS "PROSPECTIVE" 1982 RATES ESTABLISHED. ONCE AGAIN WE ARE IN A RETROSPECTIVE SYSTEM. THIS MAKES MANAGEMENT VIRTUALLY GUESS WORK WITHOUT KNOWING WHAT THE HOSPITAL'S APPROVED INCOME WILL BE.

IN ADDITION TO THESE DELAYS, IT IS IMPORTANT TO NOTE THAT A HOSPITAL'S BUDGET IS NOT TRULY FINALIZED UNTIL AFTER THE END OF THE YEAR WHEN A "FINAL RECONCILIATION" IS SUPPOSED TO TAKE PLACE. AS OF TODAY, ONLY THREE HOSPITALS' 1980 FINAL RECONCILIATIONS HAVE BEEN PERFORMED. THIS LEAVES 23 HOSPITALS TO BE "RECONCILED" FOR 1980 AND 60 PLUS FOR 1981. ALMOST ALL OF THESE HOSPITALS HAVE RECEIVED LESS THAN WHAT IS DUE. WE ESTIMATE THEIR UNDERPAYMENT TOTALS APPROXIMATELY 50 MILLION DOLLARS. THE PAYORS WILL EVENTUALLY HAVE TO PAY INTEREST WHEN THIS AMOUNT BECOMES DUE; WHICH MEANS AN ESTIMATED 6 TO 8 MILLION DOLLARS IN ADDITIONAL INTEREST PAYMENTS.

OBVIOUSLY THIS SYSTEM IS NOT PROSPECTIVE. THE HOSPITAL ASSOCIATION RECOMMENDS THAT INITIAL RATES BE SUBMITTED IN ACCORDANCE WITH A TIMETABLE WHICH WILL ALLOW HOSPITLAS TO RECEIVE A DECISION FROM THE HOSPITAL RATE SETTING COMMISSION <u>PRIOR</u> TO THE BEGINNING

OF THE RATE YEAR AND FURTHER, THAT THE FINAL RECONCILIATION BE COMPLETED WITHIN SIX MONTHS FOLLOWING THE END OF THE RATE YEAR. IF THE DEPARTMENT CANNOT COPE WITH THE SYSTEM BY SIX MONTHS, THEN 100% OF AUDITED MONIES DUE SHOULD BE APPROVED AND PAID.

INEQUITABLE FACTORS

THE SECOND ISSUE I WOULD LIKE TO ADDRESS IS THE INEQUITABLE FACTORS BUILT INTO THE REIMBURSEMENT FORMULA.

ONE SUCH FACTOR IS THE PROPOSED RULE CHANGE FOR FISCAL 1983 IN THE CAPITAL FACILITIES ALLOWANCE (CFA). THE CFA IS THAT COMPUTATION IN THE FORMULA WHICH REIMBURSES HOSPITALS FOR BUILDINGS AND FIXED EQUIPMENT USED FOR PATIENT CARE. THESE FUNDS MAY NOT BE SPENT AT A HOSPITAL'S DISCRETION BUT MUST BE USED TO RETIRE LONG-TERM DEBT OR TO REPLACE OBSOLETE EQUIPMENT.

THE CFA CURRENTLY PROVIDES FOR EITHER DEBT PRINCIPAL PAYMENTS OR DEPRECIATION. HOSPITALS MAY CHOOSE EITHER METHOD TO DETERMINE THEIR REIMBURSEMENT ALLOWANCE. THE DEPARTMENT OF HEALTH'S PROPOSED 1983 REGULATION TAKES THE DEPRECIATION OPTION AWAY FROM HOSPITALS AND POSES A LOSS OF AT LEAST $12 MILLION FOR THE INDUSTRY.

THIS PROPOSED CHANGE WOULD PLACE HOSPITALS IN A PRECARIOUS FINANCIAL POSITION. CURRENTLY MEDICARE PARTICIPATES IN OUR SYSTEM VOLUNTARILY...AS AN EXPERIMENT. THIS IS CALLED THE MEDICARE WAIVER--THEY WAIVE THEIR FORMULA FOR OURS. WHEN MEDICARE DECIDES TO SUSPEND OR DISCONTINUE ITS WAIVER OR IF CHAPTER 83 WERE MODIFIED SIGNIFICANTLY WITHIN THE NEXT FEW YEARS, HOSPITALS WOULD HAVE SIZEABLE UNREIMBURSED DEPRECIATION.

THERE IS ALSO A POTENTIAL FOR CREDITORS TO DEMAND HIGHER INTEREST RATES TO COVER THE INCREASED RISKS ASSOCIATED WITH LENDING MONEY TO NEW JERSEY HOSPITALS WITH UNCOMPENSATED DEPRECIATION. THE NONPAYMENT FOR DEPRECIATION IS CONSIDERED BY SOME AS TANTAMOUNT TO CONFISCATION OF PROPERTY.

UNDER EITHER OF THE TWO METHODS, A HOSPITAL'S TOTAL REIMBURSEM OVER THE LIFE OF THE ASSET REMAINS THE SAME. MAINTAINING THE TWO OPTIONS MERELY ELIMINATES TIMING PROBLEMS FROM YEAR TO YEAR AND PROTECTS HOSPITALS AGAINST THE POSSIBILITY OF HAVING UNREIMBURSED DEPRECIATION IN THE EVENT THE MEDICARE WAIVER IS NOT CONTINUED OVER THE LIFE OF THE ASSET. THE NEW JERSEY HOSPITAL ASSOCIATION RECOMMENDS THE PRESENT OPTIONS FOR REIMBURSEMENT UNDER CAPITAL FACILITIES ALLOWANCE NOT BE CHANGED BECAUSE THE PROPOSED CHANGE YIELDS NO BENEFITS, BUT EXPOSES HOSPITALS TO POTENTIAL SERIOUS FINANCIAL HARM.

ANOTHER MATTER OF CONCERN IS THE INFLATION ADJUSTMENT TECHNICALLY CALLED THE "ECONOMIC FACTOR." THIS FACTOR MEASURES THE ALLOWABLE IMPACT OF INFLATION ON HOSPITAL LABOR COSTS AND SUPPLIES. EACH YEAR, A HOSPITAL'S INCOME IS ADJUSTED BY THIS FIGURE. THE PROJECTED FACTOR IS LATER ADJUSTED TO THE ACTUAL INFLATION RATE AND HOSPITALS' PAYMENT RATES ARE ADJUSTED ACCORDINGLY APPROXIMATELY 60 PERCENT OF THE ECONOMIC FACTOR IS COMPRISED OF LABOR COST CHANGES.

TO DETERMINE LABOR COST CHANGES, THE EMPLOYMENT COST INDEX FOR THE NORTHEASTERN PORTION OF THE COUNTRY IS USED. THIS INDEX

COVERS ALL PRIVATE, NONFARM WORKERS. THE INCREASE IN THIS INDEX DETERMINES THE AMOUNT OF DOLLARS APPROVED FOR HOSPITAL SALARY INCREMENTS. THIS LABOR INDEX OR PROXY DOES NOT REFLECT WHAT IS HAPPENING IN HOSPITAL LABOR MARKETS, PARTICULARLY IN THE CASE OF REGISTERED NURSES AND OTHER TECHNICAL POSITIONS. THIS INDEX DOES NOT PROVIDE FOR INCREASES DUE TO MERIT OR SENIORITY, EVEN THOUGH PAY RAISES FOR THESE REASONS ARE COMMON. ALSO, BECAUSE OF THE GROWTH IN DEMAND FOR REGISTERED NURSES RELATIVE TO THE SUPPLY, THE 1979 BASE-YEAR SALARIES ARE NOT REPRESENTATIVE OF COMPARABLE 1983 SALARIES. MANY HOSPITALS ARE HAVING GREAT DIFFICULTY ATTRACTING NURSES AND OTHER EMPLOYEES. WE RECOMMEND THAT AN ADDITIONAL AMOUNT BE ADDED TO THE INDEX FOR MERIT, FOR SENIORITY, AND TO ALLOW FOR THE FACT THAT THE INDEX DOES NOT REFLECT HOSPITAL LABOR MARKET CONDITIONS.

ON A RELATED SUBJECT, HOSPITALS GRANT WAGE AND SALARY INCREASES BASED ON THE DEPARTMENTS PROJECTED INFLATION INDEX. AT THE END OF THE YEAR ADJUSTMENTS ARE MADE TO HOSPITALS RATES TO REFLECT ACTUAL INFLATION. THE PROBLEM IS THAT ANNUAL PAY INCREASES CAN'T WAIT UNTIL AFTER EACH YEAR IS OVER. WHEN ADJUSTMENTS BY THE DEPARTMENT OF HEALTH ARE RETROACTIVELY APPLIED, THE HOSPITALS FISCAL POSITION IS UNDERMINED. YOU CAN'T RESCIND SALARY INCREASES ALREADY GIVEN OR NEGOTIATED. IN 1982 THE ACTUAL WAGE COMPONENT IS 2 PERCENT BELOW THAT WHICH WAS PROJECTED. THESE WAGES HAVE BEEN GRANTED. IF THE ACTUAL WAGE COMPONENT IS APPLIED TO HOSPITALS RETROACTIVELY IT WILL MEAN 30 MILLION DOLLARS IN LOST INCOME WHICH IS NECESSARY TO PAY THE WAGE AND SALARY COMMITMENTS.

WE RECOMMEND THAT NO RETROACTIVE CHANGE TO THE INITIAL APPROVED WAGE INCREASE BE MADE; ONLY PROSPECTIVE ADJUSTMENTS SHOULD BE MADE. THE ADJUSTMENT FOR 1982 WOULD THEREFORE BE MADE IN 1984 RATES, 1983 ADJUSTMENTS IN 1985. IF A SIGNIFICANT MISPROJECTION SHOULD ARISE DURING THE RATE YEAR, WE RECOMMEND THE MATTER BE BROUGHT TO THE HEALTH CARE ADMINISTRATION BOARD'S ATTENTION BY THE DEPARTMENT FOR ACTION. THIS PROSPECTIVE ADJUSTMENT WOULD ALLOW HOSPITALS TO BE PAID NO MORE THAN THE ACTUAL ECONOMIC FACTOR OVER A PERIOD OF YEARS. HOSPITALS WOULD THEN NOT BE PLACED IN THE UNTENABLE POSITION OF HAVING TO TAKE BACK APPROVED WAGE INCREASES.

MISSING FINANCIAL ELEMENTS

THE THIRD MAJOR PROBLEM I WOULD LIKE TO ADDRESS IS MISSING FINANCIAL ELEMENTS IN THE REIMBURSEMENT METHODOLOGY.

THE LAW STATES THAT HOSPITALS WILL BE REIMBURSED FOR, AMONG OTHER THINGS, UNCOMPENSATED CARE SUCH AS INDIGENT CARE AND BAD DEBTS, AND INTEREST ON DEBT. YET THE REGULATIONS DO NOT ALLOW THE COST OF UNCOMPENSATED CARE RELATED TO CUSTODIAL CARE PATIENTS. THESE ARE PATIENTS READY FOR DISCHARGE FROM THE HOSPITAL BUT WHO CANNOT BE DISCHARGED BECAUSE THEY HAVE NO PLACE TO GO. HOSPITALS HAVE ASSUMED RESPONSIBILITY FOR THE CUSTODIAL CARE OF THESE PATIENTS AND SHOULD BE REIMBURSED A REASONABLE AMOUNT OF THEIR ASSOCIATED COSTS.

THE REGULATIONS ALSO DO NOT ALLOW INTEREST TO BE RECEIVED ON SHORT-TERM BORROWING OR INTEREST ON LOANS TO FINANCE MAJOR MOVABLE EQUIPMENT.

THE ASSOCIATION BELIEVES THAT THE REGULATIONS ARE IN DIRECT CONFLICT WITH THE LAW AND RECOMMENDS THAT THE MISSING FINANCIAL ELEMENTS BE INCORPORATED INTO THE REIMBURSEMENT FORMULA.

PUBLIC RELATIONS - BILLING PATIENTS AN AVERAGE RATE RATHER THAN ACCUMULATED CHARGES

ANOTHER PROBLEM IN IMPLEMENTING THE DRG SYSTEM IS THE MANDATE TO BILL ALL PATIENTS AT THE AVERAGE COST PER CASE. THIS AVERAGE IN MANY INSTANCES DIFFERS SUBSTANTIALLY FROM ACTUAL COSTS AND CHARGES OF TREATING INDIVIDUAL PATIENTS. THE INDIVIDUAL PATIENT IS SUBJECT TO INEQUITIES WHEN THE ACTUAL CHARGES FALL BELOW THE DRG RATE.

THE PATIENT IS ALLOWED TO APPEAL, BUT THE APPEAL PROCESS IS A TIME-CONSUMING AND COSTLY ONE. FOR THREE YEARS NOW THIS ASSOCIATION HAS RECOMMENDED THE CONCEPT OF BILLING PATIENTS BASED UPON CONTROLLED CHARGES AND THEN MAKING ADJUSTMENTS NECESSARY TO ASSURE THAT HOSPITALS RECEIVE NEITHER TOO LITTLE NOR TOO MUCH REVENUE AT FINAL RECONCILIATION.

WE RECOMMEND THAT BILLING PATIENTS ON THE BASIS OF CHARGES RATHER THAN THE DRG RATE BE IMPLEMENTED AS SOON AS POSSIBLE. (I AM HEARTENED TO NOTE THAT THIS HEALTH COMMISSIONER HAS INITIATED THIS ACTION FOR PRIVATE PAYING PATIENTS, REQUESTING APPROVAL TO DO SO FROM THE FEDERAL GOVERNMENT.)

SOLVENCY

THE FINAL ISSUE I WOULD LIKE TO ADDRESS IS HOSPITAL SOLVENCY. THE LAW REQUIRES SOLVENCY FOR EFFICIENTLY-RUN AND EFFECTIVELY-UTILIZED HOSPITALS. THE HOSPITAL RATE SETTING COMMISSION HAS BEEN MINDFUL OF THIS WHEN APPROVING RATES. HOWEVER, THERE IS ONE ITEM THAT COULD AFFECT THE SOLVENCY OF ALL HOSPITALS IN NEW JERSEY WHICH HAS NOT BEEN BROUGHT TO THEIR ATTENTION. THAT ITEM IS THE MEDICARE CAP.

WHEN NEW JERSEY RECEIVED A WAIVER FROM THE FEDERAL GOVERNMENT TO PAY DRG RATES FOR MEDICARE PATIENTS, THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION (HCFA) STATED THAT THE WAIVER WOULD BE SUBJECT TO A CAP. ANY EXCESS OVER THAT CAP WOULD NOT BE PAID BY EITHER MEDICARE OR MEDICAID. TO DATE, THREE YEARS INTO A FOUR-YEAR WAIVER, THE DEPARTMENT OF HEALTH HAS NOT GIVEN ANY REPORTS AS TO THE STATUS OF THE CAP. WE BELIEVE THAT THIS IS A CRUCIAL ISSUE WHICH HAS BEEN OVERLOOKED AND WHICH COULD AFFECT THE SOLVENCY OF NEW JERSEY HOSPITALS. FORMER DEPARTMENT OF HEALTH STAFF NEGOTIATED AN AGREEMENT WITH THE FEDERAL GOVERNMENT WHERE MEDICARE AND MEDICAID PAYMENTS ABOVE THE CAP WOULD BE PAID BACK BY OUR HOSPITALS. SINCE WE ALONE WERE MADE LIABLE, WE DESERVE A RELIABLE UPDATE ON THE STATUS OF THE CAP.

WE RECOMMEND THAT AN ANALYSIS BE PERFORMED IMMEDIATELY TO DETERMINE THE STATUS OF THE CAP SO THAT WE CAN COOPERATIVELY TAKE WHATEVER ACTION IS APPROPRIATE.

IN SUMMARY, I WOULD LIKE TO REITERATE THAT WHILE WE SUPPORT CHAPTER 83 AND THAT WHILE WE ALSO SUPPORT DRG AS AN EXPERIMENT, THE

NEW JERSEY HOSPITAL ASSOCIATION FEELS THAT THE ITEMS I HAVE JUST ENUMERATED AND ALL THE ITEMS LISTED IN OUR RECOMMENDATIONS TO IMPROVE CHAPTER 83 ARE SIGNIFICANT ITEMS WHICH MUST BE IMPLEMENTED IN ORDER TO IMPROVE THE DRG SYSTEM AND POSSIBLY TO ENABLE US TO MOVE FROM AN EXPERIMENTAL TO A PERMANENT REIMBURSEMENT SYSTEM.

YOU SHOULD KNOW THAT THE TIME SPENT AND COOPERATION RECEIVED FROM THE DEPARTMENT OF HEALTH AND ESPECIALLY COMMISSIONER MAYER TO DATE HAS BEEN NOTHING SHORT OF A BREATH OF FRESH AIR. MOST OF TODAYS PROBLEMS ARE A LENGTHY ACCUMULATION SINCE DAY ONE, EXACERBATED BY INACTION FROM THE DEPARTMENT.

I SHOULD POINT OUT THAT IN GENERAL THIS SYSTEM IS EXCESSIVELY COMPLEX FOR THE PAYORS, HOSPITALS AND THE DEPARTMENT OF HEALTH AS MANAGERS. FEW PEOPLE UNDERSTAND THE BASICS, BECAUSE OF ITS NEEDLESS, EXPENSIVE COMPLEXITY. ITS GOALS ARE RELATIVELY SOUND. THE PHILOSOPHY, HOWEVER, TO AVERAGE ALL FACTORS AND REDUCE PAYMENTS TO OUR HOSPITALS COULD EASILY RESULT IN HAVING AVERAGE CAPABILITIES, AVERAGE SERVICES AND AVERAGE HEALTH AMONG OUR 7 MILLION RESIDENTS. OUR HOSPITALS ARE STRUGGLING TO COOPERATE AND PERFORM IN SPITE OF THE EXCESSIVE AND EXPENSIVE RULES.

THE CHALLENGE TODAY IS WHETHER THE COMPLEX SYSTEM CAN BE MANAGED BY THE DEPARTMENT. DELAYS OF MONTHS AND YEARS IN FINAL AUDIT AND ADJUSTMENTS TO HOSPITALS ARE UNCONSCIONABLE AND UNACCEPTABLE. THE STATE MUST ACT IN THE SAME RESPONSIBLE FASHION IT REQUIRES FROM THE 2 BILLION DOLLAR STATE-REGULATED HOSPITAL INDUSTRY. THE BOTTOM LINE IS THE HEALTH CARE OF OUR 7 MILLION NEW JERSEY RESIDENTS, THE HEALTH OF 1.5 MILLION PATIENTS ADMITTED TO OUR

HOSPITALS EACH YEAR, THE SERVICE TO OUR 6.2 MILLION OUTPATIENTS, AND THE STATUS OF OUR WORK FORCE WHICH HOSPITALS EMPLOY AND PROVIDE JOBS TO...OVER 100,000 PEOPLE IN THIS STATE.

THANK YOU VERY MUCH, MR. CHAIRMAN. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

New Jersey Hospital Association's
Comments on the
Proposed 1983 Chapter 83 Regulations

I. Capital Facilities Allowance

Status

For major fixed capital costs, hospitals are reimbursed the higher of (1) the sum of the principal, interest, and the capital facility formula allowance (CFFA), or (2) depreciation plus interest.

DOH Proposal

The Department proposes to eliminate the second option and pay all hospitals according to the first option.

Concerns

- Hospitals would be placed in a precarious financial position. The proposed change would mean in 1983 alone that hospitals would not be reimbursed $12 million of depreciation.
- If Medicare were to suspend or not to renew the waiver or Chapter 83 were modified significantly within the next few years, hospitals would have a large amount of unreimbursed depreciation.
- Creditors may also react negatively to the presence of uncompensated depreciation and demand higher interest rates to cover the increased risk associated with lending money to New Jersey hospitals.
- Nonpayment of depreciation is tantamount to confiscation of property.
- Paying hospitals at the higher of the two options does not change the total amount paid to the hospitals over the useful life of the assets.

Recommendation

- The present options should not be changed because the proposed change yields no benefits, but exposes the hospitals to potential serious financial harm.

Benefits

- Hospitals would be ensured reimbursement for depreciation, which they must have if facilities are to be replaced in the future.
- Creditors would require less interest to loan money to hospitals.

II. One Percent Add-on

Status

Hospitals could accept or reject their 1982 payment rates. No add-on was paid if a hospital accepted its proposed rates.

DOH Proposal

The acceptance options are to be expanded from two to three to include conditional acceptance. A hospital that accepts its proposed rates will receive an add-on of one percent of the unequalized payment standards for nonphysician direct inlier costs.

--Accepting hospitals seemingly will not be allowed to appeal anything but uncompensated care and the capital facility allowance.
--Hospitals that conditionally accept their rates will have the same appeal rights as accepting hospitals have today. A one percent add-on will not be paid to these hospitals.
--Hospitals that reject their rates will automatically have their budgets recalculated based on median efficiency standards and then be required to justify "excess" costs as identified by application of those standards. A one percent add-on will not be paid to these hospitals.

Concerns

- The one percent add-on is not likely to discourage many hospitals from appealing because the dollar amount is too small.

- Hospitals have the right to an appeal, yet comparison to the median after not accepting can harshly penalize hospitals for exercising this fundamental right.

- The HCAB minutes and the cover letter to the proposed regulations explain appeal rights for hospitals accepting rates, but these rights seem to be excluded from the regulation.

- Since the proposed add-on is based on inliers, all hospitals are not given the same opportunity to accept the proposed rates because the proportion of inliers varies across hospitals. In addition, the add-on amounts to approximately $45,000 for a hospital with a $15 million budget. This is insufficient to discourage appeals.

- There is uncertainty about whether the one percent add-on will be paid in lieu of appeals for costs incurred between 1982 and 1983 or in lieu of appeal costs incurred between 1979 and 1983.

Recommendations

- All hospitals should be offered a reasonable amount to forgo appeals and the add-on should be relatively the same across hospitals.

II. One Percent Add-on

Recommendations (Cont'd.)

- A reasonable add-on is one percent of a hospital's approved preliminary cost base updated for inflation.
- The mean standard should continue to be used to screen rejecting hospitals. The median is punitive and should not be used because of its potentially serious consequences.

Benefits

- If, as we believe, the Department will apply the add-on to all approved 1982 costs, a reasonable add-on will streamline the appeals process.
- Expeditious resolution of appeals is critical to sound financial planning and will lessen cash-flow problems due to lengthy appeals.
- A shortened appeals process will minimize short-term borrowing at high interest rates.
- An add-on will provide some dollars to ensure that hospitals can keep up with technological advances.

III. Determination of 1983 Rates

Status

Payment rates for 1982 are based on 1979 costs updated for inflation. New costs incurred between 1979 and 1982 can be appealed and, if approved, are included in a hospital's rates.

DOH Proposal

Payment rates for 1983 are to be based on 1982 rates updated for inflation.

Concern

- There is uncertainty about the Department's approach. Does the Department intend to base 1983 rates on 1982 rates inclusive of all approved patient care costs, indirect costs, and successfully appealed costs? Or will the 1983 rates be based on 1982 approved costs exclusive of successfully appealed costs?

Recommendation

- Payment rates for 1983 should be based on all 1982 approved costs (updated for inflation), including items appealed successfully.

Benefit

- The recommended approach will shorten the appeals process and minimize cash flow problems.

IV. Economic Factor

Status

The proxy for labor is the Employment Cost Index for the northeastern portion of the country. This index covers all private, nonfarm workers. The increase in this index determines the amount of dollars that are approved for salary increases.

DOH Proposal

NO CHANGE IS PROPOSED.

Concerns

- The labor proxy does not reflect what is happening in hospital labor markets, particularly in the case of registered nurses.
- Growth in the demand for registered nurses relative to the supply means that 1979 base-year salaries are unrepresentative of comparable 1983 salaries.
- No amount is or has ever been allowed for seniority or merit, even though pay increases for these reasons are common.
- Hospitals are finding it increasingly difficult to compete for employees, especially registered nurses.

Recommendations

- Three percentage points should be added for merit, seniority, and to allow hospitals to provide additional wages for nurses.
- The Department, Association, and other concerned parties should conduct a study to determine the adequacy of the nurses' salary base. (A low base remains low even after it is raised by a few additional percentage points).

Benefits

- Hospitals will be able to compete for workers on the same basis as other industries.
- Additional dollars will be available to recruit and retain a sufficient number of registered nurses.

IV. Economic Factor (continued)

Status

The economic factor for any given rate year is budgeted using the best available projections at the time the rate is established.

The actual economic factor is not known until six to nine months after the rate year is over.

The difference between the initial projection and the actual economic factor is adjusted at the final settlement (final reconciliation) of the hospital's rate year.

The adjustment applies to both labor and nonlabor costs.

DOH Proposal

NO CHANGE IS PROPOSED.

Concerns

- Hospitals rely heavily on the Department of Health's budgeted wage factor and base actual salary adjustments on it.
- Retroactive adjustments to approved salary increases are unfair and impossible to implement.
- The adjustment for labor costs should be made prospectively because hospitals cannot take back wage increases.

Recommendations

- No change to the initial approved wage increase should be made at final reconciliation.
- Any difference between the Department's initial approved wage increase and the actual wage increase should be made prospectively in the first year after the actual data are available. The adjustment for 1982 would therefore be made in 1984 rates; 1983 adjustment in 1985 rates, etc.
- If a significant misprojection should arise during the rate year, the matter should be brought to the Health Care Administration Board's attention for possible action.

Benefits

- Hospitals would be paid no more than the actual economic factor over a period of years.
- Hospitals would not be placed in the untenable position of having to take back approved wage increases.

V. Coordinate Rate Setting and Planning Process

Status

Reimbursement and planning matters relating to a certificate of need application are usually viewed independently. Hospitals do not always receive full reimbursement for complying with licensing requirements.

DOH Proposal

NO CHANGE IS PROPOSED.

Concerns

- The determination of whether hospitals will be reimbursed for the operating costs of an approved certificate of need is not made until after the CN's approval; therefore, hospitals do not know if they will be paid for maintaining the project. The related problems have been especially acute with respect to CT scanners.
- The HRSC normally decides that the cost of the new equipment should be financed through efficiencies or added volume.
- The added expense of licensure requirements is usually not allowed as a reimbursable cost.

Recommendations

- Both the capital costs and the operating costs should be approved for inclusion in hospitals' rates at the time the certificate of need is approved.
- The financial and planning timetables must agree; i.e., a timely review of all costs by the HRSC is imperative so as not to delay implementation of the certificate of need project.
- All mandated licensure expenses should be approved.

Benefits

- A currently fragmented process will be coordinated.
- Financial consequences of planning and licensure decisions will be known "up front" and could impact those decisions and requirements.
- Hospitals will not risk being unable to pay the operating costs that coincide with the capital cost of a certificate of need
- Hospitals will no longer be denied reimbursement of required licensure costs.

VI. Final Reconciliation

Status

Final hospital reconciliations for 1980 have been completed for only three of the first 26 hospitals to receive DRG rates. Procedures for 1981 and 1982 hospital reconciliations have not been completed. The payor reconciliation process for 1980 is also not completed. The Hospital Rate Setting Commission and the Department seem to be opposed to letting hospitals collect amounts due for 1980 until the payor reconciliation is finalized.

DOH Proposal

NO CHANGE HAS BEEN PROPOSED.

Concerns

- Hospitals cannot monitor or even estimate approved revenue unless they are certain of reconciliation procedures.
- Hospitals are incurring cash-flow problems because approved revenues are not being received. Some hospitals have been forced to borrow money because of revenue shortfalls.
- Interest must be paid on undercollections, increasing health care costs.
- Resolution of the payor reconciliation has nothing to do with the total amount of approved revenue that a hospital is entitled to collect.

Recommendations

- The Department should complete the 1980 and 1981 hospital reconciliations and let the hospitals adjust their rates immediately. If the Department cannot complete them within three months, then cash flow adjustments should be granted to the hospitals.
- The adjustment should be made regardless of the status of the payor reconciliation. The payors could distribute the amount in proportion to amounts already paid for 1980 and make a settlement among themselves once the payor reconciliation is finalized.

Benefits

- Hospitals will be able to adjust their markup to avoid miscollecting approved revenues once they know how final reconciliations will be handled for 1981 and 1982.
- Cash-flow problems will be minimized if hospitals can collect amounts due.
- Costs to payors can be reduced since interest on undercollections will cease once adjustments are made.

VII. Interest on Major Movable Equipment

Status

Chapter 83 does not consider short-term interest to be a reimbursable expense. A hospital can, however, appeal the matter before the Hospital Rate Setting Commission and, if successful, short-term interest will be reimbursed.

DOH Proposal

The hospital's right to appeal interest on major movable equipment is to be rescinded after the hospital participates in Chapter 83 for more than one year.

Concerns

- Chapter 83 recognizes that interest on major movable equipment is a legitimate cost yet the regulations exclude it from reimbursement unless appealed.
- To prohibit a hospital from even appealing an expenditure that can not easily be avoided is to expose it to financial harm that is unwarranted and undeserved.

Recommendation

- Hospitals should continue to have the right to appeal interest on major movable equipment.

Benefit

- Retention of the right costs nothing, risks nothing, and provides a fail-safe mechanism if the policy of not reimbursing this cost causes unanticipated problems.

VIII. Cross Subsidization

Status

The first year hospitals are on Chapter 83, a 50 percent cross-subsidization applies. Twenty-five percent boundaries are in place after the first year.

DOH Proposal

The cross-subsidy margin that is to be permitted without penalty is to fall to five percent for the third and subsequent years a hospital is covered by Chapter 83.

Concerns

- Neither the Department nor the hospitals can predict individual departmental volume and case mix with the degree of accuracy required to make a five percent margin a realistic goal.
- Hospitals will be required to incur additional staff and costs to monitor and update case-mix forecasts.
- Hospitals will have to increase the number of times that charge masters are changed during the year.
- Each change must be approved by the Hospital Rate Setting Commission; therefore, this proposal will increase the workload on the Department of Health and the Hospital Rate Setting Commission as well as on the hospitals.

Recommendation

- Dropping the margin from 25 to 20 percent appears to be reasonable and can be realized within a year without imposing a widespread increase in workload, costs, and changes to charge masters.

Benefits

- The amount of cross subsidy will be reduced with minimal regulatory costs.

IX. Volume Variability

Status

If volume and intensity change by less than ±3.3 percent per year over a three-year period, a hospital collects only a portion of its payment rate for the additional cases. The Department intends to apply the adjustment to inlier and outlier revenue, even though 1982 regulations are unclear on this point.

DOH Proposal

The volume/mix adjustment is to be made over a four-year period and to apply to both inlier and outlier revenue.

Concerns

- The volume/mix adjustment is correct in theory but its calculation is flawed by the "squaring term" in the formula. If volume/mix grows by two percent per year for each of four years, a hospital gets only 36.7 percent of the "fixed" component of its rate:

$$36.7\% = \left(\frac{2.0}{3.3}\right)^2$$

  This is simply too small a piece for two percent growth a year for each of four years.

- Outlier revenue should be excluded from the calculation to avoid double counting.

Recommendations

- The squaring term should be dropped because many costs that may be fixed in the short run are not fixed over four or more years.

- Outlier revenue should not be subject to the volume/mix adjustment because it is adjusted at year end by the customary cost-to-charge ratio.

Benefit

- Reimbursement will be aligned more closely with cost when volume/mix fluctuates.

X. Controlled Charges

Status

Chapter 83 regulations require hospitals to bill essentially the same DRG-specific rate to all inlier patients regardless of services received, days of care, and charges. These rates are approved by the Hospital Rate Setting Commission and represent the amount that a hospital is legally entitled to collect for each patient assigned to a DRG.

DOH Proposal

NO CHANGE IS PROPOSED

Concerns

- DRG rates are averages--that is, they represent the average cost of treating the typical patient. In many instances, the average differs substantially from actual costs and the charges of treating individual patients.
- Individual patients are subject to inequities when actual charges fall below the DRG rate.
- A costly and time consuming appeals process is required in order to try and smooth the inequities and complaints.
- Hospitals continue to experience public relations problems while billing DRG rates.
- Billing at the DRG rate causes procedural problems within the hospital, mainly the accounting and billing departments.

Recommendation

- All patients should be billed controlled charges that are reconciled at year end to DRG rates.

Benefits

- Patients, payors and the overall public would be part of a more equitable payment system.
- Cost savings would be realized by eliminating the appeals process.
- Adverse public relations for the Department, hospitals, and physicians would subside.
- Cost savings would be realized in hospital billing departments.

XI. Full Financial Requirements

Status

Chapter 83 regulations do not reimburse hospitals all of their operating costs regardless of how efficiently they operate nor do they ensure that efficient hospitals will collect all of their full financial requirements.

DOH Proposal

NO CHANGE IS PROPOSED.

Concerns

- Hospitals are not reimbursed for interest on major movable equipment and short-term interest on working-cash loans.

- Portions of uncompensated care are unreimbursed even though they are clearly beyond hospital control, such as (1) bad debts related to custodial care, and (2) amounts that hospitals are legally allowed to collect but are compelled to forgo when a utilization review organization changes a valid DRG assignment to a lower-priced DRG.

- The regulations also do not provide any automatic add-on that enables hospitals to keep abreast of technological developments.

- Price-level depreciation on major movable equipment is paid on the undepreciated (not entire) cost of an asset at the time a hospital was first covered by Chapter 83. There is no assurance hospitals will be able to replace obsolete assets since only undepreciated cost is reimbursed.

Recommendation

- Hospitals should be permitted to include the above financial elements in their approved budgets. Inadequate reimbursement can lead to serious financial problems and adversely affect accessibility and quality.

Benefits

- As mandated by Chapter 83, the solvency of efficient hospitals would be ensured.

- Treating the aforesaid items as allowable costs would lessen the number of appeals. Fewer appeals will generate cost savings for all concerned parties and enable the Hospital Rate Setting Commission to focus its energies on exceptional requests.

XII. Utilization Review

Status

Utilization review is suggested for 100 percent of admission and includes direct review and monitoring and oversight functions.

DOH Proposal

NO CHANGE IS PROPOSED.

Concerns

- There is less of a need for comprehensive review because of incentives embodied in DRG reimbursement.
- Utilization review remains unclear, burdensome, and excessively costly.

Recommendations

- Utilization review should be restricted to patients whose need for hospitalization is clearly suspect and to the following outlier patients:

  --patients whose stays equal or slightly exceed a low-trim point;
  --patients whose stays are slightly greater than a high-trim point.

- The utilization review organization should be consolidated and the review function performed mostly by individual hospitals.

Benefits

- As much as $7 million a year in just forgone monitoring and oversight could be saved by implementing the recommendation. Additional savings would result from reduced direct review.
- Unnecessary reviews would be eliminated.
- Consolidation of the review function will help to streamline regulations.

XIII. Independent HRSC

Status

The Hospital Rate Setting Commission still does not have its own staff. Instead, it relies on Department of Health staff for evaluations of rate appeals and recommendations for action.

DOH Proposal

No change is proposed other than to increase the commission fee from $.50 to $1.00 per admission.

Concerns

- Since the Department of Health writes regulations, calculates the payment rates, and regulates virtually every aspect of hospital activity, the appeal process does not appear to be as objective as it could be.
- An independent commission staff would parallel the organizational structure of a public utility commission.
- The HRSC budget would exceed $1 million based upon approximately one million admissions per year.
- The fee is actually a "hidden tax;" funds should be earmarked by the Legislature if deemed necessary and appropriate.

Recommendation

- Money to operate the Commission should be obtained from the Legislature and used to hire staff. Commission staff would be responsible for examining rate appeals, with Department of Health staff providing technical assistance regarding whether the rates were calculated in accordance with Chapter 83 regulations.

Benefits

- The commission would have a staff that is independent of the Department of Health and financed by revenues approved by the Legislature.
- Hospital costs would be held down if the fee was not added to patients' bills.
- The cost of operating the HRSC would be spread over all citizens.

XIV. Appeals Process Timetable

Status

In 1982, hospitals had 60 working days to review their rate package before accepting or not accepting the rates.

DOH Proposal

The 1983 timeframe would be reduced to 45 working days.

Concerns

- The full 60 days is needed for a complete and thorough review of the rate package.
- Management reports are necessary to evaluate the rate package, but these reports are usually distributed well after the initially-proposed rates are issued.
- Decision-making for 1983 will be especially time consuming because the Department did not provide the hospitals with any DRG management reports until August 1982.

Recommendation

- Hospitals should continue to have 60 working days to decide whether to accept or reject their rates.

Benefits

- Hospitals are allowed sufficient time to make rational decisions.
- The Department will receive fewer requests for extensions than with a 45-day time frame.

Remaining Comments and Questions

- For Class III hospitals, 1981 costs of direct inpatient care are to be used to set rates, but there is no information of how the rates will be calculated.

- Since 1980, Chapter 83 regulations have stated that Option 2 for price level depreciation of major movable equipment is to be abolished after 1982. We hope that this means the option will not be abolished because some hospitals have considerable difficulty providing the information for Option 1.

- Departmental efforts to develop new teaching standards may not be completed for 1984 rate-setting purposes. Yet the proposed regulations say a new method will be used in 1984. The proposed change on page 7 should be modified to reflect the possibility that a new method might not be developed by then.

MURRAY: STATEMENT TO SENATE SUBCOMMITTE

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, MY NAME IS MONSIGNOR HARROLD MURRAY AND I AM VICE-CHAIRMAN OF THE HOSPITAL RATE SETTING COMMISSION. I APPRECIATE THE OPPORTUNITY TO TALK TO YOU TODAY.

THE DRG SYSTEM HAS REALLY TURNED HOSPITAL MANAGEMENT IN NEW JERSEY AROUND. THE CHANGES HOSPITALS HAVE HAD TO RESPOND TO UNDER THIS SYSTEM, OF COURSE, ARE BOTH POSITIVE AND NEGATIVE.

ON THE PLUS SIDE, THIS SYSTEM HAS PROVIDED HOSPITALS WITH INCREASED FINANCIAL SECURITY THROUGH REIMBURSEMENT OF THE FINANCIAL ELEMENTS ALLOWED BY THE DRG SYSTEM. HOSPITALS NOW RECEIVE, BUILT INTO THEIR RATES, DOLLARS FOR MANY AREAS NOT PREVIOUSLY FUNDED. THE ESTABLISHMENT OF A CAPITAL FACILITIES ALLOWANCE HAS ENABLED HOSPITALS TO MAKE MORE RELIABLE PREDICTIONS OF FUTURE GROWTH AND TO COUNT ON COLLECTING FUNDS NOW FOR THOSE FUTURE PLANS.

ANOTHER BENEFIT OF THE FINANCIAL ELEMENTS HAS BEEN THE PROVISION OF A WORKING CASH INFUSION FOR THOSE HOSPITALS WITH DIFFICULT CASH-FLOW SITUATIONS. IN FACT, THIS ALLOWANCE HAS TURNED THE ACCOUNTS PAYABLE EXPERIENCE AROUND IN SOME HOSPITALS WHO WERE IN FINANCIAL TROUBLE TO THE EXTENT THAT THEY CAN NOW START TAKING ADVANTAGE OF CERTAIN ACCOUNTS PAYABLE DISCOUNTS. FURTHER, MANY OF OUR INNER-CITY HOSPITALS MOST IN NEED OF THE WORKING CASH INFUSION WERE PROBABLY IN THAT POSITION DUE TO A LARGE BURDEN OF UNCOMPENSATED CARE. THIS PROBLEM HAS ALSO BEEN ADDRESSED BY THE FINANCIAL ELEMENTS, WHICH NOW SPREAD THE COSTS OF UNCOMPENSATED CARE ACROSS ALL PAYORS OF NEW JERSEY.

I WOULD ALSO LIKE TO ADDRESS THE BENEFITS TO HOSPITALS WHICH RESULT FROM THE NEW PERSPECTIVE IN MANAGEMENT INFORMATION SYSTEMS PROVIDED BY THE DRG SYSTEM. THE HOSPITAL ADMINISTRATOR NOW HAS AT HIS FINGERTIPS A SYSTEM WHICH ALLOWS HIM TO TRACE AN INEFFICIENCY TO ITS SOURCE, BE IT DEPARTMENT SPECIFIC, SUPPLY-ORIENTED, OR ANCILLARY SERVICE USAGE. STANDARDS HAVE BEEN ESTABLISHED WHICH ALLOW COMPARISON AND PERFORMANCE MEASUREMENT THAT SHOULD LEAD TO GREATER EFFICIENCIES. HOSPITAL PLANNING, STAFFING, AND BUDGETING ARE MADE EASIER THROUGH ANALYSIS OF PATIENT MIX AND THE ABILITY TO MORE ACCURATELY FORECAST FUTURE REVENUES. HOSPITAL ADMINISTRATORS AND PHYSICIANS CAN WORK TOGETHER WITH INFORMATION THAT COMPARES THE WAY A SPECIFIC PHYSICIAN OR HOSPITAL MAY TREAT A PARTICULAR CASE TO THE COSTS AND TREATMENTS ACROSS THE STATE FOR SIMILAR PATIENTS. THE FINANCIAL IMPACT OF CLINICAL DECISIONS IS ILLUSTRATED IN SUCH A WAY THAT PHYSICIANS CAN TAKE AN ACTIVE ROLE IN RESTRAINING INCREASES IN UNNECESSARY COSTS.

ON THE OTHER HAND, I DO NOT WANT TO IMPLY THAT ALL OF THE INDUSTRY'S PROBLEMS HAVE BEEN SOLVED. THERE ARE SOME LEGITIMATE CONCERNS WITH THIS SYSTEM THAT CAN, I BELIEVE, BE RECTIFIED.

THERE ARE TREMENDOUS DEMANDS ON HOSPITALS IN TERMS OF DATA REQUIREMENTS AND COMPLEX REGULATIONS. THE DRG SYSTEM ALSO HAS A LONG WAY TO GO BEFORE IT CAN TRULY BE CALLED PROSPECTIVE. I EXPECT THAT, OVER TIME, THE SYSTEM WILL BE ABLE TO RESPOND TO VARIOUS HOSPITAL CONCERNS WITH THE END RESULT BEING AN IMPROVED SYSTEM OF HEALTH CARE FOR THE CITIZENS OF NEW JERSEY.

DEPARTMENT OF INSURANCE

INTER-COMMUNICATION

From: Joseph F. Murphy
Commissioner of Insurance

Date: September 21, 1982

To: Hon. Richard J. Codey
Chairman
~~Senate Institutions, Health~~
and Welfare Committee

RE: Statement of Commissioner Joseph F. Murphy to the Senate Institutions, Health and Welfare Committee at the Public Hearing on Implementation of the Hospital Rate Setting Law P.L. 1978, c. 83

As Commissioner of Insurance I have taken an interest in the way that the captioned legislation is being implemented for a number of reasons including my direct involvement on the Health Care Administration Board (HCAB), Hospital Rate Setting Commission (HRSC) and the Health Care Facilities Financing Authority (HCFFA) as an ex officio member. I am not only concerned that health insurance remain available to policyholders of this State and that equity exist among authorized insurers and other third-party payors in the implementation of the Health Care Facilities Planning Act (HCFPA), but I am equally concerned that the system bring about a containment of health care costs.

It pleases me to say that the Hospital Rate Setting Commission has gone a long way in promoting equity among insurance carriers in the treatment they are accorded as payors. The statutory requirement that "All payment rates shall be equitable for each payor or class of payors without discrimination or individual preference except for quantifiable economic benefits rendered to the institution or to the health care delivery system taken as a whole" has substantially reduced unjustified cost shifting among the insurance carriers.

As to availability of health insurance in New Jersey, at the current time Blue Cross and Blue Shield take care of the residual health insurance market through their Open Enrollment programs. The residual market is composed of those individuals and family units that are unable to obtain health insurance elsewhere. Much of the Blue Cross Open Enrollment program is subsidized internally through surcharges on group accounts and the absorption of excess losses through the company's overall financial structure.

When these losses can no longer be borne by Blue Cross's group accounts, it is incumbent upon me as the Commissioner of Insurance to approve rate increases on individual policies. These increases may be such that the coverage will become less affordable or unaffordable to the residents of this State. By making Blue Cross's Open Enrollment policies less affordable we drift from one of the goals of the HCFPA. More specifically, it is my concern that the policies offered by Blue Cross under its Open Enrollment program not be priced so high as to impair the program's effectiveness. Every person who requires hospital treatment and is not able to pay the Diagnosis Related Group (DRG) per case rate because of the lack of insurance or other resources represents increased indigency costs which must now be spread among all payors. It would seem to me that it is better to make insurance affordable for as many people as possible than to force them to become medically indigent. It is important to the people of this State that there always be a viable market for health insurance. By encouraging insurers to assume this responsibility through a fair payor differential we equitably distribute the cost of providing a residual health insurance mechanism to all payors.

One of the weak areas of the DRG reimbursement method involves the manner in which services are contracted out and thereby elude hospital rate regulations. Services such as radiology, anesthesiology and other ancillary services are "unbundled" to groups of physicians who then bill the patient directly. This practice if not properly controlled constitutes a circumvention of the HCFPA and should be studied for the purpose of introducing legislation to bring these arrangements under the control of the HRSC. Not to do so may eventually result in a serious weakening of the Commission's ability to effectively control hospital costs and rates.

During my short term in office, my theme as Commissioner of Insurance has been Cost Containment commensurate with the provision of quality health care services. Unregulated hospital rates and costs for medical services not only impact on health insurance but on automobile and worker's compensation insurance as well. Efforts to "... contain the rising costs of health care services...." as expressed in the statute should have a salutary effect on premiums charged the insuring public in New Jersey. In requiring hospitals to maintain a uniform system of cost accounting, the current law offers hope that the goal of hospital cost containment can be reached without sacrificing quality of care. I wholeheartedly support your efforts and those of the Legislature to contain the costs of health care services in New Jersey.

Joseph F. Murphy
Commissioner of Insurance

by: Herman W. Hanssler
Asst. Commissioner

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NEW JERSEY REIMBURSEMENT SYSTEM TESTIMONY

BEFORE THE

SENATE INSTITUTIONS, HEALTH AND WELFARE COMMITTEE
PUBLIC HEARING ON IMPLEMENTATION OF THE HOSPITAL
RATE SETTING LAW, P.L. 1978, c. 83

Tuesday, September 21, 1982

BY

ANNE C. GRABOIS
ASSISTANT DIRECTOR
HEALTH INSURANCE ASSOCIATION OF AMERICA

NEW JERSEY REIMBURSEMENT SYSTEM TESTIMONY

FOR SEPTEMBER 21, 1982

I am Anne C. Grabois, Assistant Director, Consumer and Professional Relations Division of the Health Insurance Association of America. The HIAA represents approximately 332 insurance companies which are responsible for about 80% of the health insurance written by insurance companies in the United States today. Over 140 of the HIAA member companies are licensed to do accident and health business in the State of New Jersey. According to our most recent annual survey, private health insurers have paid over $750 million in accident and health benefits on behalf of 2.5 million private insureds in New Jersey.

The health insurance industry is a major participant in the health care delivery and reimbursement system. As such, and because of its responsibility for the vast financial resources entrusted to the industry by policyholders, the insurance industry must take an active part in looking for solutions to the problems occurring within the system. Consequently, I am pleased to be able to participate in your deliberations.

The HIAA and its member companies have continuously supported the enactment of S.B. 446 (Chapter 83, PL 1978), the establishment of the DRG reimbursement system by the Department of Health, and the Hospital Rate Setting Commission in carrying out the letter and spirit of S.B. 446. The HIAA supported S.B. 446 because it established the groundwork for a uniform hospital reimbursement system for all patients, which would achieve system-wide cost savings.

Prior to the enactment of S.B. 446 the determination of equitable rates for the payment of hospital services received only theoretical consideration. The previous hospital reimbursement system provided a fragmented approach to hospital cost containment, which focused on the reimbursement limitations of the contract payors such as Blue Cross, Medicare, and Medicaid. The reimbursement arrangements contracted by these payors produced negotiated exclusions or limitations of responsibility for certain hospital financial needs such as payment for bad debts, charity, working capital and education costs. As a result, charge payors including self-paying insured patients whose rates are not subject to contractual negotiation, were required to pay not only for their share of hospital financial requirements, but also to carry the financial burden of unmet requirements produced by negotiated payment

shortfalls. These unjustified inequities in the system did not produce cost savings for the system as a whole, but (instead) limited the financial liabilities of the contract payors. In the long run, cost increases for all payors continued escalating without producing the genuine cost savings that are available under the current DRG reimbursement system.

The DRG reimbursement system was established to carry out the intent of S.B. 446, and has clearly demonstrated its ability to contain hospital costs. The GAO recently released a report documenting the effectiveness of prospective payment systems, and New Jersey was noted as one of the states to effectively implement this type of payment reform program. This report also mentioned the incentive to shift costs when prospective payment is not applied to all payors.

According to Department of Health reports, the DRG prospective rate setting system saved New Jersey residents more than $10 million in hospital costs for 1980. For the original 26 hospitals under the system, costs rose only 12.7% in 1980 compared to the national increase of more than 14%. Medicare program savings were $6 million, even though, under the waiver, they paid more than they ordinarily would have because bad debt and uncompensated care were covered for the first time as

reimbursable costs. When comparing patient service revenues of DRG hospitals to non-DRG hospitals, there was an increase of 18.15% in the non-DRG hospitals as compared to an increase of only 1.84% in the DRG hospitals.

The existence of a prospective rate setting program in New Jersey enabled the state to collect an additional $45 million in federal aid for 1982. These federal funds were allocated in accordance with the Omnibus Reconciliation Act of 1981. The Act has a provision to allow additional funds for states with rate setting programs that keep their increases in hospital costs under the national average. This provision permits qualifying states to obtain an additional 1% in federal contributions for the Medicaid program.

In evaluating prospective payment systems, one can refer back to those basic principles that are necessary for positive outcomes. In our opinion, a successful prospective payment system needs to incorporate the following concepts:

1. Establish a meaningful reporting system which makes available community-wide data for all payors with diagnostic and hospital specific information.

2. Institute the development of effective performance standards.

3. Provide a uniform definition of hospital financial requirements.

4. Establish equity among all payors.

5. Establish an effective quality assurance program to provide hospital utilization review for all patients to insure the necessity of all admissions and the appropriateness of the length of stay.

6. Establish linkages to health planning for the elimination of excess system capacity and encourage efficiency within the system.

7. Insure the financial solvency of hospitals.

The New Jersey DRG reimbursement system incorporates all of these concepts which strengthens the rate setting program. The waiver granted by HCFA for Medicare and Medicaid guarantees equity among all payors and reimbursement of the hospital's definition of full financial requirements. It is also important

to note that this is a unique program which uses Diagnostic Related Groups as a method of reimbursement, mandates all patient utilization review and is linked to health planning.

Among the many benefits of the New Jersey prospective rate setting program, the following two are important to recognize:

1. Improved hospital administrative management to permit health care services to be delivered more effectively and efficiently, based on the availability of data for hospital administrators and physicians. Management information systems resulting from the availability of data has improved coordination between administrators and physicians.

2. This system provides incentives to seek alternative forms of care rather than those services associated with costly hospital admissions. As a result of the incentives under the system, combined with available data, length of stay has decreased.

3. The financial status of inner-city hospitals, in particular, improved and health care services for the poor and indigent continued, not like in other states which were forced to abandon their medically indigent. Finally,

hospital profit margins increased - $26 million in profits were realized by the 26 hospitals under the DRG reimbursement system for 1980.

As would be expected in any new program, certain inefficiencies and problems are to be expected. This is especially true in New Jersey where hospitals are being gradually phased into the program over a three-year period. We have noted these inefficiencies and problems and have been working with the Rate Setting Commission and the Department of Health to develop solutions.

This year a new auto-group using 467 DRGs was implemented, which is expected to eliminate many of the problems originally experienced when the previous set of DRGs were used. The new DRGs are more clinically coherent and cohesive. This means that there is greater similarity among those diagnoses designated for each group, so that resource consumption for both length of stay and costs are more equal. With regard to all patient review, there was some initial start-up problems which appear to be in the process of being resolved.

Right now, our major concern is related to the staffing situation that exists in both the Department of Health and the

Hospital Rate Setting Commission. The Hospital Rate Setting Commission must rely on the Department of Health Staff to provide the manpower and technical expertise necessary for important Rate Setting Commission decisions. This past year, with the start of a new administration, staff turnover and reassignments have interfered with the continuity necessary to successfully resolve some of the problems existing within the system. Additional problems exist with respect to obtaining adequate computer time to provide data and rates on a timely basis. Therefore, we recommend that the Rate Setting Commission develop their own independent staff in order to carry out the intent of S.B. 446. In particular, the Rate Setting Commission needs to develop policies and responses to those hospital and payor issues that impact on the total system. An independent staff will permit the Commission to carry out their adjucative role in a timely and objective manner. We further recommend that the Department of Health be permitted to use outside computer services to resolve the current problems.

A second issue of concern to us is the method of determining quantifiable economic benefits for granting a differential to payors requesting one. We recommend that this area be carefully studied and that criteria be established for the granting of differentials.

In the short time that the DRG reimbursement system has been in place, since the enactment of S.B. 446, it is apparent that it has demonstrated its ability to contain health care costs for the citizens of New Jersey. The unique features of this program are the waiver granted by HCFA, for both Medicare and Medicaid that establishes payor equity for all payors, and the use of DRGs as a reimbursement method. It is apparent that time is needed to make the system fully operational and successful. We expect that the major problems within the system will be eliminated, thus enhancing the strengths and benefits of this program for the citizens of New Jersey. We urge your continuing support for this program and, again, want to thank you for giving us the opportunity to appear before you today.

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OVERLOOK HOSPITAL

TESTIMONY BEFORE THE SENATE
INSTITUTIONS HEALTH AND WELFARE COMMITTEE
SEPTEMBER 1982

MY NAME IS NANCY MEYEROWITZ, DIRECTOR OF MANAGEMENT SYSTEMS AT OVERLOOK HOSPITAL. I AM SPEAKING ON BEHALF OF MR. THOMAS FOLEY, PRESIDENT AND DIRECTOR OF OVERLOOK HOSPITAL. WE ARE A 550 BED TEACHING HOSPITAL LOCATED IN SUMMIT.

I WANT TO THANK YOU FOR THE OPPORTUNITY TO OFFER MY COMMENTS ON OUR EXPERIENCES WITH CHAPTER 83 REIMBURSEMENT. OVERLOOK WAS ONE OF THE FIRST TWENTY-SIX HOSPITALS TO ENTER THE DRG SYSTEM. WE ARE NOW COMPLETING OUR THIRD YEAR UNDER THIS INNOVATIVE REIMBURSEMENT SYSTEM. DESPITE THE NUMEROUS PROBLEMS INCURRED IN THE IMPLEMENTATION OF THE PROGRAM, WE BELIEVE IT CAN BE A VIABLE REIMBURSEMENT MECHANISM FOR NEW JERSEY AND PERHAPS A MODEL FOR THE ENTIRE COUNTRY.

WE ARE IN FULL SUPPORT OF THE REIMBURSEMENT CONCEPTS INTRODUCED BY CHAPTER 83. THE SYSTEM RECOGNIZES FOR THE FIRST TIME THE IMPACT OF CASE-MIX ON HOSPITAL COSTS. ALTHOUGH NOT PERFECT, THE SYSTEM ATTEMPTS TO TIE PAYMENTS TO THE HOSPITAL TO THE MIX OF PATIENTS TREATED. PAYMENT FOR A STROKE PATIENT NOW DIFFERS FROM THAT FOR AN APPENDECTOMY PATIENT. IN ADDITION, THE AGE AND SEVERITY OF ILLNESS OF OUR PATIENTS IS TAKEN INTO CONSIDERATION.

THE NEW JERSEY SYSTEM IS DESIGNED TO BE A PROSPECTIVE ONE. PROSPECTIVE REIMBURSEMENT SIMPLY MEANS OUR REIMBURSEMENT, OR APPROVED REVENUE, IS ESTABLISHED BEFORE ANY SERVICES ARE RENDERED OR COSTS INCURRED. THIS SHOULD ENABLE US TO IMPROVE OUR BUDGETING, FINANCIAL MANAGEMENT, AND PLANNING EFFORTS. THE RETROSPECTIVE OR PER DIEM SYSTEM, WHICH WAS IN PLACE PRIOR TO DRG, ACTUALLY REWARDED HOSPITALS WHOSE COSTS INCREASED. A PROSPECTIVE SYSTEM ALLOWS HOSPITALS TO KEEP ANY EXCESS OR REVENUE OVER ACTUAL COSTS.

THIS IS AN INCENTIVE TO CONTAIN COSTS! WE RECOGNIZE THE NEED TO CONTAIN THE RISING COSTS OF HEALTH CARE WHILE MAINTAINING OUR HIGH STANDARD OF CARE.

CHAPTER 83 ALSO STIPULATES, AS IT SHOULD, THAT HOSPITALS SHOULD BE PAID FOR ALL REASONABLE COSTS OF DOING BUSINESS. ALL PAYORS ARE NOW REQUIRED TO PAY THEIR FAIR SHARE OF BAD DEBTS AND UNCOMPENSATED CARE. A GREATER DEGREE OF EQUITY IS ALSO REALIZED UNDER THIS SYSTEM AS PAYMENT RATES ARE ESTABLISHED FOR ALL PAYORS.

FINALLY, THE DRG SYSTEM HAS PROVIDED THE BASIS FOR A POTENTIALLY VALUABLE MANAGEMENT TOOL. THE DATA ALLOWS US TO MEASURE THE ACTUAL COSTS OF TREATING A GIVEN TYPE OF ILLNESS AS WELL AS A COMPARISON OF THESE COSTS TO THOSE OF SIMILAR INSTITUTIONS. THE REPORTS WE RECEIVE PROVIDE AN ADDITIONAL TOOL FOR OUR MEDICAL STAFF TO USE IN THE EVALUATION OF QUALITY OF CARE AND RESOURCE USE. THE INFORMATION HAS ALSO PROVED USEFUL AS A PLANNING TOOL IN THE ANALYSIS OF CURRENT SERVICES AND IN THE REVIEW OF THE POTENTIAL IMPACT OF PROPOSED NEW SERVICES OR AN INCREASED LEVEL OF SERVICE.

OVERLOOK HAS MAINTAINED ITS SOUND FINANCIAL STANDING WHILE UNDER CHAPTER 83. WE HAVE CONTINUED TO BE ABLE TO PROVIDE HIGH QUALITY CARE TO OUR PATIENTS DESPITE THE MANY DIFFICULTIES WE HAVE ENCOUNTERED DURING THE IMPLEMENTATION OF THE SYSTEM.

WE HAVE, HOWEVER, SEVERAL MAJOR CONCERNS WITH THE DRG SYSTEM. WE WOULD LIKE TO SHARE THESE WITH YOU AND OFFER OUR RECOMMENDATIONS WHICH I BELIEVE WOULD IMPROVE THE PROGRAM AND ASSURE ITS VIABILITY IN NEW JERSEY.

FIRST, THE SYSTEM HAS NOT PROVED TO BE A TRULY PROSPECTIVE SYSTEM. UNDER SUCH A SYSTEM, FOR EXAMPLE, WE WOULD KNOW IN THE FALL THE AMOUNT OF OUR APPROVED REVENUE FOR THE FOLLOWING YEAR. ONLY MINIMAL YEAR-END ADJUSTMENTS WOULD BE MADE. UNFORTUNATELY, THIS HAS NOT BEEN THE CASE IN NEW JERSEY.

- RATES HAVE NOT BEEN RECEIVED UNTIL WELL INTO THE YEAR IN WHICH THEY APPLY AND WELL AFTER THE YEAR'S BUDGET HAS BEEN FINALIZED. MID YEAR CHANGES HAVE BEEN INTRODUCED EACH YEAR. THIS YEAR WE SWITCHED TO A COMPLETELY NEW SET OF DRG's IN JUNE.
- THE METHODOLOGY FOR REIMBURSEMENT OF CERTAIN COSTS SUCH AS UTILIZATION REVIEW HAS YET TO BE FINALIZED. SIGNIFICANT REVISIONS TO OTHER METHODOLOGIES SUCH AS THAT FOR NURSING COSTS AND TEACHING STATUS HAVE BEEN PROPOSED TO TAKE EFFECT WITHIN THE NEXT TWO YEARS.
- IN ADDITION, FAR TOO MANY ISSUES ARE DEFERRED TO THE YEAR-END RECONCILIATION PROCESS. LET ME GIVE YOU AN EXAMPLE, WE GRANT OUR EMPLOYEES A WAGE INCREASE IN JULY WHICH WE ESTABLISH BASED ON, AMONG OTHER FACTORS, THE ECONOMIC FACTOR SET BY THE DEPARTMENT OF HEALTH. IF IN DECEMBER THE ACTUAL INFLATION RATE FOR THE PAST YEAR WAS 5%, NOT 8% AS PROJECTED, OUR REVENUE IS THEN LOWERED. WE CANNOT HOWEVER, TAKE BACK THE SALARY INCREASE WE GAVE TO OUR EMPLOYEES! CONSEQUENTLY, WITH THE LARGE NUMBER OF YEAR-END ADJUSTMENTS, WHAT STARTED OUT AS A PROSPECTIVE SYSTEM HAS ALMOST REVERTED TO A RETROSPECTIVE ONE.

THE SECOND MAJOR CONCERN I HAVE IS THE FAILURE OF THE SYSTEM TO ADDRESS CHANGES IN MEDICAL PRACTICE AND NEW TECHNOLOGIES. OUR 1982 REVENUE IS BASED ON OUR 1979 COSTS WHICH HAVE BEEN INCREASED ONLY BY AN INFLATION FACTOR.

THIS ASSUMES THAT OUR MEDICAL AND PROFESSIONAL STAFFS ARE PROVIDING THE SAME LEVEL OF SERVICE AS IN 1979. AS YOU KNOW, MEDICAL PRACTICE HAS CHANGED SIGNIFICANTLY IN MANY AREAS AND MANY NEW TECHNOLOGIES ARE AVAILABLE. TREMENDOUS ADVANCES HAVE BEEN MADE IN THE TREATMENT OF CANCER PATIENTS WHICH ARE VERY COSTLY BUT SAVE LIVES.

THE SYSTEM FAILS TO RECOGNIZE THE COSTS ASSOCIATED WITH THESE CHANGES IN MEDICAL PRACTICE AND THE PURCHASE OF NEW EQUIPMENT. WE HAVE IDENTIFIED NEEDS OF OUR PATIENTS AND COMMUNITY WHICH WE DO NOT CURRENTLY MEET. IT WILL BE VERY DIFFICULT TO MEET OUR RESPONSIBILITY AND PROVIDE THESE SERVICES WITHOUT ADEQUATE REIMBURSEMENT. UNFORTUNATELY, WE ANTICIPATE THAT THIS PROBLEM WILL ONLY INCREASE AS TIME GOES ON. OUR PATIENTS ARE GETTING OLDER AND ARE LIVING LONGER. THEY ARE DEMANDING THE HIGHEST QUALITY CARE REGARDLESS OF COST.

ANOTHER PROBLEM WHICH CONCERNS US IS THE BILLING OF PATIENTS WITHOUT INSURANCE. ALL PATIENTS ARE NOW REQUIRED TO PAY AN AVERAGE RATE REGARDLESS OF SERVICES RECEIVED OR THE LENGTH OF TIME SPENT IN THE HOSPITAL. THIS SYSTEM IS EQUITABLE FOR INSURANCE COMPANIES WHO PAY THOUSANDS OF BILLS EACH YEAR. IT IS NOT FAIR TO THE SELF-PAY PATIENT WHO IS PAYING ONLY ONE BILL. WE RECOMMEND THAT PATIENTS WITHOUT ANY INSURANCE BE EXEMPT FROM PAYING THE AVERAGE RATE. THE AVERAGE RATE SHOULD CONTINUE TO BE USED FOR FINAL RECONCILIATION, HOWEVER, TO INSURE THE INTEGRITY OF THE SYSTEM.

THE LAST MAJOR CONCERN I WOULD LIKE TO MENTION RELATES TO SEVERAL PROPOSED CHANGES IN THE DEFINITION OF REIMBURSEABLE COSTS. CURRENTLY, INTEREST ON MAJOR MOVABLE EQUIPMENT IS NOT AN ALLOWABLE ELEMENT OF COST BUT CAN BE APPEALED.

THE APPEAL OPTION IS TO BE REMOVED IN 1983. SECONDLY, IN 1983 HOSPITALS WILL NO LONGER RECEIVE REIMBURSEMENT FOR DEPRECIATION EXPENSE ASSOCIATED WITH FIXED CAPITAL. ONLY PRINCIPAL AND INTEREST WILL BE GUARANTEED. THIS PLACES HOSPITALS IN AN EXTREMELY PRECARIOUS POSITION PARTICULARLY IF THE REIMBURSEMENT METHODOLOGY WERE TO CHANGE IN THE FUTURE.

IN CONCLUSION, I WOULD LIKE TO OFFER OUR SUPPORT FOR THE INNOVATIVE CONCEPTS INTRODUCED BY THE LEGISLATURE IN CHAPTER 83. THE PROGRAM HAS RECTIFIED MANY OF THE INADEQUACIES AND INEQUITIES OF THE PREVIOUS SYSTEM, AND AS YOU KNOW, MAY SERVE AS A MODEL FOR THE REST OF THE COUNTRY. WE DO HAVE SERIOUS CONCERNS REGARDING THE IMPLEMENTATION OF THE SYSTEM IN NEW JERSEY AND WITH REGARD TO SOME OF THE PROPOSED CHANGES AS MENTIONED IN MY EARLIER REMARKS. THE SYSTEM NEEDS TO FUNCTION IN A CONSISTENT MANNER FOR SEVERAL YEARS IN ORDER TO EVALUATE ITS SUCCESS IN CONTAINING COSTS AND THE IMPACT ON THE QUALITY OF HEALTH CARE.

HOSPITALS CANNOT BE SQUEEZED TOO TIGHTLY WITHOUT IT AFFECTING THE QUALITY OF CARE WE PROVIDE OR OUR ABILITY TO DELIVER NEEDED SERVICES. I HOPE YOU WILL TAKE OUR COMMENTS INTO CONSIDERATION IN YOUR OVERSIGHT OF CHAPTER 83 IMPLEMENTATION.

GOOD MORNING -

I AM HOWARD SLOBODIEN, PRESIDENT OF THE MEDICAL SOCIETY OF NEW JERSEY.

IN A FEW WEEKS I SHALL BE PRIVILEGED TO APPEAR ON NEW JERSEY TELEVISION - THE SUBJECT: QUACKERY: IN ORGANIZING MY THOUGHTS ON THAT TOPIC I TRIED TO IDENTIFY THE COMMON DENOMINATOR PRESENT IN ALL FORMS OF QUACKERY. AND THERE IT WAS - THE AVOIDANCE, BY THE PROMOTORS, OF ALLOWING THE PRODUCTS OR METHODS TO BE SUBJECTED TO SCIENTIFIC ANALYSIS BY IMPARTIAL INVESTIGATORS.

AND THEN I BEGAN TO CONSIDER WHAT I MIGHT SAY TO THIS DISTINGUISHED ASSEMBLY.

NOW, I AM NOT SUGGESTING THAT THOSE WHO OPPOSE A CRITICAL EVALUATION OF DRG ARE QUACKS. THEY MAY BE MERELY WELL-INTENTIONED BUT MISLEAD. BUT I DO FEEL THAT THEY ARE ACTING NEITHER IN THE BEST INTERESTS OF THE CITIZENS OF THIS STATE NOR IN THE TRIED AND TRUE TRADITIONS OF THE SCIENTIST.

AS A PRACTISING SURGEON I HAD GREAT HOPES FOR DRG. AFTER ALL, I HAVE BEEN RE-IMBURSED ALONG DRG LINES SINCE ENTERING PRIVATE PRACTISE. MY CHARGE TO THE PATIENT, IN THE VAST MAJORITY OF CASES, INCLUDES THE FEE FOR BOTH THE OPERATION AND THE TOTAL HOSPITAL CARE, REGARDLESS OF THE VARIATION IN NUMBER OF DAYS INVOLVED. AND THIS METHOD HAS WORKED WELL THROUGH THE YEARS. SO I LOOKED FORWARD TO THE DRG EXPERIMENT WHEN IT WAS FIRST PROPOSED.

BUT NOW I HAVE GREAT RESERVATIONS ABOUT ITS APPLICABILTIY IN PAYING HOSPITAL COSTS OR CHARGES. I AM FAR FROM CONVINCED THAT THERE HAS BEEN A SAVING IN COSTS TO THE STATE. AND I AM PARTICULARLY CONCERNED THAT THE QUALITY OF CARE MAY BE DETERIORATING, THAT PATIENTS ARE BEING FORCED OUT OF THE HOSPITAL SETTING STILL HURTING, STILL IN TROUBLE AND STILL IN NEED OF ACUTE CARE, MERELY BECAUSE THE SYSTEM REWARDS THOSE INSTITUTIONS WITH RAPID TURNOVER OF PATIENTS.

THE DRG PROGRAM HAS BEEN CRITICIZED ADVERSELY IN OUTSTANDING PUBLICATIONS BY EXTREMELY WELL-QUALIFIED INDIVIDUALS LOCATED IN AREAS STRETCHING FROM THE ATLANTIC TO THE PACIFIC. AND THIS CRITICISM COVERS MANY AREAS IN THE APPLICATION OF THE PROGRAM.

YET, THE ONLY REBUTTAL TO THESE CRITICS, AS FAR AS I KNOW, HAS COME FROM THOSE RESPONSIBLE FOR INITIATING OR EXPANDING THE DRG CONCEPT IN NEW JERSEY. AND THESE INDIVIDUALS, WHO COUNT SUCH AS MD, MPH AND PHD AMONG THEIR ENTITLEMENTS, CONTINUE TO OPPOSE THE APPLICATION OF SCIENTIFIC INQUIRY, DESPITE THEIR BACKGROUNDS IN THE SCIENTIFIC METHOD AND DESPITE THEIR AVOWAL, AT THE ONSET OF DRG, THAT IT WAS TO BE A SO-CALLED "PILOT PROGRAM" INVOLVING APPROXIMATELY TWO DOZEN HOSPITALS. TO MAKE MATTERS WORSE, THE CONGRESS OF THE UNITED STATES IS BEING PROSELYTIZED MOST ACTIVELY TO APPROVE DRG FOR FEDERAL PROGRAMS, DESPITE THE LACK OF PROOF OF ITS MERITS.

THE MEDICAL PROFESSION HAS BEEN GIVEN A BUM RAP - THAT IT IS PRIMARILY RESPONSIBLE FOR MUCH OF THE RISE IN HEALTH CARE COSTS, DESPITE THE FACT THAT PHYSICIANS DO NOT RECEIVE EVEN ONE CENT OF EVERY FIVE SPENT ON HEALTH CARE. IF FOR NO OTHER REASON, AND THERE ARE MANY OTHERS, DOCTORS SHOULD BE INTERESTED IN CONTAINING THESE COSTS, AND WE ARE. WE SHALL CONTINUE OUR EFFORTS BOTH TO CONTROL COSTS AND TO ASSURE THE MAINTENANCE OF QUALITY CARE, UNDER WHATEVER REIMBURSEMENT MECHANISM YOU MAY CHOOSE.

I DON'T KNOW WHETHER DRG HAS BEEN GOOD FOR NEW JERSEY, EITHER IN WHOLE OR IN PART. BUT (ON) ONE ELSE DOES EITHER. IF IT HAS MERIT, LET US UTILIZE ITS POSITIVE ASPECTS AS EFFECTIVELY AS POSSIBLE. IF IT IS GARBAGE AND WE CONTINUE ITS EXPANSION, THERE WON'T BE ENOUGH LANDFILLS IN THE COUNTRY TO CONTAIN IT. ISN'T IT ABOUT TIME WE FOUND OUT THE TRUTH? THAT IS WHY WE URGE SUPPORT OF A LEGISLATIVE RESOLUTION TO CONDUCT A THOROUGH AND LONG-OVERDUE EVALUATION.

THANK YOU FOR LISTENING. I WILL BE PLEASED TO ANSWER ANY QUESTIONS.

TESTIMONY FOR THE

STATE OF NEW JERSEY
SENATE INSTITUTIONS, HEALTH
AND WELFARE COMMITTEE
CN-042
STATE HOUSE, TRENTON, N.J. 08625

SEPTEMBER 21, 1982

Good morning. My name is Richard J. Mellman; I am Vice President and Actuary for the Prudential Insurance Company of America. I am responsible for developing and coordinating Prudential's policy on major health issues at the state and national level. As you know, Prudential has taken a close interest in the development and implementation of both Chapter 83, the state rate setting law, and also the operation of the DRG program. As a matter of fact, both Joe Frankel and I attended all the mark-up sessions of this committee in 1977-78 which produced the law that established this innovative program.

Prudential is the largest domestic New Jersey member company of the insurance industry trade association, the Health Insurance Association of America. Accordingly, I speak for both the Prudential and the HIAA, which will be submitting its own written statement.

The most important point we would like the committee to recognize is that the DRG system, while admittedly not perfect, is a good system and good for the public. Federal and state governments and the American people are concerned about the steeply rising cost of hospital care. New Jersey's DRG program is an innovative program that shows promise of providing some of the answers. We see the positive features of this system as far outweighing any of the problems encountered thus far. We trust the committee will recognize that the positive aspects of DRG result from the way the system works; the problems we have encountered are those to be expected in the implementation of a new system. These can be corrected. Many of the start-up problems we saw in 1980 have already been corrected by 1982.

We see the DRG program providing the following benefits in New Jersey: First, by paying hospitals on a per admission basis, the system alters hospital incentives and reduces many of the inflationary forces in effect in other states. A general

complaint of the prevailing system in other states is that it pays the hospitals for whatever the doctor orders; the more services are performed, the greater the bill; and thus there are no incentives for moderation or cost awareness. By giving hospitals and doctors an incentive to eliminate unnecessary tests and services and not to prolong hospital stays, New Jersey's system does promote cost containment. Second, the DRGs represent a significant improvement over other management tools that define hospital resource use. The DRGs help hospital administrators identify their own costs for treating particular types of cases, which allows for better management, through productive monitoring of attending physician treatment patterns. Third, the program has restored the solvency of New Jersey's inner-city hospitals, most of which were financially distressed under previous methods of hospital payment. Finally, by providing for equitable charges to all patients, regardless of which payor provides their coverage, there can be more meaningful competition between Blue Cross, insurance companies, HMOs, and other plans. Employers and individuals now have a choice, and the system is fairer.

In considering the merits of the program, I believe it's important to consider four questions:

1. Is it good for the public? I believe the answer to this question is clearly yes. Although the public doesn't completely understand the program, it offers the clear advantage of improved incentives for cost effectiveness and, therefore, a slow down in the inflationary expansionist forces that plague the hospital system nationwide.

2. Is it a system that is fair to the hospitals and a system with which they can live? Note that I don't define it in terms of a system which all the hospitals necessarily have to like, although many New Jersey hospitals are very positive about the program and what it does for them. I believe the answer to this second question is also clearly in the affirmative.

3. Is the system administrable? I believe that the system meets this test also. Hospitals, payors and the state have all learned how to administer their parts of the system. Although the administrative expenses are not insignificant, I don't believe there is any indication that they are unreasonably high in relation to the benefits afforded.

4. Is the system fair? I believe the answer to this question is also yes. In fact, by addressing equity, it is considerably fairer than the system that existed prior to enactment of S.446.

I believe it is also important to consider the principal complaints that have been made about the system:

(1) The "Goldfinger" claim -- You will recall that this $6,300 finger story made the wire services coast to coast two

years ago. We checked into it and found that the figures were somewhat exaggerated. In any event, the system has been fine-tuned since then so that (1) fractured fingers and hips no longer fall in the same DRG, and (2) this claim would now be an outlier. Thus, this well publicized odd ball claim can not happen again.

(2) The complaint that the system is subject to "gaming" by the hospitals in order to maximize reimbursement. Note that this complaint comes from the hospitals, not from the state, the payors or the public. While it is undoubtedly true that the system is subject to a certain amount of gaming, that is true of any system; and in fact, I think we will all agree that the system is

subject to less gaming than the previous system in which incentives for cost effective treatment were so totally lacking. The longer the patient stayed and the more services he was provided, the greater the hospital bill. Also, it should be noted that the state's reconciliation processes are designed to prevent flagrant gaming.

(3) The complaint is sometimes made that the system is too complicated. I believe this complaint should also be dismissed. We live in a computer age. Our hospitals have mastered the most sophisticated technology, such as implanting atomic-powered pacemakers. Surely they can master how to charge patients "by diagnosis" and "per admission".

(4) The complaint is sometimes made by some payors that the new system costs them more than the old system did. This may undoubtedly be true in the short haul, because when equity first appears, those who had previously

enjoyed a preferred arrangement may find that their costs are increased. Short range, we are optimistic that savings for the public as a whole are being achieved. However, in the long haul, given time for the savings of a more cost-effective program to accumulate, savings for each payor should result.

In contrast to the significant system-wide improvements under DRG, the implementation problems are definable and correctable. For example, there has been criticism of the DRG system because of the delay in hospitals receiving their annual rates. This is certainly something that can and should be corrected as the Department of Health becomes more experienced in capturing and reporting data. As DOH completes the 3-year phase-in of the system this year, with all hospitals now on line, this lag in rates should be reduced.

We do believe, however, that for the implementation problems to be worked out satisfactorily, it is essential that the Department of Health be adequately staffed with competent technicians. To the extent that this committee has jurisdiction over

the Department of Health's budget, we urge that this budget be made adequate to fill the key jobs that have been vacant for the last year. New Jersey hospitals net revenues this year will amount to approximately $3 billion. What we are talking about is an extremely small fraction of one percent of that figure, and is a very modest price to pay for a cost-effective system in this state.

In summary, we urge the committee to take a judicious view of any problems that may have been brought to the members' attention, remembering that any major change in a system as complex as the health care system will cause ripples to begin with. The Department of Health is well into the "clean-up phase" in which they debug and fine tune the system. We strongly urge the committee to consider the benefits of this system, in terms of lowering costs, improving hospital efficiency, and keeping hospitals solvent. If there is any question whether this system is a model for the nation, I would merely point to recent public reports that Secretary of Health and Human Services, Richard Schweiker, has instructed his department to develop a nationwide system, using DRGs as the basis.

HRET HEALTH RESEARCH AND EDUCATIONAL TRUST OF NEW JERSEY

at the Center for Health Affairs 746-760 Alexander Road CN 1 Princeton, New Jersey 08540 (609) 452-9280

TESTIMONY OF JEFFREY WASSERMAN
BEFORE THE NEW JERSEY STATE
SENATE'S INSTITUTIONS, HEALTH
AND WELFARE COMMITTEE

SEPTEMBER 21, 1982

MY NAME IS JEFFREY WASSERMAN. I AM VICE PRESIDENT FOR RESEARCH FOR THE HEALTH RESEARCH AND EDUCATIONAL TRUST OF NEW JERSEY.

FOR THE LAST TWO AND A HALF YEARS, OUR ORGANIZATION HAS BEEN INVOLVED IN AN EXTENSIVE EVALUATION OF THE DRG SYSTEM. ALTHOUGH OUR STUDY IS STILL IN THE PROCESS OF BEING COMPLETED, I AM HERE TODAY TO SHARE WITH YOU SOME OF THE OBSERVATIONS AND INSIGHTS WE HAVE GAINED DURING THE COURSE OF OUR WORK. BECAUSE I KNOW THAT THERE ARE MANY PEOPLE WHO WISH TO TESTIFY TODAY, I WILL BE BRIEF. MY OFFICE WILL BE HAPPY TO PROVIDE MORE DETAILED INFORMATION TO THOSE WHO WOULD LIKE IT.

-- THE FIRST BASIC QUESTION WE SOUGHT TO INVESTIGATE WAS WHETHER THE SYSTEM WAS WELL DESIGNED, AND WHETHER IT WORKS AS ANTICIPATED? IN THIS REGARD, WE NOTED THAT:

1) 37 OF THE 383 DRGs INITIALLY USED TO CLASSIFY PATIENTS IN 1980 WERE JUDGED TO CONTAIN PATIENTS WHOSE ASSIGNMENTS FAILED TO RECOGNIZE TRUE DIFFERENCES IN CLINICAL STATUS. NO LESS THAN 16 REASONS FOR SUCH INACCURATE ASSIGNMENTS WERE IDENTIFIED BY OUR SURVEY PANEL -- FOR EXAMPLE, PLACING PATIENTS WITH A GIVEN ILLNESS BUT WITH WIDELY VARYING DEGREES OF SEVERITY IN THE SAME DRG. IT MUST BE POINTED OUT, HOWEVER, THAT THE CLASSIFICATION SCHEME HAS SUBSEQUENTLY BEEN CHANGED AND IT IS MY UNDERSTANDING THAT MANY OF THE PROBLEMS WE IDENTIFIED HAVE BEEN RECTIFIED.

2) IN OUR STUDY OF THE RATE-SETTING FORMULA, A STATISTICAL ANALYSIS WAS CONDUCTED TO SEE IF THERE WERE VARIABLES, IN ADDITION TO TEACHING STATUS, WHICH SHOULD BE INCORPORATED INTO THE RATE-MAKING PROCESS, SO AS TO IMPROVE THE INCENTIVE STRUCTURE. WE FOUND THAT ALTHOUGH SOME OF THE VARIABLES CONSIDERED -- SUCH AS SIZE AND LOCATION -- DID IN FACT LEAD TO STATISTICALLY SIGNIFICANT REDUCTIONS IN UNEXPLAINED VARIANCE IN THE DEPENDENT VARIABLES -- WHICH WERE COST AND LENGTH OF STAY -- THE SIZE OF THESE REDUCTIONS WERE SMALL. THEREFORE THE ADDITIONAL COMPLEXITY THAT WOULD INEVITABLY ACCOMPANY THEIR INCLUSION INTO THE RATE-SETTING PROCEDURE COULD NOT BE JUSTIFIED. FURTHERMORE, THE ANALYSIS CONFIRMED THAT, AGAIN IN TERMS OF BOTH COST AND LENGTH OF STAY, IT IS INDEED APPROPRIATE TO COMPUTE DRG RATES SEPARATELY FOR TEACHING AND NON-TEACHING HOSPITALS.

3) WHEN WE TURNED TO EXAMINING THE ACCOUNTING ASPECTS OF THE SYSTEM, WE CONCLUDED THAT WITH A FEW RELATIVELY MINOR EXCEPTIONS, THE COST ACCUMULATION, COST FINDING, AND COST ALLOCATION PROCESSES USED IN THE DRG SYSTEM ARE CONSISTENT WITH TRADITIONAL COST ACCOUNTING DEFINITIONS AND CONCEPTS -- ALTHOUGH SOME SPECIFIC PROBLEMS WERE IDENTIFIED.

-- A SECOND MAJOR AREA STUDIED WAS HOW THE DRG SYSTEM HAS AFFECTED HOSPITAL OPERATIONS. HERE, SIGNIFICANT EFFECTS WERE OBSERVED AS A RESULT OF THE SYSTEM'S IMPLEMENTATION.

1) THE MEDICAL STAFFS IN DRG HOSPITALS ARE MORE DIRECTLY INVOLVED IN HOSPITAL OPERATIONS THAN ARE THEIR COUNTERPARTS IN NON-DRG HOSPITALS.

2) THE IMPORTANCE OF THE MEDICAL RECORDS DEPARTMENT, IN RELATION TO OTHER HOSPITAL DEPARTMENTS, HAS INCREASED DRAMATICALLY IN THE DRG HOSPITALS.

3) THE QUANTITY AND TYPE OF INFORMATION COLLECTED IN DRG HOSPITALS HAS EXPANDED -- ALLOWING FOR THE DEVELOPMENT OF MORE SOPHISTICATED MANAGEMENT AND INFORMATION SYSTEMS.

4) DECISION-MAKING AUTHORITY IN DRG HOSPITALS IS MORE DECENTRALIZED THAN IN NON-DRG HOSPITALS.

5) DRG HOSPITALS APPEAR, AS ONE WOULD EXPECT, TO BE MORE "OUTCOME" ORIENTED -- WHEREAS NON-DRG HOSPITALS ARE MORE "PROCESS" ORIENTED.

-- ANOTHER CONCERN REGARDING IMPLEMENTATION CENTERS ON THE QUALITY AND TIMELINESS OF THE DATA GENERATED TO MEET THE SYSTEM'S REQUIREMENTS.

IN GENERAL, WE FOUND THAT THE DATA PRODUCED AFTER THE SYSTEM WAS IN PLACE WERE MORE ACCURATE THAN PREVIOUSLY -- YET TOOK CONSIDERABLY MORE TIME TO PRODUCE. FOR INSTANCE, IN THE EIGHT DRG HOSPITALS STUDIED, THE FACE SHEET INCOMPLETION RATE DROPPED FROM 22.8 PERCENT TO 15.8 PERCENT. AT THE SAME TIME, HOWEVER, THE AMOUNT OF TIME REQUIRED BY THE MEDICAL RECORDS DEPARTMENTS TO COMPLETE THE ABSTRACTING PROCESS AND SUBMIT THE DATA FOR BILLING INCREASED FROM 4.5 DAYS TO 5.3 DAYS. ADDITIONALLY, THE TIME IT TOOK PATIENT ACCOUNTING TO RELEASE THE BILLS WENT FROM AN AVERAGE OF 6.5 DAYS TO 8.5 DAYS AFTER DISCHARGE. IT'S LIKELY THAT AS HOSPITALS BECOME MORE EXPERIENCED WITH THE SYSTEM, THE TIME REQUIRED TO PROCESS ALL OF THE REQUISITE DATA WILL DECREASE.

IT IS IMPORTANT TO BEAR IN MIND THAT THERE ARE INDEED COSTS ASSOCIATED WITH MEETING THE NEW DEMANDS OF THE SYSTEM. OUR ANALYSIS HAS SHOWN, FOR EXAMPLE, THAT THE AVERAGE COST OF COMPLETING ALL OF THE WORK NECESSARY TO CREATE AN INPATIENT BILL

HAS RISEN FROM $15.93 TO $23.16 PER DISCHARGE -- NEARLY $8 MILLION ON A SYSTEM-WIDE BASIS, THOUGH ONLY ONE-THIRD OF ONE PERCENT OF ALL EXPENDITURES MADE FOR HOSPITAL CARE. BUT THESE AND OTHER COSTS OF OPERATING THE SYSTEM HAVE NOT RESULTED IN AN ACCELERATION OF THE INCREASE IN HOSPITAL COSTS. IN FACT, IN CONTRAST TO AN 18.7 PERCENT INCREASE IN OPERATING COSTS FOR HOSPITALS NATIONWIDE IN 1980, THE 26 DRG HOSPITALS EXPERIENCED AN INCREASE OF ONLY 13.5 PERCENT.

ADDITIONALLY, THOUGH WE CANNOT YET BE SURE, IT APPEARS THAT THE FINANCIAL STANDINGS OF THE NON-DRG HOSPITALS REMAINED, AS A WHOLE, ROUGHLY THE SAME FOR 1979 AND 1980 -- WHEREAS THE FINANCIAL POSITIONS OF THE DRG HOSPITALS IMPROVED CONSIDERABLY.

HOWEVER, SEVERAL OTHER FACTORS RELATING TO THE HOSPITALS' FINANCIAL POSITIONS NEED TO BE CONSIDERED AS WELL. FOR INSTANCE, DESPITE THE FACT THAT THE DRG HOSPITALS HAD MORE MONEY ON THE BOOKS THAN THEIR COUNTERPARTS WHO WERE STILL BEING REIMBURSED ON A PER DIEM BASIS, THEIR LIQUIDITY HAS BEEN REDUCED. MUCH OF THE REDUCED LIQUIDITY CAN BE ATTRIBUTED TO THE FACT THAT THE DRG HOSPITALS' ACCOUNTS RECEIVABLE INCREASED. THESE INCREASES ARE PRIMARILY DUE TO DELAYS IN GENERATING BILLS AND THE LONGER TIME TAKEN BY PAYERS TO PAY AND PROCESS CLAIMS. AGAIN, THESE DELAYS CAN BE EXPECTED TO DISSIPATE AS HOSPITALS AND PAYERS BECOME BETTER ACQUAINTED WITH THE INTRICACIES OF THE SYSTEM. IT IS IMPORTANT TO REALIZE THAT THERE ARE SEVERAL PROVISIONS OF THE CHAPTER 83

REGULATIONS WHICH AFFECT THE CASH POSITIONS OF HOSPITALS AND THAT NOT ALL OF THEM ARE RELATED TO DRG-BASED REIMBURSEMENT PER SE. THEREFORE HERE, AND ELSEWHERE, CARE MUST BE TAKEN TO MAKE THE PROPER DISTINCTIONS.

IN CLOSING: ALTHOUGH IT IS UNCERTAIN AS TO WHETHER OR NOT THE SYSTEM HAS ACHIEVED SIZEABLE REDUCTIONS IN THE COSTS OF PROVIDING CARE; IN TIME WE WILL BE ABLE TO CONFIDENTLY DETERMINE WHETHER THESE REDUCTIONS ARE LARGE ENOUGH TO OFFSET THE ADDED COSTS THAT HAVE ACCOMPANIED THE SYSTEM'S INTRODUCTION. IN THE MEANTIME, IT IS OUR VIEW THAT THE SYSTEM HAS LED -- AND WILL CONTINUE TO LEAD -- TO THE ADOPTION OF BETTER MANAGEMENT PRACTICES ON THE PART OF HOSPITALS, INCREASED COMMUNICATION BETWEEN PHYSICIANS AND HOSPITAL ADMINISTRATORS, GREATER ACCURACY IN THE DATA, AND A HEIGHTENED AWARENESS OF THE COSTS ASSOCIATED WITH PROVIDING PATIENT CARE. WE CAN HOPE THAT, OVER TIME, SUCH IMPROVEMENTS WILL REDUCE HOSPITAL COSTS AND HENCE EXPENDITURES ON THE PART OF CONSUMERS OF HOSPITAL CARE.

THANK YOU.

TESTIMONY OF LEGAL SERVICES OF
NEW JERSEY

BY STEVEN LATIMER, ESQ., DIRECTOR OF LITIGATION

LEGAL SERVICES OF NEW JERSEY IS THE STATEWIDE UMBRELLA ORGANIZATION FOR THE LOCAL LEGAL SERVICES PROJECTS THROUGHOUT THE STATE. WE WELCOME THE OPPORTUNITY TO APPEAR BEFORE YOU TO TESTIFY ABOUT THE IMPLEMENTATION OF THE HOSPITAL RATE SETTING LAW, CHAPTER 83. WE SPECIFICALLY WANT TO FOCUS ON HOW OUR CLIENTS AND THE INSTITUTIONS THAT SERVE OUR CLIENTS HAVE FARED UNDER THE RATE SETTING SYSTEM.

HOWEVER, IT IS IMPORTANT TO GIVE YOU SOME BACKGROUND ABOUT OUR EXPERIENCE PRIOR TO THE ENACTMENT OF CHAPTER 83. AT THAT TIME, OUR CLIENTS, PREDOMINATELY LOW INCOME, WOMEN, CHILDREN, AND ELDERLY PERSONS, WERE OFTEN TURNED AWAY FROM CARE OR "DUMPED" ON HOSPITALS THAT ACCEPTED INDIGENTS. MOREOVER, THOSE CLIENTS THAT OBTAINED CARE WERE USUALLY NOT TOLD ABOUT THE HILL-BURTON ACT, THE COUNTY FREEHOLDER AND ADJUSTER PROGRAMS OR MUNICIPAL WELFARE PROGRAMS IN COUNTIES OF FIRST CLASS THAT PROVIDE COVERAGES FOR INDIGENT CARE. THESE INDIVIDUALS AFTER RECEIVING SERVICES BUT BEING DENIED THE AFOREMENTIONED ENTITLEMENTS WERE SUBJECTED TO CONSTANT DUNNING AND HARASSMENT FROM HOSPITALS AND THEIR COLLECTION AGENCIES, AND IMPROPERLY HAD COLLECTION LAWSUITS BROUGHT AGAINST THEM. NEEDLESS TO SAY, THESE ACTIONS RESULTED IN EMOTIONAL DISTRESS, EVEN PHYSICAL PROBLEMS TO THE ELDERLY, AND AT TIMES INCORRECT WAGE GARNISHMENT AND LIENS ON PROPERTY.

FOR LEGAL SERVICES THESE PROBLEMS MEANT UNNECESSARY TIME, ENERGY, AND MONEY SPENT NEGOTIATING OR DEFENDING AGAINST COLLECTION CASES. A RECENT CASE IN POINT INVOLVED A HOSPITAL THAT FAILED TO POST NOTICE OF OR OFFER HILL-BURTON BENEFITS TO A SINGLE PARENT FAMILY WHO WAS ELIGIBLE FOR THOSE BENEFITS. THE COURT HELD THAT THE HOSPITAL COULD NOT COLLECT, WHEN BENEFITS HAD NOT BEEN OFFERED. HOSPITAL CENTER AT ORANGE v. SAVANNAH COOK. THIS IS A CASE THAT SHOULD NEVER HAVE OCCURRED AND IT HIGHLIGHTS THE NEED FOR GOOD ADMISSION PRACTICES IN DETERMINING ELIGIBILITY FOR BENEFITS.

WITH THIS BACKGROUND IN MIND, WE ARE PLEASED TO NOTE THAT THE NUMBER OF COLLECTION CASES HAVE SUBSTANTIALLY DECLINED. WE FEEL THAT THIS DECLINE IS A DIRECT RESULT OF CHAPTER 83's PROVISION THAT REIMBURSES HOSPITALS FOR THEIR LEGITIMATE UNCOMPENSATED CARE AND BAD DEBT COSTS. BY SO DOING, CHAPTER 83 HAS HELPED TO ELIMINATE A PORTION OF THE FINANCIAL ROADBLOCK THAT KEEPS THE POOR FROM OBTAINING NEEDED SERVICES. CHAPTER 83 CREATED INSTEAD AN INCENTIVE FOR HOSPITALS TO LIVE UP TO THEIR CHARITABLE PURPOSES AND DELIVER CARE TO THE POOR.

EQUALLY IMPORTANTLY, CHAPTER 83 PROVIDES FUNDS TO HOSPITALS, ESPECIALLY THOSE IN THE INNER CITIES, THAT HAVE SUFFERED LOSSES FROM CONTINUALLY DELIVERING CARE TO PERSONS UNABLE TO PAY. FOR EXAMPLE, ST. JOSEPH'S HOSPITAL IN PATERSON STATED THAT CHAPTER 83 PLACED THEM IN THE BLACK AFTER BEING IN THE RED

FOR MOST OF THE HOSPITAL'S EXISTENCE. WE HAVE ALSO HEARD POSITIVE REPORTS ABOUT IMPROVEMENTS IN THE FINANCIAL PICTURE FOR NEWARK-BETH ISRAEL HOSPITAL AND COOPER HOSPITAL IN CAMDEN, TO MENTION A FEW MORE FACILITIES THAT SERVE SUBSTANTIAL NUMBERS OF INDIGENTS. THUS, CHAPTER 83 WHILE NOT MAKING UP FOR PAST LOSSES IS HELPING TO ASSURE THE SOLVENCY OF THESE HOSPITALS IN THE FUTURE. OBVIOUSLY, THE VIABILITY OF THESE HOSPITALS IS ESPECIALLY IMPORTANT TO OUR CLIENTS FOR WHOM THESE FACILITIES OFTEN REPRESENT THEIR ONLY SOURCE OF HEALTH CARE. THIS FACT BECOMES EVEN MORE IMPORTANT IN AREAS OF HEALTH MANPOWER SHORTAGE, SUCH AS NEWARK, PATERSON, TRENTON, ATLANTIC CITY, CAMDEN, AND RURAL SOUTHERN NEW JERSEY.

CHAPTER 83 IS ALSO NOT WITHOUT SOME PROBLEMS. SPECIFICALLY, THE COLLECTION CASES THAT HAVE BEEN BROUGHT SINCE CHAPTER 83 WAS ENACTED ARE GENERALLY THE RESULT OF POOR ADMISSION PRACTICES. INVESTIGATIONS BY LEGAL SERVICE STAFF HAVE UNCOVERED HOSPITALS THAT DO NOT MAKE PROPER ELIGIBILITY DETERMINATIONS OR DO NOT UNDERSTAND HOW UNCOMPENSATED CARE UNDER CHAPTER 83 IS SUPPOSED TO WORK. WE FEEL THAT AT LEAST PART OF THIS PROBLEM STEMS FROM THE FAILURE TO PROMULGATE SIMPLIER ELIGIBILITY GUIDELINES.

PRESENTLY, CHAPTER 83 REQUIRES AN ASSET AND LIABILITY TEST THAT IS CUMBERSOME AND NON-SPECIFIC. IT CONFUSES BOTH THE CLIENTS AND THE HOSPITALS. TO AVOID THIS PROBLEM WE RECOMMEND THAT ELIGIBILITY BE DETERMINED BY AN INCOME ONLY TEST SIMILAR TO THE TEST PRESENTLY USED TO DETERMINE ELIGIBILITY FOR UNCOMPENSATED CARE UNDER THE HILL-BURTON ACT. IT APPEARS

TO US THAT THE LOW INCOME ELIGIBILITY LEVEL FOR CHAPTER 83, - 133% OF AFDC ELIGIBILITY OR $6624 FOR A FAMILY OF FOUR IS A SUFFICIENT GUARANTEE AGAINST PERSONS WITH SUBSTANTIAL ASSETS ABUSING THE SYSTEM.

FURTHER, THE CHAPTER 83 OUTPATIENT AND EMERGENCY SERVICE UNCOMPENSATED CARE REGULATIONS REQUIRE THE POOR TO PAY FOR CARE EXCEPT UNDER "EXCEPTIONAL FINANCIAL CIRCUMSTANCES." THIS REQUIREMENT ONLY CREATES AN EXCUSE FOR NOT DELIVERING NEEDED CARE TO THE POOR. WHAT CIRCUMSTANCE COULD BE MORE OF AN EXCEPTION THAN POVERTY. IT IS OBVIOUS THAT A FAMILY OF FOUR EARNING SO LITTLE ALREADY FINDS IT'S CIRCUMSTANCES FINANCIALLY EXCEPTIONAL. IN FACT, THE CHAPTER 83 ELIGIBILITY LEVEL IS LESS THAN THE NATIONAL POVERTY GUIDELINES. WE RECOMMEND THAT THE EXCEPTIONAL FINANCIAL CIRCUMSTANCES LANGUAGE FOR OUTPATIENT AND EMERGENCY ROOM SERVICES ALSO BE ELIMINATED FROM THE REGULATIONS.

FINALLY, WE ARE ANXIOUS TO EXAMINE THE DATA THAT WILL RESULT FROM THE DIAGNOSIS RELATED GROUP (DRG) METHODOLOGY. THIS DATA, ESPECIALLY IF IT IS BROKEN DOWN BY INCOME, RACE, AND ETHNIC CATEGORIES, IN RELATION TO THE DRGs WILL HELP US ANALYZE OUR CLIENTS HEALTH CARE NEEDS AND PROVIDE US AS THEIR ADVOCATES ADDITIONAL TOOLS TO ADDRESS THOSE NEEDS.

WE THANK THE COMMITTEE FOR AFFORDING US THIS OPPORTUNITY TO TESTIFY AFFIRMATIVELY ON CHAPTER 83 AND URGE YOU TO CONSIDER OUR RECOMMENDATIONS IN YOUR DELIBERATIONS.

New Jersey State Nurses Association

Lucille A. Joel, Ed.D., F.A.A.N., President
Barbara W. Wright, M.A., R.N., Executive Director

NEW JERSEY STATE NURSES ASSOCIATION

testimony on

IMPLEMENTATION OF THE HOSPITAL RATE SETTING LAW

P.L. 1978, C. 83

to

SENATE INSTITUTIONS, HEALTH & WELFARE COMMITTEE

by

Lucille A. Joel, Ed.D., F.A.A.N.
President

Tuesday, September 21, 1982

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The New Jersey State Nurses Association fully supports the implicit goals of the Hospital Rate Setting Law, P.L. 1978, C. 83. Control of escalating hospital costs and equity in the financing of health care continue to be a priority in rate setting. A system of prospective budgeting, incentives, and a dual case mix orientation built on Diagnosis Related Groups (DRGs) and Relative Intensity Measures of Nursing (RIMs) promise effective instrumentation to address this charge. The effectiveness of this program will only become apparent as we have the opportunity to observe the cost of hospital care over a period of time.

Two factors should temper our tendency to criticize. First, it is difficult to predict what will constitute a fair "start-up" period. The full impact of any new approach to rate setting may not be immediate. Time is needed to identify the weaknesses in the system, strengthen the supportive mechanisms, and resolve procedural and philosophical dilemmas. Success is dependent on clear communication and a fair modicum of trust between the hospital industry, provider professionals, and governmental rate setters. An openness to revision and refinement is basic to success. The ability to refine the system will be contingent on a full, knowledgeable and speedy grievance process. A system originally devised to correct inequities must promise nothing less to all those it impacts.

Care should be taken in comparing the cost of hospital care in New Jersey with other states and then moving on to consider intrastate changes. Cost efficiencies in those hospitals which have moved on to implementing the case mix model may have stimulated a rippling effect in agencies still pending full institution of the Chapter 83 system. In other words, an observation about the lack of significant difference between the two groups of hospitals may merely be a serendipitous finding defying interpretation.

The Association is concerned that the certified revenue base be sensitive to increases in salaries for nurses above and beyond the inflation factor. Nurses' salaries have substantially lagged. The reimbursement system created through Chapter 83 creates a situation which will both cause nursing salaries to explode and create a call for sophisticated clinicians. Every hospital bed will be filled with an acutely or intensively ill patient. Therapeutic effectiveness and a cost efficient operation will require adjustments in staffing ratios and skill levels of personnel. The cost of living index will not address this need adequately.

The Association contends that incentives should not be used to subsidize salary demands. Creating incentives is dependent on innovative systems management and should be used to fund enrichments. The Association believes that one of the most effective enrichments is masters prepared nurse clinicians who can direct rapid patient progress towards discharge.

This approach to rate setting and reimbursement provides the framework to allow nursing to eventually be costed-out according to actual patient consumption of nursing resources. Predictive equations for Relative Intensity Measures of Nursing (RIMs) resource use are currently in a public hearing period. The RIMs methodology represents a milestone achievement and a landmark in consumer equity. DRGs and RIMs have been designed as complementary systems. In most instances the nursing budget represents about 35% of the patient care costs and up to 50% of the hospital's non-physician personnel budget. The DRG/RIM methodology would allow control of a vast economic factor.

The committee should be aware that changes in hospitals will have complementary repercussions on long-term care. There are pressures to reserve residential long-term care for those who have the greatest need. In view of this, care should be taken in framing a routine service rate for hospital operative long-term care. Realistically, all residents may eventually deserve classification at a Skilled Nursing Facility (SNF) level.

The success of this rate setting system is directly dependent on the generation of timely management reports. In a totally computer driven system, there is no excuse for "stale" or "out-dated" information. The federal government monies which were essential to develop-

ing the instrumentation to work this system assumed the computer capacity to operate at a high level of currency and to digest a voluminous amount of data. If this technology did not exist, we accepted that funding on false pretenses.

A philosophical dilemma persists in resolving the instrumental and expressive purposes of hospitals. Provider professionals will have to approach their diagnostic and therapeutic prerogatives with a sensitivity to cost. This does not assume a dilution of quality, constraints on individuality, or "cookbook care". Sensitivity to cost and quality care are not mutually exclusive. Provider professionals and administrators will have to deal in a climate of openness and reality. They will find a need to show a united front and address the consumer. Polarizing the consumer in support of one's vested interests is unethical and only diffuses the trust the people of this State have placed in their health care system.

In summary, the New Jersey State Nurses Association supports Public Law 1978, C. 83 and the Diagnostic Related Groups methodology for reimbursement of hospital costs. It appeals to the Department of Health to hold firm in its convictions and to the communities of interest to be supportive through this inevitable and predictable period of development and refinement. We have created an approach which is pace-setting, better, and promises to become more perfect with time and perserverance.