PUBLIC HEARING

before

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

Examining the Effects of the Diagnosis Related Group (DRG) Reimbursement System on Hospital Costs and Quality of Care

July 14, 1986
Room 341
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Harold L. Colburn, Chairman
Assemblyman Rodney P. Frelinghuysen

ALSO PRESENT:

David Price
Office of Legislative Services
Aide, Assembly Health and Human Resources Committee

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Hearing Recorded by
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State House Annex
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Trenton, New Jersey 08625

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May 30, 1986

NOTICE OF A PUBLIC HEARING

THE ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE ANNOUNCES A PUBLIC HEARING TO EXAMINE THE EFFECTS OF THE DRG SYSTEM ON HOSPITAL COSTS AND QUALITY OF CARE IN LIGHT OF RECENT FINDINGS FROM A STUDY BY RESEARCHERS AT HARVARD UNIVERSITY AND M.I.T..

Monday, July 14, 1986
Beginning at 10:30 A.M.
Room 341 of the State House Annex
Trenton, New Jersey

The Assembly Health and Human Resources Committee will hold a public hearing on Monday, July 14, 1986, beginning at 10:30 A.M., in Room 341 of the State House Annex, Trenton, New Jersey, to examine the effects of the Diagnosis Related Group (DRG) reimbursement system on hospital costs and quality of care in light of the conclusions drawn by a research team from Harvard University and the Massachusetts Institute of Technology based on a three-year study of the DRG system.

The study, which was financed by the Robert Wood Johnson Foundation and is scheduled for publication in the Summer 1986 issue of the quarterly journal, Health Affairs, concluded that the DRG system has been no more effective than the SHARE

(Standard Hospital Accounting and Rate Evaluation) system which preceeded it in containing hospital-cost inflation, and has not significantly altered the behavior of doctors or hospital administrators.

The study did not specifically address quality of care; however, the researchers found that hospital administrators encouraged doctors to discharge patients as soon as medically feasible. This issue has been raised by critics of the DRG system, including some physicians and nurses who blame the system for causing premature patient discharges that result in relapses or readmissions.

The findings of this important study and the impending prospect of significant changes in New Jersey's DRG system because of adverse federal actions relating to the existing Medicare waiver warrant a re-examination by the Legislature of the DRG system and its impact on New Jersey's hospitals and their patients. This public hearing is intended to provide a forum for consideration of the important issues relating to New Jersey's hospital reimbursement system and alternatives to the DRG system.

Address any questions and requests to testify to David Price (609-292-1646), State House Annex, Trenton, New Jersey 08625. Persons wishing to testify are asked to submit eight copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses or the time available for each witness.

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ASSEMBLYMAN HAROLD L. COLBURN JR. (Chairman): Ladies and gentlemen, we're going to call the public hearing to order. Any of you who wish to testify please fill out one of these slips and let us know. It looks like we have a pretty good attendance and a fairly full schedule. I certainly would like to welcome you all to this hearing. It's involving a subject that's not only complicated but very important and one which I need to understand a lot better as a legislator. I hope somebody understands it all because I don't think I ever will.

Before I actually get into the formal part of the hearing I would like to introduce some of the people here. We have Mary Messenger from the Democratic staff representing the Democratic minority this year, I'm pleased to say, at least for the time being. (laughter) Welcome, Mary. She's all right. This Committee is not too bad.

David Price walking over there. He's the nonpartisan staff person who was in that position when Mr. Otlowski was the Chairman for the past six years. And I don't know how many years you've had that job, but at least a couple, wouldn't it be?

MR. PRICE: Three and a half.

ASSEMBLYMAN COLBURN: We all rely on Dave and we know he won't fib to us, so we're very pleased to have him here.

John Kohler, who is our number one Republican staff man, and Donna Bank in the back and Bill Noli (phonetic) behind me. He's our number one staff person from our Assembly office, Senator Haines and Assemblyman Shinn and myself. Is Bob Mince (phonetic) in the audience here? I lost him. He's the Governor's representative to the Assembly Health and Human Resources Committee. He'll come back in shortly.

And then we have Assemblyman Frelinghuysen, who is the only other Assemblyman here today, but of course we're the most important ones, so it's all right.

As we said in the notice of this hearing, the purpose of the hearing is to examine the effects of the DRG reimbursement system on hospital costs and the quality of care. And also to

consider any other alternatives which might be brought to light as to how hospitals might be reimbursed. I was planning to have a hearing such as this, but I must say my attention was attracted by a report I had heard was to come about from the Boston area, Harvard and MIT I think, and since that was somewhat in accord with my fears about DRGs when they first started, I really thought that DRGs were a way to pit hospital administrators further against physicians, since I'm one of those. But I guess it's more complicated than that. And since I've looked into it some more I find there is some difference of opinion as to how successful the DRG system has been thus far, and perhaps it hasn't been in existence long enough to really be able to tell the final story.

But we welcome the participation of everyone here, particularly those who have come so far. I hope you have seats, those of you from Boston. Do you? I don't know who you are. Okay, good. The least we can do is give you a seat down here.

The first person that we're going to call on to testify this morning is Dr. Molly Coye, who is from the Department of Health, and we'd like to hear what she has to say about the system. Want to step up here, Dr. Coye?

C O M M I S S I O N E R M O L L Y J. C O Y E: Thank you very much. Good morning. I'd like to introduce Christine Grand, who is the Director of the Reimbursement Division in the Department. I think that Christine has probably already met Assemblyman Colburn and Assemblyman Frelinghuysen. I appreciate the opportunity to make remarks this morning.

As you know, this is an issue of tremendous concern to us. The Department of Health is very pleased to offer comments specifically on the DRG technique of rate setting. My comments are general. Forty-nine states employ the DRG technique for payment of Medicare patients. At least 10 use DRGs for Medicaid as well. Ten to 15 of the states have some form of rate control which combines DRG payments for Medicare and/or Medicaid with some other form of rate control for other payers.

The State Legislature of New Jersey showed remarkable foresight in 1978 in passing Public Law 1978, commonly known as Chapter 83. A reading of that law and a review of the background of its passage and the successful implementation since then is impressive, especially as a relative newcomer to the State. The remarkable continuing and constructive tension between the Department of Health, which regulates the all-payer system, and the regulated parties, both the hospital and the payers, is unparalleled anywhere else in the country.

It's unfortunate that we blur the distinction between the general proposition of New Jersey's statewide all-payer prospective rate-setting system and the particular technique which is used to set rates, the DRGs -- the diagnosis related groups. Students of the history of Chapter 83 will recall that this aspect of the system, the particular technique of setting that portion of the total rate that pays for direct patient care, is only referred to in the law as a case-mix approach, and doesn't even specify the DRG methodology.

This is a very significant point and I want to present it clearly early in my testimony. DRGs are just one methodology for rate setting, and rate setting is just one method of rate control. When we use the phrase DRGs throughout the morning we should be very clear on what exactly we are referring to, to rate setting as a whole or to DRGs as one method of doing rate setting.

I've been given to understand that DRGs were chosen rather late in the legislative process as the technique that would be identified to set one portion of the total rates. This technique classifies all patients who enter New Jersey hospitals in a given year into 468 groups by their diagnosis. The historical costs of caring for these patients, that is the cost of caring for such diagnoses in the past, are then translated into a prospective or future rate by a complex formula which includes comparisons to other hospitals' costs as well. There are several other elements in addition to the DRG which make up

the total patient's bill. And in the back of the testimony you will see a graph, this sheet here (refers to handout), which shows all the various factors that go into making the total patient bill.

There's no question that this is a complicated issue and a complicated system, but our estimates are that the cost of the State work, the work by the Department of Health and the Rate Setting Commission to administrate this system costs less than 1% of the total hospital revenue base, which is regulated.

Since DRGs are still a relatively new technique of rate setting, it's reasonable to scrutinize their effectiveness. But while we scrutinize DRGs as a method of rate setting, we shouldn't lose sight of the more important aspects of the total system which are generally acknowledged, even in the study by Dr. Sapolsky and his colleagues which to some extent precipitated this hearing. And I'd like to list those general points.

First of all, that hospital rates in New Jersey are determined prospectively and rate increases have been constrained from year to year. This is what directly achieves savings and it's the process which is overseen by the Health Rate Setting Commission. In other words, that rate setting has worked as a general approach in New Jersey.

Secondly, all payers subject to the law pay equitable rates and are not subject to cost shifting. In most other states the constraint by PPS, by the Medicare system results in increases in rates paid by the commercials and Blue Cross. The result of this in New Jersey has been a stable and favorable climate for employers in terms of the constraints on rate increases.

Third, uninsured persons are assured access to medical care in New Jersey because the system pays for uncompensated care. In fact, I think it's a point that's not been adequately publicized throughout the country that the New Jersey system disproves the charges that are made in many other states that we can't afford to pay for indigent care, that it's simply too

expensive. New Jersey manages to pay for indigent care and to control the rate of increase in hospital costs better than any other state. So it's a remarkably effective program.

Fourth, New Jersey hospitals which are efficiently and effectively managed have rates set at levels which do keep them solvent.

Fifth, and finally, both patients and hospitals have the right of appeal to increase or reduce their rates, and they do this by coming before the Rate Setting Commission.

These are the most important aspects of the law and of the system as it works now. Once we understand this framework it's much easier to understand and separate out critiques of the DRG rate setting methodology itself from the broader discussion of rate setting or prospective cost containment.

There is a fairly large and conclusive body of research published which demonstrates the success of prospective rate setting and all-payer systems per se in containing costs with no demonstrable adverse effect on the quality of care. Studies focusing on the relative merits of different techniques for prospective rate setting, including the DRG technique have been fewer and more recent in their publication.

Three recent studies do support that contention that the New Jersey prospective rate setting system has been outstandingly effective in containing costs when compared with the State's SHARE system. Rosko and Broyles published in the Spring '86 edition of the journal "Inquiry" the results of a comparison between our Chapter 83 all-payer DRG system and the SHARE system which preceded it. This study found that the annual increases in the cost per case were significantly less in hospitals paid through the DRG system than comparisons with institutions paid via SHARE. It also noted, as we already knew, that the DRG payment mechanism has been associated with reductions in length of stay, but not with reduction in the rate of admissions.

The same study team published in the "British Journal

of Social Medicine" a comparison of our system with the Medicare PPS. It concluded that both the cost effectiveness and all-payer and uncompensated care aspects of our system are superior to Medicare's PPS from a health policy point of view. We managed to take care of more problems with our approach than the PPS system does.

Finally, there's a forthcoming study from the Johns Hopkins Center for Hospital Finance and Management which shows very favorable performance comparisons for all-payer hospital systems, especially in comparison between our system and the pre-existing Medicare payment system. Since the old Medicare system is still used by Medicare in New Jersey for hospitals that aren't paid under the DRG system, this study is of some usefulness in comparing the limitations of the SHARE system to the DRG all-payer system now.

You also should be aware that when the Department of Health prepared its application for the continuation of the Medicare waiver HCFA acknowledged that New Jersey's DRG rates were substantially below the Federal Medicare DRG rates that would have been paid in New Jersey. We may have, in fact, done too good a job [illegible] how successful the State's cost containment efforts have been because, as you know, the Federal government plans initially to pay no inflation for fiscal year '87 and to add no more to the national rate until 1988. This event, of course, requires us to develop the means to adapt to these cuts and this we are doing now.

We have already convened a steering committee of public leaders and State officials to work through the issues related to the need to adapt to these Medicare cutbacks and to an increased climate of inter-hospital competition. We intend to bring in national experts on prospective payment to advise at the appropriate point.

We welcome a constructive critique of the strength and weakness of the system and, therefore, we look forward to hearing from the other witnesses in this morning's hearing to provide

constructive criticism. I've asked our staff to prepare a packet of the full range of the published literature on the subject of the DRGs as a rate-setting technique as well as on alternative methods. We would offer this for the Committee's use within the next several weeks. We welcome any specific requests you may have so that we can focus more sharply on the facts of the subject and topics about the DRG system which are most of interest to you. We really do appreciate your convening this hearing and we look forward to hearing from the other witnesses. As you acknowledge, Dr. Colburn, this is a complex subject and one which we've already embarked on relooking at, and we look forward to learning from this morning.

ASSEMBLYMAN COLBURN: Thanks very much. Mr. Frelinghuysen, do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman, I was wondering if the Commissioner would comment on the Federal DRG waiver and its status and its impact on the system that we're in now.

COMMISSIONER COYE: Okay. We have reasonable hopes for retaining the waiver into the next year at a minimum. We have interest in doing that because on the whole we will continue to receive more money from the Federal system to use for uncompensated care than if we gave up the waiver. As you know, there finally has been a decision about the rate of inflation that will be used to calculate the PPS payments from Medicare and we are beginning our recalculations, our reprojections at the State level in order to compare our rates with their rates. That will require that we submit to HCFA those reprojections and that they agree to allow us to continue with the waiver, so there will be a negotiation process involved in that. But we do expect that we will be able to show the conditions required in order to keep the waiver, and that it will be very much to our benefit; to the State as a whole, to the hospitals, and to the payers, as well as to our benefit to retain the waiver. We do expect that we will be able to now.

The point at which we would give up the waiver and we would prefer eventually to give it up rather than having it taken away so that it can be an orderly transition out of the waiver and into the future system that we will evolve. We hope that we will keep the waiver at least for the next year and the point at which we would want to transition out would depend, to a large extent, on the inflation factor, the economic factor that Medicare adopts for next year and for succeeding years. If that factor is very low, if they allow very little increase for inflation, it may be less advantageous to us to keep the waiver. Does that--

ASSEMBLYMAN FRELINGHUYSEN: I think that's a fairly good synopsis. I had a question. I happened to attend Senator Codey's meeting up in West Orange where you testified on his legislation, the uncompensated care pool. While it was difficult to hear your testimony because of the acoustics, I just had a few general questions. What is your feeling on, first of all, on his legislation, that proposal? And how does it fit into the continuation of the present DRG system? In other words, the DRG system, as I understood it as a lay person, was supposed to look after those who were poor and had no insurance. Maybe you can give us your general comments on that proposal and how, in fact, it could possibly fit into a revised diagnostic related groups system?

COMMISSIONER COYE: Thank you for the opportunity to talk about that. As I hoped you gathered that morning, we strongly support that legislation. And, as a matter of fact, the commitment of the Governor to the issue of indigent care and the need to support indigent care was reinforced in his line item veto message when he pointed out that one of the highest priorities is the need to contribute State funds to the establishment of a pool as well.

Let me talk for a minute about why a pool is necessary. The DRG system was set up on the premise that all payers in the State would pay equally, that Medicare would contribute

proportionately to the cost of uncompensated care. As Medicare is cutting back in the total amount of reimbursement under the new budget passed by Congress and authorized by the Administration, that means that there's going to be a shortfall for uncompensated care, and the issue arises of how that would be handled. If it was passed on under the current system without a pool to the other payers, meaning that the commercial insurers and the Blues are increasing their rates, under our current system that increase would be hospital specific. In other words, hospitals that are providing a lot of uncompensated care right now would wind up having enormously increased rates for the Blues and the commercials.

What the pool does is even out that effect. The pool means that every hospital pays the same amount for uncompensated care, independent of the amount they're actually delivering. So that a hospital such as University or Jersey City or a hospital like Cooper, hospitals like that would draw down on the pool because they have a higher rate of uncompensated care. Hospitals which have a very low rate of uncompensated care would pay into the pool.

And if I could take the chance to point it out, this is really an unparalleled step that the hospital industry themselves organized in order to approach this issue with anticipation and to setup a system which does allow this effect to be evened out among hospitals. This has not been done in any other state and it's really very impressive. And we're very pleased with it. We think it's very important. Otherwise we would probably see a recurrence of the disastrous situation for inner-city hospitals that was happening in the late '70s that led to the passage of Chapter 83. I hope that isn't too lengthy. It's just a difficult issue to cover.

ASSEMBLYMAN FRELINGHUYSEN: Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Dr. Coye, could I ask: Are there any hospitals in the State now who are not covered under the DRG system? They're all in, aren't they?

COMMISSIONER COYE: The acute care hospitals are in the DRG system, but some of the non-acute care hospitals are not in, and I would ask Christine to elaborate on this. As an environmental scientist you're approaching the edges of my knowledge.

ASSEMBLYMAN COLBURN: Okay.

C H R I S T I N E G R A N D: The DRG system, prospective rate setting system covers only general, acute care hospitals. Rehabilitation hospitals, specialty hospitals, psychiatric hospitals are not under the system right now. They are, for the most part, under the SHARE system. The SHARE system is a prospective system. It, however, is not an all payer system. It does not include payment, for example, for uncompensated care in those hospitals.

ASSEMBLYMAN COLBURN: I see. Thank you.

Ms. Messenger, would you like to ask any questions at this point? (Negative response)

Thanks very much. I think we'll go on and perhaps we'll have a chance to call on you again as this thing evolves.

COMMISSIONER COYE: Okay. I know you have a long morning. I look forward to hearing the other witnesses, too. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Now, the Boston group. I think you need one more chair at least. We have Dr. Sapolsky.

D R. H A R V E Y M. S A P O L S K Y: Yes. I'm the real Harvey Sapolsky, despite what these other people might want to call me.

ASSEMBLYMAN COLBURN: Dr. Hsiao is it?

D R. W I L L I A M H S I A O: Yes, Hsiao.

ASSEMBLYMAN COLBURN: And Dr. Weiner.

S A N F O R D L. W E I N E R: Weiner.

ASSEMBLYMAN COLBURN: Weiner, thank you. Gosh, I did all the others perfectly. Your's was the easiest one I did

wrong.

MR. WEINER: We provide a bit of real test.

ASSEMBLYMAN COLBURN: Who would like to lead off?

DR. SAPOLSKY: I'll start. Let me begin by thanking you for the invitation to report on our study of hospital reimbursement in New Jersey. One of the purposes of the project was to draw some lessons -- policy lessons -- for the State, and this is obviously a good opportunity to do that.

You'll understand if I make a disclaimer on behalf of the Robert Wood Johnson Foundation. The Foundation supported our work but is not responsible for the findings. We hope they'll take credit for whatever good work we did, but they can't share the blame. Those of us who live by the grant have to be nice to the grantors.

Now at the outset I'd like to draw a distinction, as did the Commissioner, between hospital reimbursement policy in New Jersey and DRGs. Both the use of DRGs as a method for rate setting and State policy grew out of the reimbursement reform passed by the Legislature in 1978. The legislation set certain objectives for hospital reimbursement in New Jersey. Cost containment was an objective, but so, too, was the financial stability of hospitals. At that time several of the inner-city hospitals were in deficit. There was also an intent to assure access to care for New Jersey residents who lacked adequate hospital insurance and a desire to guarantee that there would be fair competition among insurers in the State.

Prior to the reform, New Jersey operated the rate setting system known as SHARE, which controlled only Medicaid and Blue Cross rates and that caused a big gap in prices between the Blue Cross would be charging and the other insurers. The solution was to mandate an all-payer rate system that would even out the rates and provide a mechanism to share the cost for what uninsured -- something that the system known as SHARE did not do, share the costs.

Nothing was said, as the Commissioner pointed out,

about the method of determining the rates other than it would recognize case mix. The Department chose the DRG system. With DRGs, fixed prices are established for hospital services based on patient diagnosis and paid regardless of the actual cost incurred in providing the services. They're calculated on the past cost to the hospital and the group averages, but they're fixed in advance. Because hospitals are allowed to retain the difference between fixed prices and their actual costs, they supposedly have incentive to become efficient managers of resources.

The adoption of DRGs in New Jersey attracted much attention, particularly because of its potential for improving efficiencies of hospitals. In 1983 the Federal government adopted DRGs for the Medicare program, accelerating the interest in DRGs because of its impact on hospital management. Understandably much of our work has focused on the management effects of DRGs, but it's also part of our study to seek out the lessons for Medicare of the New Jersey experience.

I should like to point out the only link between New Jersey and the national system is the use of DRGs. The Medicare approach was to select DRGs without reimbursement reform. It is not an all-payer system. It is not concerned with the financial stability of the hospitals. It's not concerned with assuring access to care for the poor or for sharing the cost of the poor among the payers, and it has no concern for fair competition among insurers. Medicare nationally is basically interested only in cost containment, while New Jersey -- because of the legislation -- has multiple goals.

I'd like to summarize our findings and briefly discuss the implications for New Jersey. Professor Hsiao will elaborate on the economic findings, and as he is expert on Medicare and interstate comparisons, he can place them in the appropriate context. Sanford Weiner is also to testify, and he managed the project and conducted most of the interviews with hospitals in New Jersey. As he knows the New Jersey hospital situation quite well, he can elaborate on the lessons for New Jersey.

Briefly stated we found that the cost control under the reform was in line with the results achieved during the period when SHARE was the regulatory system in place. The new arrangements were no better, but also no worse, than SHARE because SHARE as it turned out was a fairly effective cost control system. DRGs did little to change the management practices in the hospital. This was partly due to the fact that the rates were only moderately constraining in New Jersey because the reform served other goals besides cost containment. It also was due to the fact that the DRGs are an awkard system for classifying and directing physician behavior and the use of hospital resources. The hospitals didn't become especially efficient in New Jersey under the DRG arrangements but that's, as I said, partly because the DRGs themselves are a flawed way to guide hospital behavior.

What lessons did we draw from New Jersey? Well, New Jersey's all-payer system does quite well when compared, I think, to the Medicare system. The cost containment achieved in New Jersey, although not spectacular, is quite respectable, especially when you look at what's happened in the region and what's happened nationally. More importantly, New Jersey has achieved financial stability for the hospitals and has assured a way to share the costs for the poor and has made competition among the payers for health care costs fairer than it was during the 1970s.

What New Jersey did in 1978 will, I believe, have to be done nationally if Medicare continues to seek stringent cost control. New Jersey in this sense is a decade ahead of what will be national reimbursement policy, I believe. I'm no particular fan of DRGs, which I think are just overly complicated ways to set rates, but I am impressed -- and that is, I think, the summary of our study -- with the achievements of the prospective payment system and the reimbursement policy that New Jersey has followed.

ASSEMBLYMAN COLBURN: Thank you. Before we go on to

the next speaker, I know I have a question or so. Rod, do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: Little later.

ASSEMBLYMAN COLBURN: I was going to ask you, and you said what I'd been thinking, that it seems like a very complicated way to achieve a goal which could be achieved in a simpler way. Do you have any idea of the resources it takes from hospitals or from the State government? I meant to ask Dr. Coye about the State government.

DR. SAPOLSKY: No, I don't.

ASSEMBLYMAN COLBURN: Do you have any idea what it takes? I know when it went into effect at the hospital with which I'm affiliated they had to hire outside consultants. I think they hired Touche Ross or somebody like that and I think it was maybe even a couple hundred thousand dollars or more to get this thing geared up. And then I was going to talk to the former head of the records room because she retired shortly after that, but-- I don't know. It just seemed to me as though it was terribly complicated.

DR. SAPOLSKY: Oh, it certainly is. I believe Sandy Weiner might be able to comment when he testifies about the impact it's had on the--

ASSEMBLYMAN COLBURN: What it does to the hospital?

DR. SAPOLSKY: Yeah.

ASSEMBLYMAN COLBURN: Okay. Thanks.

DR. HSIAO: Mr. Chairman, we're pleased to be here this morning. I have a confession to make. Although three of us are from Boston, we actually have not seen each other for about four months and this is the first time we have the opportunity to meet. So we thank you for this chance.

I'd like to just first of all, perhaps, provide a little bit more detail on the economic findings, and second, then, I'd like to also mention something about the quality of care, the impact of DRG on quality of care.

As Dr. Sapolsky mentioned earlier, our empirical

findings concludes that the DRG regulation as a technique of regulating hospital rates is as effective as the previous regulation, which is SHARE. Statistically we subjected the data to some rigorous statistical tests we could not find-- The DRG regulation is any significantly effect— More significantly effective than the previous regulation. However, if you look at just the average data, that is not subject to rigorous statistical test, in the period from 1980 through '84 the New Jersey rate of increase in hospital cost per person averaged around 2% — a little bit less than 2%. For the rest of the northeastern states of the United States, that averaged out to be about 2.4%. And for the United States as a whole, that averaged out to be about 2.8%. So under DRG regulation the rate of cost increase in New Jersey was kept below other northeastern states or the United States as a whole. So that is a fact I think the State can be proud of in terms of saving the patients and the citizens of this State in terms of the cost — the expenditures they may have to provide for hospital services.

The other important finding we have is related to the quality of care. I'd like to first make clear what we-- We did not find any measurable systematic changes in quality. Quality is like, often is like beauty; is in the eyes of the beholder. And in medical science nor in health services research there is no common definition, "What is quality of services?" I'm sure physicians in this room and elsewhere can give you many anecdotal evidences quality may have been effected. However, in our study we pursued with all the diligence, and with all the methodological know-how that we know trying to measure any systematic changes in quality care. Thus far we have not been able to find any.

Let me elaborate a little bit on that. One of the most significant changes in New Jersey hospitals' practice since the introduction of the DRG is the decrease in average length of stay per admission. Under the previous regulation -- SHARE regulation -- the average length of stay in New Jersey was increasing, going

against the national trend or the trend in other states. Under DRG, New Jersey's hospitals average length of stay began to drop and drop sharply, but even at this moment the data we have on New Jersey shows the average length of stay in New Jersey for case mix is about the same as the national average. So it's not significantly different from what the practice is in other states.

Let me then elaborate where these big drops came from since 1980. The largest drop in the average length of stay came from abortions with D and C. That dropped 37%; the average length of stay, now at 1.4 days. This is for abortion with D and C. The other largest drop in average length of stay is in normal deliveries without complication. In that now the average length of stay is reduced to 3.4 days. The third and fourth one in the largest drop come from simple length extraction. That has now reduced down to an average of 2.5 days. And the fourth one is in tonsillectomy, that now the average length stay has dropped to 1.4 days.

Why I give you these elaborations is simply because you can judge for yourself where these largest drops in the length of stay -- in other words, earlier discharges -- are not necessarily impacting on the technical or medical quality of care. But is, perhaps, impacting on some discretionary stays.

Also under DRG there is, perhaps-- People suggest there could be a change in the quality of care because the services are shifted to same-day surgery. In the data we have examined we find that there are three types of services have shown the greatest change to same-day surgery. They are endoscopy, breast biopsy, and simple lump extraction. Previously many of these procedures were performed as inpatient hospital service. That is where the patient would stay at least one night. Now many of these services are shifted on a same-day surgery basis. Therefore, at least from a--

ASSEMBLYMAN COLBURN: I was going to ask you, what about hernias?

DR. HSIAO: The hernias, also, the average length of stay did drop, but it is not one of the biggest changes.

ASSEMBLYMAN COLBURN: Not the biggest. Not same-day either.

DR. HSIAO: No, not shifted to same-day service.

ASSEMBLYMAN COLBURN: Okay. Thank you.

DR. HSIAO: So, I want to report to the Committee that at least with what work we have done thus far we have not been able to find any measurable, systematic changes in the quality of care.

Lastly, let me just say, another part of our study, which is not published yet but has been written in manuscript form, is trying to understand how the hospital behaves as an organization. Hospitals, as you know well, are nonprofit community service organizations. The question is do hospitals-- From economist perspective the question is whether hospitals compete on price, or they compete on some other dimension. Because if the hospitals do compete on price, then, perhaps you do not have to regulate a hospital. Instead through competition, the price will be driven down and because of price competition there will be greater efficiency promoted in the hospitals.

To our disappointment we find the hospitals, at least using New Jersey data-- We find it's more likely to be competing on prestige and on the loyalty of the physicians, not price competition. Therefore, under any kind of retrospective cost reimbursement method as used in the 1960s or 1950s, hospitals then tend to have the incentive just to increase their cost, and that's what generates cost inflation.

These facts tend to show then hospital rates have to be regulated. Whether it should be done through a DRG technique or through some other system, that remains to be an open question. But what we can say with some confidence is hospitals would spend whatever amount of money the regulators gives. We found this particularly in the sense the introduction of the DRG regulation in New Jersey. Therefore one of the suggestions I have for the

Committee is that if the Committee's concern is on hospital cost inflation, then close attention has to be given to how tightly those rates are regulated. Thank you very much.

ASSEMBLYMAN COLBURN: Thank you.

Rodney, do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: Yes, Mr. Chairman. I have a question. I note in your summary— I want to make sure it's yours before I make reference to it.

DR. SAPOLSKY: More mine than his, but that's all right.

ASSEMBLYMAN FRELINGHUYSEN: Well, I'll hold you both responsible.

DR. HSIAO: All three of our names are on it.

ASSEMBLYMAN FRELINGHUYSEN: It says here interviews were conducted with New Jersey and Federal officials, insurers, employers, physicians, and administrators, etc., etc. Now, did you interview patients?

MR. WEINER: No, we didn't.

DR. HSIAO: We did not interview patients. The interviews were conducted by Mr. Weiner and others and he will be in a better position to answer you.

ASSEMBLYMAN FRELINGHUYSEN: Did you interview other professionals in the hospital setting?

DR. SAPOLSKY: Yes.

ASSEMBLYMAN FRELINGHUYSEN: Other than physicians?

DR. SAPOLSKY: We interviewed primarily physicians. We did also talk to some of the nurses and some of the ancillary staff. We interviewed a number of people on the management side; DRG coordinators, finance officers, people involved with data processing and up the chain to the executive officers in the hospitals. We didn't try to do a study of patients per se. That's a rather different kind of study. To do that as comprehensively as we were doing our study would have been another year's work of a different sort, so we drew a line, and said we will do what we can do.

ASSEMBLYMAN FRELINGHUYSEN: My general feeling as a layman is that while obviously you didn't include interviewing patients, much of what we receive as legislators, obviously, perhaps as you point out, is anecdotal. But the public perception, I think at times appears to be accurate based on anecdotal — what appear to be primarily anecdotal stories. I just wondered whether, perhaps, in some ways, we have missed out on an important factor in the overall equation and perhaps some of your overall findings.

ASSEMBLYMAN COLBURN: Wouldn't you say that this might be the subject of their next study? I think they did say--

DR. SAPOLSKY: On the way back we're planning to stop by at the Robert Wood Johnson Foundation. With that endorsement I'm sure we'll get somewhere. (laughter) But there may be another thing to look at too. With this system the patients have a place to complain to in a sense. It's a State-run system. You can complaint to the State about care in the hospitals. There's always complaints about care in a hospital. It's a difficult undertaking. There's always going to be some dissatisfaction. So the fact that letters were received and people are upset has to be considered, but you have to compare it with what? How was it before? What will it be in the future? It may not change, no matter what is done to reimbursement systems.

ASSEMBLYMAN FRELINGHUYSEN: My general feeling is -- and some comments were made about in-and-out surgery and the types of things that you can go into the hospital for one day and get out in the afternoon -- that a lot of people traditionally have expected that they would be kept in the hospital for a longer period of time. My question is whether we would be going towards that, the use of more in-and-out surgery even if we had not as a State gone into diagnostic related groups as a system. In other words, were we going to be-- Were physicians, hospital administrators, going to be moving into that as a method and a way of doing business regardless of whether New Jersey was the first state in the nation to initiate this type of system?

MR. WEINER: I can answer that question, Mr. Assemblyman. In our model we tested that hypothesis, whether in the absence of DRG regulation whether there will be this kind of shift between inpatient surgery versus same-day surgery. And definitely the statistical data shows that the DRG regulation most likely had a significant impact on the shift, that is a shift toward same-day surgery. But I suggest, though, you need to ask next level question: Does that really harm the patient? Or that was the inefficiency in the old system that you want to change anyway? And I think that's the-- We do not have answer for that.

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman, I have just one additional question.

ASSEMBLYMAN COLBURN: Yes.

ASSEMBLYMAN FRELINGHUYSEN: In terms of the 16 hospitals, how many were inner-city hospitals as opposed to, shall we say, suburban and rural? Just because I think, obviously, many of the inner-city hospitals take care of, shall we say, poor, older patients, those who have not had traditionally access to physicians in any period of their life. I just wonder whether you had any comments relative to the inner-city versus the rural or suburban hospitals?

MR. WEINER: We were quite sensitive to that for exactly the reasons you pointed out. I think of the 16, at least six, and perhaps more, depending on how you define inner-city, were either real inner-city -- Camden, stuff like that -- or urban. There were some classic suburban places. There were a couple truly rural places. We were quite conscious of trying to get both a geographical spread, a spread by ownership, religiously organized hospitals or voluntary hospitals, and by management style, places that were more aggressive with their physicians, places that have a tradition of being laissez faire. Some places along the shore that have been growing very quickly and had problems of that sort or type, we looked at as well. But what was interesting was only one thing stood out across the

range of hospitals, and that was the reimbursement for back debts in the predominately inner-city hospitals had made a striking difference in their financial status, which has been commented on before and which shows up quite dramatically in our data. That aside, the system seemed to operate statewide more or less the same. We did not get very different responses from administrators in one part of the State and the other -- we looked north and south -- or from one type of hospital and another.

Indeed, the thing that stands out most dramatically is how much stability there was. There was this whole learning process of learning new techniques and new jargon and new forms and all that. And that was quite disruptive for a lot of people for a year or two, but what was remarkable in terms of patient care and administrator/physician relationships is how much stability there was and how much insuring the financial stability of the hospitals that were most troubled, that the whole system become considerably more stable. And beneath the sort of waves on top, much of the hospital system was unchanged except that it now had a budget constraint.

ASSEMBLYMAN COLBURN: Why don't we go on and--

ASSEMBLYMAN FRELINGHUYSEN: I just have one question I can't resist, since we're on this.

ASSEMBLYMAN COLBURN: I guess I can't resist either.

ASSEMBLYMAN FRELINGHUYSEN: The technology issue; access of hospitals to technology. You know imaging-- Did you draw any conclusions from the availability of technology vis-a-vis one hospital, one region versus another and ability to provide services based on the State's, shall we say, rather selective system of deciding which institutions can provide what services? I said that as kindly as I could. (laughter)

MR. WEINER: Do you want to talk about inside your district? (laughter) I know there have been these debates across the State.

ASSEMBLYMAN COLBURN: There might be times that you

would wish to decline to answer a question.

MR. WEINER: Oh, sorry.

ASSEMBLYMAN COLBURN: Why don't we go on, Rod. I want to hear what they have to say.

ASSEMBLYMAN FRELINGHUYSEN: He appears to want to respond. I think we should let him respond.

ASSEMBLYMAN COLBURN: I'd rather keep more on the track. I think we're getting a little bit afield.

ASSEMBLYMAN FRELINGHUYSEN: I think it is related to DRGs, the availability and access to various types of equipment and where, in fact, people feel comfortable that they're going to get the highest quality care. So if you have a reaction, I'd like to hear it with the Chairman's permission.

ASSEMBLYMAN COLBURN: The Chairman makes no difference.

DR. HSIAO: Well, again, I'm just going to speak from aggregate statistical point of view. I did not do the interviews and Mr. Weiner may address that part. From all the-- First of all, under the DRG regulation the capital cost is a pass through, that is after the State has given approval for the purchase of major equipment or the construction or renovation of physical facilities. So the DRG, theoretically, would not even have much impact on the -- have any direct impact on the purchase of new equipment or diffusion of new technology. There is an indirect effect, namely to what extent the surplus position of the hospitals in New Jersey may be affected by the DRG regulation. I can say unequivocally the DRG regulation has improved the surplus position of the hospitals. So therefore both directly and indirectly you would not -- cannot logically infer that there is an adverse effect on any kind of diffusion of technology in New Jersey.

MR. WEINER: What we found as we went and talked to the individual hospitals was very much the same thing, that though the era of retrospective cost payment, where everything was paid for, had ended, the fact that capital remained, in effect

retrospective, pass through, and the fact that surpluses on the whole were growing over time and on the average, meant that the hospitals really did not overall change their view in terms of their basic values, that what was important to the local community was new facilities and new technology, and what was important to their local physicians. And indeed, there's an interactive effect because this system does reward increasing admissions, and one way to do that is to keep both your patients, and especially your physicians, quite satisfied. Indeed, attracting a few more physicians is the easiest way to attract a few more patients. And the easiest way to do that is to keep competitive in the new technology.

So what we found — even though that on the whole New Jersey has a somewhat constraining rate-setting program that we support, and compared to other states considerably more constraining than one finds in most of the country -- the notion that the new technology was the heart of the modern hospital, continues. And therefore, the struggle for the planners and the other part of the Health Department as to how to allocate that technology remained an acute one. We did not get enough in detail to try to second-guess them about which parts of the State should get that technology. We think that in New Jersey, as in other states, it's quite unfortunate that loopholes in the certificate of need law, which are traditional around much of the country, have allowed major pieces of technology like the scanners of various sorts to be placed outside the hospital and outside the regulations. We think there should be a level playing field there to in that if they're going to be allocated they should be allocated for the whole State and not just: if it's in the hospital it's in the regulation, and if it's in the shopping center next door to the hospital, it's regulation-free. That creates all the wrong incentives, whether it's in New Jersey or other states. So the notion of allocating it fairly across the whole State makes sense. We expect that problem to continue because there's enough money in the system and the hospitals are

still eager to buy those things. There will be a continuing problem of basically statewide allocation in some kind of reasonable notion. We are sort of sympathetic to the notion that that's not easy to do, and it has obviously given rise to some specific controversies over which hospitals should get it. We expect, despite the fact that it looks like a tight system overall, those kinds of controversies are going to continue because it's worth a lot to an individual hospital to get that new scanner. And we really wouldn't want to be in the position of the person who has to make that decision for the State.

ASSEMBLYMAN COLBURN: Would you say that's more a function of the certificate of need process than of the DRG process at the moment -- although the surpluses are lending themselves to request, I guess?

MR. WEINER: Yeah. Rate setting has provided the funds in general so that the competition for technology continues.

ASSEMBLYMAN COLBURN: Okay. Now, I presume you have some formal comments to start making?

MR. WEINER: Yeah. We've covered a number of the things that I [illegible] wanted to say. I want to come back to basically some of these distinctions we've been kicking around. A lot in terms of evaluating these kind of systems depends on what your goals are and what your benchmarks are. It turns out when we look back at SHARE -- which was attacked quite vociferously, I assume, even in this room, five or six years ago -- that if your single-minded goal was getting your hospitals to save money at any cost. SHARE was quite effective at that.

The biggest change in hospital expenditures is between the unregulated period before SHARE and the SHARE/DRG period combined. That's where the curve really bends. As Bill was saying, between SHARE and DRG there's a statistically insignificant difference and even, in actuality, numbers a very tiny difference. Though I would point out that Bill's numbers are in constant dollars, that is to say leaving inflation out.

That's where we get those particular numbers.

But the problem with SHARE is that it squeezed on half the system, on half the dollars, on Medicaid and Blue Cross and, therefore, was unstable and unfair in a lot of ways. It was unstable in that some insurance payments were regulated and others were not so that the differentials became quite dramatic. It was unstable in that the inner-city hospitals were being particularly squeezed without any resources to cover the poverty population that tends to use those hospitals. So that it was a system like what may yet happen in the Federal system. It was a system that the more the squeeze, the more acutely the pain was felt in a particular places.

When we look at the Chapter 83 system-- In many ways we think it's missed-named as a DRG system because that highlights the wrong aspects of it. When we look at the post-1980, Chapter 83 system what's remarkable is that the level of cost containment in the aggregate statewide is more or less in the same range as in SHARE, but the pain is spread much more evenly across all payers, across all hospitals, with a few exceptions. And the bad debts, which were the-- And therefore access of the poverty population, which was the thing that was dragging down those inner-city hospitals are now covered and now taken care of.

When we look at DRGs per se, which were then added on as the particular technique, we find that they are an extraordinarily complicated way of what could be a much more simple adjustment for case mix. That the specific incentives -- that were much talked about -- attributable to DRGs as opposed to the overall system. The DRG aspect tends to be rather insignificant when you look at the individual hospital because DRGs give you rates per case per diagnosis, but if you go and talk to hospital administrators, they're interested in the overall budget as if they were a university president or any other public institution. And they manage an overall budget-- Whether they make or lose money on hysterectomies matters a lot

less than whether next year's deficit is a million dollars in the red or a million dollars in the black. And therefore, the DRG component in this system includes a whole lot of extra detail that turns out to be irrelevant for most of the people involved in the system.

Therefore there was a lot of time and effort that went into some of these details that we would suggest other states perhaps not bother with. In New Jersey it's already been learned, so it's embodied in the system. But as we look at New Jersey and as we compare it to the other systems in the other all-payer states it struck us that what really stood out is that there is a fixed limit per case, and it doesn't really-- And you can set that limit in a wide variety of ways without making a whole lot of difference.

What matters is, for the hospital administrator, we've drawn an overall budget total and said that's how much you get. You get extra adjustments if your admissions go up; you get extra adjustments if you case mix changes. But basically you have to meet a budget just the way any other organization would as opposed to the pre-SHARE days and the pre-regulatory days when you could get reimbursed for whatever you spent. Now there's a limit. We found that the limit is not dramatically constraining. It's constraining enough to save money. It's not constraining enough to change hospital behavior within the hospital very dramatically. So in some-- I think the hospitals might say that that's a reasonable balance. It saves the State money. It saves the citizens money.

Yet the stuff that was feared -- that there would be acute changes in quality or in relations between hospitals and physicians or in relations between physicians and their patients -- after talking to several hundred people who spend their time in these hospitals we found them irritated by many bureaucratic things. But we did not find a fundamental change in the way the hospitals work because nothing happened inside the hospital that was so Draconian as to make that happen. And that much of the

commentary about the DRG aspect, which assumed those kind of Draconian changes, was really -- in the first years -- was really anticipating things that did not happen.

So we come back to the fact that sort of an all-payer system which provides the hospital with a total budget, and which pays for the cost of the poor through picking up the bad debts makes a lot of sense and is something that we would prefer to see, on the whole, in a lot of other states. And it's something that we can sort of enthusiastically support in New Jersey.

What, unfortunately, what's gotten national attention the further you get away from Trenton is not the all-payer part of the system, and not the fact that it's a rate-setting system, but the little DRG component, that technique, which seems so fascinating, and it's so elegant, and you know, it's this new hi-tech approach to rate setting. Our notion is that rate setting matters, whether it's lo-tech or hi-tech. And that the DRG component is, in some ways, unfortunate in that people focus on that as being the magic. It's actually much more prosaic. If you set a budget and tell people they have to stay within it you can save money. And DRGs are in the whole fairly irrelevant to that.

So we suspect that Medicare could have done a lot better focusing on the parts of the New Jersey system that do work rather than the technique which, as far as we're concerned, is pretty optional.

ASSEMBLYMAN COLBURN: Is the cost of running the DRG system greater than running a SHARE system?

MR. WEINER: Somewhat, but still relatively small compared— Well, you have to separate two things. SHARE as a system was so unstable that it changed every year. Regulations kept shifting. The hospitals found that quite disruptive as well. DRG had an enormous learning cost, partially because of the complexity DRG aspect, which may or may not have been crucial. Once now learned, it's still a complicated system and it still costs them some money, but the money saved by the

overall budget thing probably dwarfs that. So if you were starting from scratch, which is kind of an academic position, one could probably simplify the system. Given what you've already gone through and the learning you've already done, we suspect the system you've got looks a lot better than most other states. So there is a cost to running a DRG system that could be simplified somewhat we think. But a lot of it was learning costs and has already been paid.

ASSEMBLYMAN COLBURN: Thank you. Rod, do you have another one?

ASSEMBLYMAN FRELINGHUYSEN: I can only ask this question given the Chair. The behavior of physicians relative to--

ASSEMBLYMAN COLBURN: I wasn't going to get into that. I think you should submit your questions in advance, Mr. Frelinghuysen. (laughter)

MR. WEINER: Then we could submit our answers.

ASSEMBLYMAN FRELINGHUYSEN: What about altering the traditional way of doing business relationship between the physician and their patients? Could you give us some short, concise comments on what you have been able to pick up from your study and your interviews? Whether we've altered behaviors and individual physicians and group of physicians within the hospital setting or those associated with hospitals in some way?

MR. WEINER: On an average, relatively little because the cost pressures were not that dramatic. There has been an emphasis on decreasing length of stay, on getting those people out a little earlier and on the same-day surgery. But it is fair to say, as Bill was pointing out, that that's part of a long-term national trend. New Jersey to some extent has been lagging behind that national trend and what we've seen is, to some extent, catch up.

It's also true that as the costs of a hospital day becomes more expensive everywhere, and every year it's just harder and harder to justify keeping people there whatever the

system. Once you get up to $500 a day it's an expensive resource and whatever the system, it's going to focus on getting those people out a little sooner.

As I said, we did not talk to patients, but we did try and talk to a number of physicians who were perfectly happy not to take, say, the hospital line, who drew their own life as a patient advocate rather than as a hospital advocate. And they were prepared to talk about the increasing bureaucracy and the increasing paperwork and that sort of stuff, but we couldn't get any significant changes in how they actually treated their patients or what they did to them. Indeed, things like nursing hours per patient or ancillary services in New Jersey are up under the last four years, have gone on increasing per case. So we don't see any dramatic changes in either hospital/physician relations or physician/patient relations that stand out beyond the notion that everyone knows they have to live within a budget and everyone is being encouraged to think hard about length of stay.

ASSEMBLYMAN FRELINGHUYSEN: Thank you.

ASSEMBLYMAN COLBURN: Thank you. I might say as a physician who admits almost no patients to the hospital -- I'm a dermatologist -- that I have seen in the other physicians many influences upon them that are outside the DRG that I think are influencing their behavior. I see them cooperating amazingly with the administration and committee work and checking up on each other and setting up systems of-- So I was going to let maybe some of the medical people get into that because I really do feel that there's an ongoing, and maybe slow, but nonetheless relentless process of change of physician behavior. And just what the turning point comes between that and malpractice rates. I don't know, but you know, that worries me a little bit I must say.

I'm going to ask that we go on. Thanks very much. I really appreciate your patience and I hope you can stay for a while. Do you have to get back?

DR. SAPOLSKY: We have to get back, yes.

ASSEMBLYMAN COLBURN: Well, I certainly appreciate your coming. I think it's an extraordinary thing that you did this for us.

We're going to go a little bit out of order and ask Dr. Carnes to make his presentation next. Dr. Carnes is President elect of the Medical Society of New Jersey and a fellow sufferer along with me.

D R. H A R R Y C A R N E S: Now we're going to hear from those in the trenches.

ASSEMBLYMAN COLBURN: I count myself as one of them.

DR. CARNES: The ones who are talking to the patients that Assemblyman Frelinghuysen was speaking of before.

I'm here this morning as the President elect of the Medical Society of New Jersey with approximately 10,000 members representing the overwhelming majority of physicians practicing medicine in the State of New Jersey. I want to thank Dr. Colburn and all the other members of the Health and Human Resources Committee for permitting me to present the MSNJ's views on the DRG reimbursement issue.

The Medical Society of New Jersey has been opposed to the DRG reimbursement program and concept since its inception in '78 and '79. While New Jersey physicians have cooperated in every way possible with the hospitals during the intervening seven years to make this program operable, we have seen nothing of practical value to recommend it.

The DRG program was developed at Yale University as an experimental utilization review mechanism, not as a reimbursement system. It should also be noted at the onset that New Jersey physicians have had the most experience with this program, more than any other physicians. We were the trailblazers for the program. It was in New Jersey that the first DRG trials began, and where all patients -- not just Medicare -- were covered by the so-called all-payers plan. Today there are four states with the all-payers plan. The remaining states have only the Medicare

recipients under the DRG system.

With the above as background information, we feel that New Jersey physicians have unique qualifications to make judgment about the DRG system. In 1985 the Medical Society of New Jersey developed a position statement on the current Federal and State of New Jersey DRG reimbursement program. We remain strongly opposed to it. Quite simply stated our opposition was due to a concern over the premature implementation of what had become a national program that we felt could impact negatively on the quality of medical care for our patients. The quality of care issue becomes apparent in a prospective fixed pay system that possesses the inherent potential for a reduction of services plus an inappropriate reduction in the length of stay in an effort to maximize profits. Our worst fears have come true. Patients are leaving the hospital quicker and sicker. This is a given ladies and gentlemen. The Federal government has great concern for this problem at this very present time. Senator Heinz and his Committee are studying this issue.

It is our considered opinion that there is something ethically wrong with a system that rewards one for doing less. This can only lead to a rationing of care because the less done, the more profit the hospital makes. We, as physicians, have a conflict of interest. We are encouraged to consider our hospital's financial health along with our patient's welfare. This environment lends itself to less than the best medical care for the citizens of this State. Mediocrity becomes the norm and we hear words like "average" bandied about. We see no redeeming virtue in a system that rewards mediocrity at the expense of quality.

In closing, let me state that as physicians we are and shall remain our patients' advocate. They come to us in time of personal health crisis and they deserve our best efforts. We will continue to strive to give them nothing less. However, it is very difficult to do so in the environment that now exists. As noted previously, the Medical Society of New Jersey does not

believe that our patients' health needs are best served by the prospective DRG payment system. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Do you have some questions? (Negative response) No. I wanted to ask you, would it make a difference if the SHARE system or any form of control on the cost of hospital service were imposed or would it lead to the same problem that you see?

DR. CARNES: We feel that the SHARE system wasn't entirely inequitable. We realize that there will have to be some rate setting of some type and with close utilization we see no problem.

ASSEMBLYMAN COLBURN: One of the things that I heard -- and we talked about it. When we increased nursing hours for nursing home care, we spoke of the fact that -- or at least the anecdotal fact that nursing home operators have told me that they get people sicker in the nursing home now because they're leaving the hospital faster. I assume that's true.

DR. CARNES: We don't have studies to prove same, but anecdotal -- here we go again -- you know, there's 10,000 of us looking around here hearing the same thing from patients constantly. We're letting them out sooner, in essence, truthfully. Medicine is a-- It's an art; it's not an exact science. There are very few cases of white and black. There's a lot of gray. To decide what day you're going to do what on, is a difficult, very subtle thing. And there is pressure, if there's only subtle pressure, there is pressure to move and pressure to send that terminal cancer patient out a little sooner, to be transported back and forth to the hospital by ambulance every day, this type of thing. There are many, many things in every field that go on, but this is what we face. There are practical problems, but very significant in the practice.

ASSEMBLYMAN COLBURN: I think the cost of transporting them back and forth in the ambulance can be significant, too, because I think it's about $125 where I am to take them from one place to another in something that's supposed to be an ambulance.

DR. CARNES: Well, there's also a thing here that one can get out quicker, they're weaker going home. If they have a problem-- If they're elderly, they have a problem, readmit them. I mean readmission is no problem under DRG. It's-- No one dislikes readmissions. That's not to be discouraged at all.

ASSEMBLYMAN COLBURN: Do we know how often that's happening? I thought we were going to study that. I don't know what the result was.

DR. CARNES: No, there are no long-term -- to my mind there are no long-term studies in practically any sphere. This was implemented nationally without practically any studies being done. We have more experience, as I stated here, than anybody else in the country and we're lacking.

ASSEMBLYMAN COLBURN: Any other questions that you'd like to-- Feel free since you're--

DR. CARNES: Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot, Dr. Carnes.

Now, Craig Becker. There you are. Thanks for deferring.

C R A I G A. B E C K E R: Craig Becker with the Hospital Association. I'd like to thank you for allowing us to testify today.

Pretty much everything that I was going to say in my testimony has already been expounded by the previous witnesses. However, I'd like to point out a few points that were not brought up in the previous testimony and also some points that we think probably exemplify our system and the good points of it, at least as we have been seeing it and have been expounding it for the last four or five years.

The first thing, which has already been stated, is that there is no question that the most, single most important fact of the all-payer/DRG system has been the effect of paying of uncompensated care. Before 1980 this was a serious problem among our hospitals. In fact, there were over 16 of our inner-city hospitals who were in danger of defaulting on bonds or closing

down their doors altogether. This has been the single most important aspect of the all-payer system/DRGs.

We'd also like to applaud the authors of the report for indirectly taking on the Federal government for not paying their fair share of uncompensated care. Medicare right now does not pay or does not recognize uncompensated care other than its own and has avoided its responsibility by dropping this uncompensated care problem squarely on the states, hospitals, and the payers. Some states do a good job on this but none do it as well as the State of New Jersey does.

There were several other points that were raised by the report that we find significant. We concur with the report's finding when it noted that administrators do not use or do not view their hospitals as businesses per se with product lines. That's encouraging. This is one of the myths of the DRG system that this was going to -- the DRGs were going to be used as a tools, administrators would use this as a tool in order to bring their physicians in line in admission and discharge procedures. And it just has not happened. The administrators responded to budget restraints by persuading physicians to become more resource conscious. And I think as you pointed out, Mr. Chairman, that this has been a very -- a cooperative effort among the hospital administrators and the medical staffs in attempting to make physicians more aware or more conscious of their admitting practices. But again it was not the kind of gun in hand where the administrator went to a physician and threatened to cut his privileges if he did not cut back on his admission practices.

Also the DRGS -- the administrators did not use the DRGs in order to cut clinical services. In fact, they were the last to go. Having worked in a hospital for six and a half years in one of the ancillary services, I can tell you that I was worried many times whenever the cuts came because they never came in the clinical areas but rather came in the ancillary services. Clinical services are given and still will be given the highest

priority and are the last areas to suffer cuts. Administrators are primarily concerned with maintaining quality care and took budget restraints out of other departments.

But addressing that last issue, having said that, that of quality care. I think that one thing we must be aware of, that the cutbacks that are happening at the Federal level under Medicare, the other restraints put on by the State to our hospitals, it is getting more difficult to ensure the quality of care is not going to be affected. We cannot continue to restrict hospital revenues without expecting levels of treatment to suffer. To this end it's not only the DRG system that is to blame but also the rate-setting mechanism that's involved in our all-payer system.

There's no question that the cost of care is down, as the previous witnesses have pointed out. New Jersey patients paid approximately $338 less than the rest of the nation in per admission charges. By accepting the DRG all-payer system, hospitals have been assured of fiscal solvency which includes payment of uncompensated care, but our revenues have also, likewise, been severely restricted.

I'd like to just address one comment that was made by a previous witness that New Jersey hospitals have better surpluses than they did before. While this may be true, we are not swimming in dollars. Last year or 1984 we had a total bottom line of $43 million. It sounds like a lot of money until you start talking about a $4 billion system and a bottom line of about 1.3%. All you have to do is go across the river to Pennsylvania and those hospitals were running anywhere between 12 and 17% bottom lines. The surpluses are not available to us to take care of capital costs. We have to borrow far more dollars than the rest of the nation does because we don't have the equity to put into it. This is certainly a problem and it's one that needs to be addressed in the future.

As for early discharge, I would just like to point out one thing I think that it is probably doing more than the DRG

system is -- the recent implementation of the peer review organizations. This has turned the practice of medicine topsy-turvy in terms of when we discharge patients. The hospitals are at risk. They just will not be paid for patients who stay in longer than the peer review organizations state. And, in fact, we have many cases where our admissions are denied after we have provided the care. This is going to-- We're just now gathering statistics on the impact of this in terms of dollars, but we see this as probably going to be an even more significant problem facing us than anything that could happen on restraints of our revenues by all-payer system.

That's pretty much my testimony, Mr. Chairman.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen? Yeah, John?

MR. KOHLER: There were some feelings that with regards to uncompensated care as a reimbursement factor in the whole DRG mechanism that the hospitals and the Department of Health have been less than rigorous in pursuing bad debts or even defining bad debts. In Exhibit 4 in the article published in "Health Affairs" by the three gentlemen who testified previously they show that over time, since '79 to '83, that the percent charity care indeed offered by New Jersey hospitals, the percent charity care dropped, whereas the percent bad debt care went from 2.96 to 4.50. How do you account for that increase?

MR. BECKER: It's a difficult question and it's multifaceted. First, we are not much different from the rest of the nation. That is a trend that's going on in the rest of the nation. Since the all-payer system was instituted yes, there has been an increase in uncompensated care, primarily because that is now paid as a factor. In previous times hospitals did not even bother reporting that to the State because they knew they weren't going to pay for it. So obviously there has been an increase in that.

The other point is that some people would say we're doing our job too well. That because of the services that we

offer and that our outreach programs that we are bringing more people into the system and the word is getting around that they can get care and that it's to their advantage to get into the system as quickly as possible prior to their really getting ill. So therefore, from that standpoint, yes, it has gone up.

How you define uncompensated care is a different question altogether. Is the individual who perhaps has a $30,000 home, but that is it, and is living on Medicare, and perhaps does not pay their debts, do we go after that person's home? There's many who would say, "No," that we shouldn't do that. It should end up being uncompensated care. And that is where a good portion of it— What we're finding in our studies is that a good number of our uncompensated care also is the working poor. The majority of the people do have jobs, but they're at the poverty level and their insurance policy -- either they are not insured at all by the businesses that they work for, or that it is so little that it just doesn't even cover the basics.

ASSEMBLYMAN COLBURN: Could I ask, is the cost of running the DRG system within the hospital any different than the SHARE system?

MR. BECKER: There was an initial startup. There's no question about that. It was very expensive in terms -- because all the hospitals had to be on computer systems. Prior to that time there were several hospitals who did not have computers. I think now that everybody is into the harness that the costs are fairly minimal when taken into the global picture. They are a pain, there's no question about that. Hospital administrators, at least in the beginning, were very reluctant and complained loudly, but now— In fact, we just asked our board of trustees the other day what they felt about it and primarily everybody said, "We can live with it. We're used to it now."

ASSEMBLYMAN COLBURN: Apparently the payment is made for the primary DRG diagnosis, is that—

MR. BECKER: Yes.

ASSEMBLYMAN COLBURN: Or category or whatever you call

it.

MR. BECKER: Yes.

ASSEMBLYMAN COLBURN: What happens when you get all these extra diagnosis? Is it useful for the hospital to develop as many diagnoses as they can on the front sheet of the chart?

MR. BECKER: I would ask that Chris Grand probably might be able to answer that one a little closer, better than I can. I believe that the primary diagnosis is what we're paid for and if they — if there are other extenuating circumstances then I believe it falls into outlier category, and that's a totally different setup.

ASSEMBLYMAN COLBURN: And that's paid under a different system?

MR. BECKER: Yes.

ASSEMBLYMAN COLBURN: That's paid outside the DRG, right? No?

MS. GRAND: Well, the outlier patient -- it becomes an outlier by virtue of the DRG system, by virtue of the length of stay. Hospitals are paid, it is true, for outliers differently than those who fall within the typical average length of stay. Generally speaking outlier patients with long lengths of stay and therefore to the extent these long length of stay patients are, indeed, patients with multiple diagnosis, multiple complications, are generally paid at higher rates than those patients falling within the bell-shaped curve. There is some consideration they're given for patients with multiple illnesses. It may be debatable by some as to the adequacy of that payment.

ASSEMBLYMAN COLBURN: Well, I didn't know how much all these extra diagnosis meant to the records room or to the physicians or to the nurses or you know.

MS. GRAND: It is important. From a financial point of view it is important to the hospital to accumulate all those costs in looking forward to the future when a new cost year might be taken into account. It is definitely to their benefit to total all resources used for every patient because in the future

if the patient has multiple illnesses that patient will fall into that DRG rate, the payment rate could well increase if you had enough of those patients within a DRG. But it's really not so much concurrent benefit as future benefit.

ASSEMBLYMAN COLBURN: Thanks.

MS. GRAND: There is the issue. There's no question that hospitals and administrators are knowledgeable as to the most serious diagnosis of the patient with respect to where the rates are for the varied diagnosis.

ASSEMBLYMAN COLBURN: Which one pays the most, right? Okay. I just wanted to get, again, to this question of the behavior of the physicians and the hospitals and I guess all the rest of us in the health care. Are there not a great many influences in addition to DRG which are modifying our behavior?

MR. BECKER: Absolutely. I think the PRO right now without a doubt has had the single most important impact on physician admission patterns, the length that they leave patients in, and for hospital administrators who must look very closely at these, primarily because they are not paid at all for services rendered. And, again, I believe we're just now starting to get the statistics dollarwise, but systemwide we believe it is going to be a very significant dollar amount.

ASSEMBLYMAN COLBURN: Thank you. Rod?

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman, I have two questions for Mr. Becker. One is on hospitals that teach. What do you see, given the present system the viability of those hospitals that have traditionally been teaching, shall we say, the next generation of physicians?

MR. BECKER: It's probably going to be other factors that are going to impact on the teaching facility as opposed to the DRG system. In fact, the DRG system probably helped -- the all-payer system/DRG system helped the teaching facility because they were primarily the ones that were located inner-city and had high uncompensated care lists. So therefore their needs were more taken care of.

However, once again, the Federal government is cutting back fairly severely in its payment for graduate medical education and that certainly is going to have hospitals who have major teaching programs reviewing that. In addition to that, the glut of physicians in the market, the current glut of physicians on the market now also will have them looking at it. Incidentally, the State, along with the Hospital Association and other groups, are now sitting down and grappling with that particular problem.

ASSEMBLYMAN FRELINGHUYSEN: My second question is what about the growth of joint ventures between physicians and hospitals in profit-making ventures -- something that I think is occurring around the State, and how does it impact on the present system? Where is the interaction?

MR. BECKER: The interaction with the DRG system and these--

ASSEMBLYMAN FRELINGHUYSEN: Yes, and the overall financial soundness of the system.

MR. BECKER: There's no question that the emphasis now is to do as much as possible on an outpatient basis outside of the hospital facilities. Hospitals are attempting, at least in terms of recouping some of that lost revenue, by starting these outpatient type facilities. I think it's good for the system because obviously this is not going to -- the dollars that are made on these entrepreneural situations are not going to shareholders. They're going plowed back into the hospitals to provide care in order to pay for much-needed technology. I think perhaps that's how it impacts more than anything else. I'm not sure that it truly affects the DRG system itself or the all-payer system.

ASSEMBLYMAN FRELINGHUYSEN: Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot.

Now we have Barbara Wright Executive Director of the New Jersey State Nurses Association. Good morning, or good afternoon by now.

B A R B A R A W R I G H T: Thank you very much, Dr. Colburn. Yes, I'm afraid so.

ASSEMBLYMAN COLBURN: By the way, before we go any further, we're not planning to take any break for lunch. We feel that some of the witnesses might wish to do that, but the Committee— I'm outvoting you this time, Mr. Frelinghuysen. Thanks a lot.

MS. WRIGHT: Thank you, sir, and we certainly are pleased to have the opportunity to come and discuss our concerns today.

There isn't any question that the changes in the system have caused a tightening. Our admissions are discouraged and the length of stay has been reduced. Everyone who can be, is being treated on an outpatient basis. The only patients admitted are the seriously ill or those who will require sophisticated nursing care after surgery or medical intervention. All others are taken care of at home.

What we see, then, in hospitals are patients who require nursing care that only a few years ago would be called intensive nursing care. Even on so-called general medical surgical floors nurses are giving intensive nursing care on a 24-hour basis. In other words, admissions of very ill patients and discharge of patients who still require a substantial period of recuperation at home translates into a hospital census of acutely ill patients who demand the full attention of registered professional nurses.

We applaud the hospital cost containment. New Jersey hospitals have reported their '84 average hospital stay is $388 less than the national, and in fact, compared to the northeast our patients are paying $597 less according to the Hospital Association's data.

However, in New Jersey our association is questioning if these savings are really the overall efficiencies or are they the result of nurses working hard and faster to enable earlier discharges that can be translated into less cost per hospital

stay? Therefore we want to bring at least four compelling factors to your attention.

The first one is nurse staffing. As reported by many of our registered members it is at a critically low level. The second is nurse salaries are not adequate compensation for the responsibilities nurses assume. Third, nursing enrollment in schools preparing registered nurses could reach a dangerously low level if these issues of nurse staffing and nursing salaries are not addressed. And fourth, the payment for nursing services and their allocation must be removed from the room and board charges is our position.

Let me just elaborate on those four items briefly for you. The first, nurse staffing. Nurses are our first line of defense in maximizing health potential, minimizing illness, and reducing hospital stays. Yet New Jersey's rank for the number of registered nurses per hospital admission has plummeted from 17 in the country in 1979 to 25th in 1984. This represents a ranking drop of nearly 50%. And we've recognized in studying the data in the Hospital Association report that these pieces of data really need to be studied carefully.

As the state with the second oldest population in the nation, this staffing situation is critical. For while the ranking of nurses per hospital admission has dropped, we all know that the Medicare admission rate has continued to rise and in the same period it was increased by 10%.

The second is nursing salaries. Nurses are the largest group of health care professionals in hospitals. Nevertheless the average salary for staff nurses is only $22,000, a little more than the $19,000 average for all employees, which obviously includes people who may have less than an high school education. These inadequate salaries exist despite the life-and-death crises nurses face regularly and the length of education and practice skills the profession demands. Little attention is being given to dismally low salaries, the increased work load for more intensely ill hospital patients, and complex care needed by these

patients receiving care from nurses in their homes.

The third is nursing enrollments. The recruitment of nursing students into the profession has become such a serious concern that a Boston Globe editorial recently addressed this potentially dangerous situation. With greater opportunities for women in professional career choices, and a substantially reduced college-aged population nursing enrollments in New Jersey are already on the decline. I would just add that while we are eagerly recruiting minorities, including men, and they are slightly on the decline, they are still a very small population of nurses.

Fourth, and lastly, the payment for nursing services and their allocation. Since 1977 NJSNA has been working with the Department of Health to establish a system for clarifying the cost for nursing care. Nursing costs have traditionally been included under room and board charges. In addition to separating out costs, we are trying to develop a system to assure that the most intensely ill patients are receiving the greatest amount of resources. Isolating nursing cost is one step in addressing the need for additional staffing and appropriate salaries we believe.

In summary, we believe nurses burnout is not a healthy state for anyone. We cannot wait until patients' entire recuperation periods are found to be longer, fraught with more complications, and thus more costly to patients and society.

Our costs contained budgets can't be balanced on the backs of New Jersey's loyal and dedicated nurses. Therefore we call upon the New Jersey Assembly to promote nursing's health by supporting the Health Department's efforts to develop a nursing cost allocation method and by addressing the need for more nurses at greater salaries. These actions will ensure that the adequate numbers of new nurses can be motivated to choose nursing as a career and through these measures we can maintain our citizens' health.

We certainly thank you for this opportunity to share our concerns with you. And we would be happy to answer any

questions if we can or do further research for you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: No questions. Excellent.

ASSEMBLYMAN COLBURN: I think you brought up a question that I was neglecting, and that I think in the hospital setting probably all the health care professionals are having to try harder with all the things that are happening. I'm sure that can give rise to — I call it fatigue, people call it burnout and exhaustion. I don't know, don't think it's a good idea for a patient to be treated by a tired professional no matter whether it's a physician or a nurse. And I was interested that you mentioned putting the nurses' salaries in with the room and board. Is that true of other professionals in the hospital too, would you think? Or are they split out into another category?

MS. WRIGHT: Well, physicians' salaries are not--

ASSEMBLYMAN COLBURN: Let's say there's a physician who is a full-time. I guess he's in a separate category.

MS. WRIGHT: These are nursing costs. These are costs for the delivery of direct care to patients and there's another entire category. I think the Hospital Association probably could answer those question better than I can, but I know that physician costs are another separate--

ASSEMBLYMAN COLBURN: Separate.

MS. WRIGHT: Yes.

ASSEMBLYMAN COLBURN: And physical therapy and respiratory therapy and things like that?

MS. WRIGHT: Now I can't answer the question.

ASSEMBLYMAN COLBURN: See, I don't know, when you speak of this, whether we're getting into the question of negotiations with the hospital or not or whether, you know-- I feel that it's hard to separate professional questions from negotiating questions if we are in any kind of a situation where one group or another is represented by a union.

MS. WRIGHT: Okay. We don't-- We happen to represent the largest group of organized nurses in the State.

ASSEMBLYMAN COLBURN: And I know you're not a union. Do hospitals have unions?

MS. WRIGHT: We're a professional association that offers a collective bargaining service.

ASSEMBLYMAN COLBURN: Oh, do you have that ability?

MS. WRIGHT: Yes.

ASSEMBLYMAN COLBURN: I didn't know that.

MS. WRIGHT: But I think -- just as the NJEA, the AAUP -- I think the question that you're asking, I do not think that what you're asking me relates to whether a hospital is under contract. Only probably less than maybe 5% of the nurses in New Jersey are under contract and maybe 10% of the other-- If you add all the physicians, nurses, physical therapists and all the health professionals who are under contract, if there's 10% of us that would be a lot. So I wouldn't want you to think because people are or are not under contract it would make any difference. What we're telling you is that the hospital rate setting system, which is what you're here to address, it is a prospective payment system. We had some of the problems under SHARE, there's no question. Our problems are fraught with the fact that they are a majority women's profession and therefore nurses' salaries when they weren't regulated were not appropriate either. But as we have moved and become more articulate and more powerful, for lack of a better term, we have been able to address to you the concerns that this is just-- You know, pay equity doesn't exist.

ASSEMBLYMAN COLBURN: Do you think it's any different under DRG than it was under SHARE?

MS. WRIGHT: Not really. I don't think we can say. I think some of the nurse managers would tell us that they have fewer resources to manage, and so right now we're in such a critical state of staffing that I would-- In our experience in working with the system, the rate-setting system our problems are germane to a profession that has not been rewarded for the kinds of contributions it's made. And truly, and I hate to say this to

you because I realize you're a physician, if you look at the average nurses' salary-- I just saw some stats recently on the average physicians' salary. If you look, many people-- Linda Akin (phonetic) compared them, and as you look at the nursing salary rising over the last 20 years and physician salary rising the gap-- You talk about gender gap. Well, the economic gap between physicians and nurses is astronomical today.

ASSEMBLYMAN COLBURN: Getting wider.

MS. WRIGHT: Yes. Compared to-- We were much closer. As bad as we may have been 20 years ago, you probably were not as well off and as you progressed we did not progress at the same rate. So obviously we're a very cost-effective source of care.

ASSEMBLYMAN COLBURN: Any differences between categories of nurses as opposed to categories of physicians or are you just making an average for all the specialties in every field?

MS. WRIGHT: Our figures are so bad, in terms of a professional group and its reimbursement, that we don't even go beyond the general. I mean, the $22,000 that we gave you is very close to a national average and is a New Jersey average, despite the kinds of economics that we have. We heard a nurse speak in a meeting recently. She has been a nurse for 38 years, made $25,000 and these nurses are saying that the children that they're educating are coming out making $25,000 in two years with a bachelor's degree. The parents of these children are saying, "What am I doing wrong?"

And in spite of it, I think I would just hasten to say, that there are still many, many nurses who are totally committed to the professional care, who, I guess, we have been in some ways supported as a second wage earner so many of us didn't have to pay the rent and so we could afford to work for less money. But that's not the case today. You have people not stopping out of their profession or just stopping out long enough to have a baby and they're right back in. I've talked to nurses who are raising two and three children. Our past president, who is the President

of the ANA has eight children. She's been the Associate Dean of Rutgers College of Nursing. She has never-- She's done a lot of academic years but she has never stopped out of nursing in her 20 years in the career and that is a pattern that we're seeing because that's a pattern for professional women.

So in regard to basically how it relates to the total hospital bill and whose costs are pulled out and who are not, we can get that information about who is in the room and board.

ASSEMBLYMAN COLBURN: I think we'd be interested in that.

MS. WRIGHT: But I think the critical thing is it is not our view, collective bargaining for the few nurses that are under contract that we represent have the best salaries in the State. I think it's pretty safe to say that. They were lead by United Hospitals of Newark, but there are some other institutions approaching because that is an influence. But I think to in any way indicate that whether they're under contract or not, if the money isn't in the system the money is not in the system. So we're not blaming hospitals.

What I think that the prospective payment system has helped us to do is to see where the money is going and hopefully as efficiencies occur and as we allocate the nursing costs more accurately we can show you that the patient who is sickest may or may not be getting the care, which we think is what you would be interested in and what we're interested in. We're trying to get the care to the most intensely ill person. Historically that wasn't the case in our view under SHARE because whether the patient-- I live in the Princeton area so I apologize if someone is here from Princeton, but whether a patient was admitted to Princeton Hospital with myocardial infarction or to Newark Beth Israel, the chances in many cases were that the patient who came to Princeton had many more resources around him than the patient that went to Newark Beth Israel. And so the intensity of nursing care in many cases, and I'm generalizing, of the patient who might have been a single parent, might have had many other

chronic problems, may not have had a job-- It's a whole different ballgame to nurse that patient. And so from that perspective it may be that as we've moved into prospective payment we've improved some aspects of the care, but we have been under serious difficulty under any system. It is because we weren't there struggling when we didn't have regulation and now when we do have regulation it's probably even tougher.

But I speak for nurses in New Jersey who are at the bedside. The majority of our membership are people giving care. There are managers in our association also, and I think they will speak to you and they can give you a much more graphic picture of where it is from the management point of view. We try to understand both sides and certainly work very closely with all and represent all nurses. But it is a dilemma and I feel badly having to bring these kinds of messages because we think New Jersey nurses are superior. We think that they give fantastic care. I mean you're on the other end of that.

ASSEMBLYMAN COLBURN: I see them giving very good care myself.

MS. WRIGHT: That's right. And so to have to report this kind of a message -- think what we're trying to say is if we don't get on these issues and address them, we can expect that we're going to have increasing problems. I think that ranking figure, the fact that we would drop from 17 in the country of nurses per admission to 25th tells me-- We just found that statistic in that way. It was released earlier. Where we said now we know why the nurses are telling us it's so tough out there. They used to have more nurses to do the kinds of care they needed. Now they have more intense care and fewer nurses to do it. So it's really, it's tough.

We know your job is tough, too, and I think the only one that might be harder than a nurse--

ASSEMBLYMAN COLBURN: Dermatologists don't have such a tough time in the hospital.

MS. WRIGHT: I don't know your area of practice.

ASSEMBLYMAN COLBURN: That's what I am. I just observe over there. I really don't work very hard in hospitals and I think you should tell us these things, as you are. You're supposed to be candid in these hearings. I'm usually pretty candid, too, so—

MS. WRIGHT: Well, we think maybe as a politician your job is as hard as a nurse.

ASSEMBLYMAN COLBURN: No, I think the nurses' job is harder. I have to admit that.

MS. WRIGHT: Well, we want to work together with you.

ASSEMBLYMAN COLBURN: Okay. Just a minute.

ASSEMBLYMAN FRELINGHUYSEN: You made reference in your testimony to the Health Department's efforts to develop a nursing cost allocation method?

MS. WRIGHT: Yes.

ASSEMBLYMAN FRELINGHUYSEN: There's some material on that or is that something that's in the wishful thinking department?

MS. WRIGHT: It's interesting. That's an example of New Jersey being in the vanguard. In 1970 under the waiver there were moneys for research under the waiver and we started in '77 and nine years later we still haven't been able to develop the system. Part of that has to do with the fact that the Health Department has priorities. They've had to get the waiver renewed. Now they're trying to get uncompensated care and so we haven't been able to get the resources in the Health Department that we need.

ASSEMBLYMAN FRELINGHUYSEN: Well, through the Chair and with the Chair's indulgence, maybe you could provide us with some of your feelings on this area. I must say that as a group, and I'm sure Dr. Colburn shares this, the nurses have been extremely active in lobbying and educating us. I personally find that, I've found it fascinating getting to know those hospitals in my neck of the woods better and the role the nurses, as part of the team, essential part of the team. So for that I thank you, but I

think it would be valuable given some of the discussion we've had to have whatever thoughts you may have on paper.

MS. WRIGHT: Good. We didn't want to overwhelm you at this point because we know the kinds of issues that are being brought before you, but that probably is the only way that we can come up with some kind of attempt-- It isn't a solution, but it will begin to help us. And the Health Department is doing what they can, but we need more resources in the Health Department to do it.

ASSEMBLYMAN COLBURN: We'd be happy to know more about that.

MS. WRIGHT: Yes.

ASSEMBLYMAN COLBURN: Because, you know, really I'm sure the public agrees and the physicians certainly know that the nurses are extremely important in hospitals, but I will have to warn you that when you start making too much money the public will turn against you.

MS. WRIGHT: We'd like to experience that enviable position.

UNIDENTIFIED SPEAKER FROM AUDIENCE: We don't see any danger in that.

ASSEMBLYMAN COLBURN: They tend to do that, at least when they think you are, you know.

MS. WRIGHT: One of the things, going back to your comments about contracts and collective bargaining, we have found that institutions that are having strikes are literally short of being closed. Hospitals cannot function. Hospitals are places where people go for nursing care, as you know, and the physician may give certain treatment, surgery, or whatever, but the 24-hour treatment plan is the nurses' plan.

ASSEMBLYMAN COLBURN: That's true.

MS. WRIGHT: So without the nurse we see them-- Well, you shared one with us for 77 days I believe, if you are in the Willingboro area.

ASSEMBLYMAN COLBURN: Yeah, I'm on the staff.

MS. WRIGHT: All right. And we grieve those kinds of situations. We don't like to see hospitals have to move to strikes, but to get the message out sometimes you have to do this. But hospitals cannot function without nurses and we know that you're hearing us, and we don't mean to say you're not, and Assemblyman Frelinghuysen is being featured in our newsletter and is meeting with the nurses this month. So we want to continue to work. We'll be back on compensating care, I have to tell you. That's a separate issue, but we're working on that. We think that is critical. Obviously that will make a difference in terms of the whole system and we'll save that, too.

So we'll get back to you on costing out nursing services and also on our views on compensating care.

ASSEMBLYMAN COLBURN: Okay. Fine. Thanks a lot.

MS. WRIGHT: Thank you, sir. We appreciate it.

ASSEMBLYMAN COLBURN: Mr. O'Donnell, are you available? He's the Bureau Chief of Planning and Management, Division of Medical Assistance, Department of Human Services.

C H A R L E S O' D O N N E L L: Yes. Thank you for the opportunity to testify on one of the most important public policy dilemmas facing the nation, The impact of cost containing efforts on the quality of our health care.

As some of the previous speakers mentioned, there is an impact because of Federal cuts. I would like to discuss DRGs from the vantage point of their relationship to a concurrent attempt by the Federal government to curtail the use of Medicare home health benefits. I would like to do so because of the special relationship between home health care and our DRG reimbursement system. It is essential to remember that DRGs and Chapter 83 do not exist in isolation. They are only components of a fair large health care system. In order to control costs of hospital care, New Jersey and the nation have looked to DRGs as a way to reduce lengths of stay. At the same time the federal government is now trying to restrict the use of post-hospital home health care. The combined effects of these cost containment

efforts are therefore multiplied.

First, however, I want to stress that none of my remarks should be misconstrued as being in any way critical of New Jersey's unique DRG system. We in New Jersey are very fortunate for several reasons. As my colleagues have already stressed, New Jersey's DRGs system is quite different from the national Medicare system. Under our Federal waiver we have retained a DRG system that is considerably more humane and responsive than the one used elsewhere throughout the nation. Ours covers all patients and protects those hospitals with a high percentage of indigent patients. Moreover, our system treats outliers, those patients with exceptional lengths of stay, very differently. The net effect of these various features is to greatly reduce the pressure on New Jersey hospitals to force early discharges. While our DRG system certainly provides an incentive towards shorter lengths of stay the incentives are considerably more flexible and reasonable than the national system.

An effective DRG system must be predicated on an equally effective system of home care. For DRGs to be cost beneficial and ethical there must be a good network of sophisticated home health care to which patients can be discharged. If patients leave the hospital earlier and sicker we must ensure that they can receive appropriate follow-up care at home. For example, think of an 85 year old woman who fractures her hip in a fall. Prior to DRG she may have endured a lengthy and expensive hospital stay while recovering. Now, however, the hospital is likely to arrange an early discharge to her home with weekly visits from a nurse and frequent assistance from a home health aide. The home health care enables the early discharge and resulting savings. Good home care is what makes the DRG system work.

For the elderly the principal source of this home health care is the Medicare program, and that's the problem. We have evidence suggesting that an intensive effort is being made

by the Health Care Financing Administration to make major reductions in Medicare home health benefits through unwarranted and unannounced new interpretations of long-standing statutory and regulatory language.

It appears that HCFA has directed its fiscal intermediaries to force cutbacks in home health care by shifting the cost for essential Medicare services to providers, to the states, and to the infirm. This has evidently been done without the benefit of congressional authorization, regulatory review, or public notification.

The New Jersey Department of Human Services fully supports all reasonable attempts to control the escalation of public health care expenditures. Indeed, we have been at the forefront of numerous cost-saving initiatives and utilization control efforts. However, we will never condone or tolerate attempts at saving money by covertly shifting the cost of legitimate and badly needed care onto the shoulders of our most vulnerable and infirm.

HCFA and the intermediaries have not been willing to publish for comment and review their guidelines for interpreting the rules, which have always been extremely vague and, therefore, subject to a wide range of interpretation. We are convinced that there is no case that could not be denied based on one of the arbitrary reasons currently being given to provider agencies. This sort of ad hoc denial of individual cases does not reduce overall cost of care by reducing overuse of service by those who do not need it. That we could support. Instead it leads to denial of care to some of the sickest individuals with the highest care needs and no alternative care.

Our proposed solutions to end this intolerable situation center on actions at both the Federal and State levels. We are strongly supporting efforts of our congressional delegation to hold hearings leading to legislative reform of HCFA's policies. Additionally, we are currently working with the Department of the Public Advocate and the Division of Aging to

develop a program of legal assistance for Medicare patients in which attorneys would appeal each Medicare denial of care. Other states have had great success with such legal initiatives and have been both financially and morally victorious in hearings before administrative law judges.

If we can defeat the Federal attempts at cutting Medicare home health benefits and if we can continue to develop and expand other post-acute alternatives to inpatient care, then our DRG system can succeed in its mission. But if we fail to ensure the availability of alternatives to hospital care, DRGs may well fail. In summary, the DRG system can work only to the extent that the rest of the health care system can meet the post-acute needs of discharged patients. Thank you.

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen, anything? (negative response) I think this gets us almost onto another subject and sort of indirectly back to DRGs. But one thing that has concerned me, and I guess this is my anecdote that I keep repeating, but when Medicare went into effect the home health agencies suddenly operated under their rules. And I think in one day, in my county in my town, the cost of sending the nurse to someone's home to treat a patient went from something like two or three dollars to $10. And now-- And the nurse wasn't getting this money, you know. And now I think it's well over 50. I just don't know whether in the organization of some of these services we have organized them to the point where they may cost more than they need to through the organizational requirements. So that's something else I'd like to see worked on because as we move more out of the hospital into the home we have the matter of the personnel to treat the patients in the home and we also have the transportation.

I once saw a Medicaid patient in my office who was sent from Burlington to Moorestown and I think they paid this ambulance service $125. I won't tell you what they paid the physician. But in the future I went twice to the patient's home so they wouldn't have to pay that because even though it wasn't

worth my going financially I just couldn't see spending $125 twice to have that person come to my office. To me it's ridiculous. But things like that trouble me, and that's really another subject. But I appreciate what you said and we'll have to take all these things under advisement.

MR. O'DONNELL: Thank you.

ASSEMBLYMAN COLBURN: Now we have Mr. Morasi, is it? Is anybody here representing the home health agencies? (no response) I guess we'll move on then to Dr. Rubin of the New Jersey Psychiatric Association. Good morning, or good afternoon.

D R. K E N N E T H J. R U B I N: There are three of us from the Psychiatric Association. We wanted to all come as a team.

ASSEMBLYMAN COLBURN: Would they all like to sit up there with you? We understood you were to go first and Dr. Videtti and Dr. Nadel--

DR. RUBIN: I'd also like to apologize because I might have to leave before the end of all our testimony because I do have to go back and take care of patients.

ASSEMBLYMAN COLBURN: Sure.

DR. RUBIN: First, I would like to thank the Committee for the opportunity to appear before it. I am Kenneth J. Rubin, M.D. I am President elect of the New Jersey Psychiatric Association. I am a member of the General Hospital Psychiatry Committee of the New Jersey Psychiatric Association. I'm attending in the Department of Psychiatry at Monmouth Medical Center in Long Branch. I am also the Medical Director of the Inpatient Psychiatric Unit at Monmouth Medical Center and the Chairman of the Quality Assurance Committee. I have a private practice in Long Branch.

In my testimony I would like to inform the Committee of some of the issues regarding the DRG system in New Jersey and how they affect psychiatric services, as well as the problems and inadequacies that the DRG system has failed to developed -- excuse me -- has helped to develop and foster.

One, clinical treatment of psychiatric disorders and psychiatric patients in general hospitals is often compromised by the shortened length of stay, which is set by the DRGs. The classic example is the treatment of depression. There are many different categories and subtypes of depression. For example, psychotic, non-psychotic, adjustment disorders, recurrent disorders, first episodes of depression, and these are all lumped together in one DRG with one payment and one length of stay. However the treatment necessary for each one of these is difficult and requires different resources, yet we are given only one amount of time to treat all of these patients. More specifically is the issue of pharmacol therapy. It is difficult. It takes a period of time to get a response to a trial of an antidepressant. An adequate trial is usually three to four weeks, which is just about the whole length of DRG and is clearly over the mean for the DRG for depression, at which point the hospitals begin to lose money.

In clinical practice you admit somebody, work them up for tricyclic antidepressant and then begin the medication and treat them for about three weeks before they have an adequate level before you could expect them to have a response to the medication. If then they do not respond to the medication you are forced into the issue of giving another medication, but yet you're over the DRG and it makes them an outlier, which is a problem. If you wanted to switch the patient to electroconvulsive treatment there toward the end of the DRG and there is also a great deal of pressure to get the patient out. You may not get a second treatment or even an adequate attempt at the treatment and these people are pushed out of the hospital.

Another aspect of what happens is the pressure of not waiting a full three weeks and to push these drugs to higher dosages sooner and possibly running into side effects with different patients which you wouldn't have before.

There are other issues of treating major illnesses, like bipolar affective disorder in a manic state. It takes a

considerable amount of time for a patient to respond to lithium as well as a major tranquilizer which has been used in this State. By this they are near the end of the DRG. Then there is the push to get these people out again before they have had an adequate dose of the medication or their symptoms are not in remission to the extent one would like. You had more time to treat these people where we're not bothered by the constraints by an artificial set of time.

Also what is happening because of the DRGs are cuts in budgets and the resources to treat the patients in the hospital. Like recreational therapy, occupational therapy, nursing time have been diminished. So therefore some of the therapeutic groups that could help the patients in the hospital are lessened and again the patients are suffering and not getting an adequate that they should in a general hospital psychiatric unit.

Number two, the DRGs are discriminatory against the psychiatric patients because the comorbid conditions are not reimbursed at all under the DRGs. Comorbid conditions would be anything which is not the major diagnosis. For example, in the "Diagnostic and Statistical Manual Three" of the American Psychiatric Association psychiatrists list diagnosis in five different axises. Axis one is the major disorders like schizophrenia, psychoses, depression, and dementias. Axis two is the personality disorders which can greatly influence the length of time and the problems that arise with the people. Axis three are the medical conditions which affect the first axis. For example, hypertension, diabetes, congestive heart failure and surgical procedures like fractured hips. These all clearly influence the drugs used, the side effects that occur, the more problems with the toxicity of the drug and the potential for toxicity, the time needed to treat the people and the combined factors.

At this time we are seeing patients who are sicker, older, have more complicated cases with many comorbid conditions which clearly influence the treatment, the length of time, and

the medications. They are not being taken into consideration in the psychiatric DRGs. For example, recently I had a patient who came into the hospital who had a myocardial infarction a number of months ago, was severely and psychotically depressed, was not able to take -- not able to have electroconvulsive treatment and had medications, but I had to titrate and increase the medications on a very slow basis because of this. It took more time than would usually be the case. During this period of time the patient developed an obstruct in prostrate that required surgery. All of these are complicating issues, but yet the payment to the hospital was based on a psychiatric DRG, not his hypertension, his heart disease, or his necessary surgery and would not be reimbursed to the hospital.

I also recently had another patient who had had coronary artery bypass surgery and had some irregularities in his heartbeats who became severely depressed. There's a great deal of cardiology time, electrocardiograms, and he was even transferred to the CCU at one point, and that will not be covered.

Also there is the issue that some of the time the psychiatric payments come in through the medical service or the intensive care unit; for example, after an overdose. Those diagnosis and treatments rendered to these patients in other parts of the hospital are not considered in the final diagnosis at all as payment to the hospital once they come onto the psychiatric floor. But the time that is spent in the ICU or the medical floor is clearly necessary treatment but is just not covered. This is clearly discriminatory, not fair, and it affects the reimbursement schedule for psychiatric patients.

Number three, the State has now mandated that all physicians have malpractice, but there has been inadequate stay in the hospital with patients with inadequate treatment for a variety of illnesses. As state above, for example, in treating depressions a lot of patients will come in with a suicide attempt or be psychotically depressed. And clinically it is known that

the time of greatest risk for someone who has made a suicide attempt or is severely depressed to make another attempt is when the patient starts to feel better and is less depressed. At this point in time, with the DRGs pushing to get people out by the medium, that it's just at the time that they might be responding to the medication, which is between the second and third week. Then there's a push to get the patient out and into outpatient care and a less restrictive environment. This is the time, again, that these patients are at the most risk to have a suicide attempt. It is not unlikely that there will be more suicide attempts by people who were discharged prematurely.

It is also a question of treating people with psychosis and agitation, that just as the psychosis begins to resolve and some of the primary symptoms are lessening there is a push to get these people out. They're not improved enough or stable enough. There's a question of discharging a lot of people into the community in a more tenuous state when they are barely being held together as opposed to, if we had more time to treat these people they'd be in a better clinical state, more stable with less risk of something happening to them, or other complications, or readmissions. Therefore I think the recidivism rate would decrease.

Number four, the DRGs are not indicative of the intensity of treatment required or the allocations of resources needed to treat the patients. The DRGs are based on categories of diagnosis, but they are not indicative at all of the level of intensity of treatment which is whether it be individual therapy, milu therapy, group therapy, the nurses' time, pharmacol therapy, that is required or the allocation of the resources that is needed in the hospital by the staff, physicians, and ancillary staff. Reimbursement is based on the diagnosis and as we're aware, a diagnosis is just a classification of a patient or a disorder.

There are many other factors that go into what the person's problems will be and how to treat them. For example, a

schizophrenic patient who has been a high functioning person and had their first psychotic episode might reconstitute in a short period of time. They might have a good family support system which would help them to function better in the community and get better follow-up. But for someone who has been ill for a long period of time, for example, the chronic State hospital patients, more chronically ill patients we see in the community, the street people, etc. who have no family support system, people who have been in the State hospital system for long periods of time are many times much more difficult to treat, take a longer period of time to reconstitute and then to manage them and set them up in follow-up programs in the community.

We are also seeing patients who are more complicated, who are more resistant to medications, by the nature of their having illnesses for longer period of time, and none of this is being taken at all into consideration for psychiatric DRGs. As the State hospital system is becoming less utilized because of deinstitutionalization more of the State hospital patients are being treated in the community general hospitals. They're more difficult to treat, require more resources, require more manpower. They [illegible] clearly have-- This should be taken into consideration.

At Monmouth Medical Center we performed a study of bipolar affective disorders. They were staged according to severity of illnesses of stage one, two and three. We found that the stage one patients had an average length of stay of 15 days. Stage two patients were more severe and had an average length of stay of 27 and the stage three patients had 36 days. Therefore for the last stage, the most severely ill patients, they were outliers in the DRG and stage two they're way past the median.

It is clear that the average length of stay for psychiatric illness will vary according to the stage of the illness. The more severe the stage of the illness it would require more time in the hospital. This is true for all the major psychiatric disorders, the schizophrenias, schizo-affective

disorders, depressions and the manic depressive disorders. These factors have to be built into the system and taken into consideration of how much treatment is needed, the degree of compensation, illness, chronicity, community resources, community help, hospital resources, doctors' and nurses' time and energy to treat these people. Some weighing should be considered of how often, also, the patient has been in the hospital before.

Number five, the DRGs is a reimbursement system that has been disguised by using medical terminology and lumping all of the different psychiatric diagnoses into a few DRGs. It is shown that you cannot just use the diagnosis as stated above as a way to reimburse. We find that a lot of the psychiatric diagnosis require a longer length of stay and almost all of them are clinical outliers. Initially the State Department of Health was paying for those on a cost basis but in 1985 the State Department of Health did away with the clinical outliers, basically as a way to save money and not because they were clearly inappropriate, which they are.

As stated in some of the other reasons, you can see why the psychiatric conditions require more time for treatment than is being allocated.

Number six, it is the assumption that the DRGs as a statistical model for reimbursement that psychiatric diagnoses and lengths of stay approximate a normal curve. However, there have been numerous studies shown to the Department of Health and published elsewhere showing that the length of stay of psychiatric diagnosis clearly does not approach a normal curve. The distribution for psychiatric diagnoses were a rectangular, bimodal, with long tails and long beginnings. Therefore having diagnoses fit into a normal curve, when they clearly don't, makes it difficult if not impossible to work under this system.

Seven and last, another one of the problems for DRGs for psychiatry is that not all of the hospitals providing care for the mentally ill in the State of New Jersey are included as is the case for all medical and surgical illnesses. For example,

no State hospitals are included, only one county hospital is included, Bergen Pines, and some of the other free standing hospitals are not included, for example, Princeton House. The private for-profit or the private not-for-profit psychiatric hospitals are not included either. Therefore what has happened is that in these hospitals, specifically the later private hospitals, are not included in the DRGs, that do not have the same restrictions. The doctors are not under the same pressure, and the patients are treated for a longer period of time and could possibly be treated more completely than could be done at a general hospital at this point in time with our restraints. The system is forcing a lot of patients to leave the general hospitals and to go further away from home to get care, which also makes numerous problems in dealing with a lot of these patients since they need family therapy as part of the hospital and they're leaving their area.

Many of these issues will be addressed further in other testimony. These are some of the issues that I have seen that is inadequate. Dr. Vicetti will continue with some of the other deficiencies that we see in the psychiatric DRGs and Dr. Nadel will give a summary.

I'd like to thank you once again for allowing me to testify.

ASSEMBLYMAN COLBURN: Thank you. I think we might want to ask you a question or two before you go. Rod, do you have one?

ASSEMBLYMAN FRELINGHUYSEN: I'm overwhelmed by the amount of testimony you've given. I have so many questions I'm not sure where to begin, but maybe we'll get some of them sorted out when the other gentlemen give their testimony. I think I'll wait until completion.

ASSEMBLYMAN COLBURN: Okay. Yeah, go ahead.

FEMALE AIDE: Is there any tendency to over-diagnose? Like in a hospital a broken hip is a broken hip. You can play a little more. Is there any tendency to do that, to go for the

higher waiver?

DR. RUBIN: Well, you can't in psychiatry because all the comorbid conditions don't pay. We were told, initially, you know-- I think for the general medical staff something that Dr. Colburn alluded to before was to put down as many diagnoses and I think that was answered before that there was some kind factoring. But what happens in psychiatry, you just get paid for schizophrenia and nothing else is my understanding of it. So you can have ten other diagnosis but in psychiatry it doesn't make a difference. In fact, the problem is in the general hospitals, like the two to three examples that I gave, you're seeing people that have two, three, sometimes four system diseases and frequently my discharge summary will have patients that have diagnoses of six, eight diagnoses, you know, which complicate things and so on, but that you can't do-- I mean there might have been some thought before, like some is neurotic depression versus a psychotic depression, but that's all one DRG anyway, so I don't think there is a tendency to do that.

ASSEMBLYMAN COLBURN: Is any of the DRG problem reflective of the limitation on insurance generally for psychiatric things? Does it have any relationship at all to past practices or present practices of other coverages with different -- not other coverages, but insurance coverages that are available for psychiatric disorders?

DR. RUBIN: Most of the basic coverage will cover an adequate amount of time. Standard Blue Cross coverage--

ASSEMBLYMAN COLBURN: It would. So that if these folks could go into the hospital not under DRG they're better off getting their coverage without the DRG system applied to their case, right?

DR. RUBIN: Right.

ASSEMBLYMAN COLBURN: That's what you were saying, I think, in that last one.

DR. RUBIN: Even though the standard Blue Cross policy is like 28 days and that's well below the national length where I

think national length of stay in short-term hospital, which I think is 26 days or so, still would be lower and Medicare and Medicaid is above that, so it wouldn't influence that at all.

DR. COLBURN: Okay. Thanks. Thanks very much. I think, let's see, Dr. Videtti is next.

D R. N I C H O L A S V I D E T T I: My name is Nicholas Videtti and I have the dubious honor to be one of those people quoted in the lessons from the New Jersey DRG payment system in that I am one of the 25 physician losers in every hospital. I am the Chief of Psychiatry at Holy Name Hospital. They are specific in--

ASSEMBLYMAN COLBURN: One of the money losers of the hospital.

DR. VIDETTI: The big money loser. But we make up for it in volume.

ASSEMBLYMAN COLBURN: So you lose more.

DR. VIDETTI: I came here originally with the idea that I didn't really have to say much about DRGs because I felt that it would be beating a dead horse in the sense that DRGs do not apply to psychiatry. Nationwide there is an exemption for psychiatric illnesses in general hospitals and they will not be included in the DRG system nationwide for the next two years because there is not an adequate amount of information yet to put these various diagnosis into a category. For instance, we have eight different categories for psychiatry under the DRG system. Right now the experience in the 40-some hospitals in New Jersey that have psych units is that 90% of all these patients are under category 430 and 426. There are only a minimal amount going into other categories. The name or the diagnosis does not indicate the length of stay or the cause for admission.

Three people can come in with a diagnosis of depression and one will have the depression resolved because the social situation was resolved in two or three days. But you take the nice older person that is coming in with the depression that is an onset, it's a slow onset almost like diabetes is an onset in

older life. We're going to have 28% of women in this State and 12% of men suffer from depression at some point in their lives, most of whom will need some form of treatment. However, if they put off the treatment and they don't arrive in the hospital until they haven't eaten and they've lost 30 pounds and they're frightened to leave the house and they're not sure of themselves anymore, it's going to take much longer to get that person back to health. And if you're given the DRG allows you, let's say, 12 days or $3600 total to treat this patient, it's a losing proposition. It's a given.

As Dr. Rubin said, it doesn't include all the x-rays that have to be taken, all the lab tests. If they had diabetes as a concurrent illness, the restabilization of the diabetes is not included in this DRG factor. It does not include the suicidal patient who needs around-the-clock watching on a one-to-one basis. All it takes is two days of this constant watching of someone who is threatening to kill themselves and you're trying to keep them alive, and you've utilized an awful lot of the funds that we were given for the whole stay. If you can reverse this thinking, this tunnel vision, a depressed person has to get to the point where they'll take medication and want to live, then you've already passed the amount of time you're allotted for a depression.

DRGs in this State, and maybe in other states too, were an afterthought. They threw this in-- For psychiatry, please, I'm talking about psychiatry. I have trouble just knowing about psychiatry, let alone the rest of medicine. And the reason, they were thrown in was just to have something to offer. When psychiatrists from New Jersey offered the State Department of Health input they choose not to take it. Now, whatever the system was at that point, two disastrous things happened. One is that we were saddled with-- We went from being a winning system, that is in psychiatry in New Jersey all you needed was a 52% occupancy rate and you broke even. So that every patient you admitted beyond that was a moneymaker for the hospital. This was

pre the imposed DRGs. At this point depending on the physician, each hospital will tell you we lose money. One physician was told that he lost $60,000 for us with your 100 admissions with the diagnosis of depression. Now what also happens if you're in the losing system you're not going to get the newest equipment, you're not going to get extra services. If there is a shortage in another part of the hospital they have even pulled the nurses, as short as we were, from our unit.

Now, people from the Hospital Association did say, and rightly so, that we're not getting direct pressure from administration. It's not that kind of pressure. But when you go to the administrator of the hospital and you say, "We need more funds and more help to function" he will say that, "You're losing money for us." When we ask, "Why don't you go to the State to complain?" the answer is, "There's a one percent bonus at the end of the year for not complaining." And psychiatric services in this State, the 1000 beds, approximately, that we cover in the general hospitals would cost the Hospital Association more than the one percent they would lose. They would rather get their one percent than fight for equality.

Second problem that we really have that's going to be a big problem for the State of New Jersey a few years down the line is that, sadly, only the general hospitals with DRGs have left private hospitals without DRG payment reimbursement. Which means that the cost for the same treatment for the same length of time in a general hospital versus a private hospital could be the difference between $3600 for your general hospital and $30,000 for your private hospital. Now, if you have good coverage right now, the first thing you say is, that's wonderful, nobody suffers. But the truth is that the insurance companies that are paying private hospitals have to increase their rates for all subscribers in all parts of the State, so really we all end up paying for having the privilege of a few private hospital be free of DRGs. If we're going to burden everyone, it should be with an equal burden. And psychiatry doesn't fit.

Now we all know that there has to be some form of cost containment and we all are willing to go along with anything that is feasible, but when you start off with something that gives you a pair of lead shoes and doesn't allow you to run the race, it is unfair to say the least.

DRG-- For instance, the DRG system as it was established was worked on a diagnosis. It did not include the social pressures that the person had in the past year and what that patient will go back home to. The person who has a good family who is caring and supportive will be able to leave the hospital much earlier than the patient whose family doesn't understand, doesn't care, or has no family at all. It's-- The revamping that has to be done, really, on the DRGs, if we're going to use that term at all, has to be within psychiatry because we're the ones that are going to, in the long run, suffer the most with minimal payments to psychiatry as quoted in this New Jersey experience. More of our staff, more of our psychiatrists are leaving the general hospital staff. They'd rather not be on the staff if they have to be hampered in their treatment.

I think I'd like to pass it on.

ASSEMBLYMAN COLBURN: Could I ask you sort of a semi-related question, maybe. Are the private psychiatric hospitals subjected to these screening programs?

DR. VIDETTI: Screening programs?

ASSEMBLYMAN COLBURN: The ones that you have these local screening units in the counties that decide whether the patient can be admitted to a psychiatric hospital.

DR. VIDETTI: No. I would have to say offhand, "No" in this sense that when you screen, your insurance is also screening.

ASSEMBLYMAN COLBURN: I don't think they would be.

DR. VIDETTI: And if you're-- For instance, at one of the private hospitals if you do not have adequate coverage you must have $20,000 up-front before you can get in the door.

ASSEMBLYMAN COLBURN: Okay. I just wanted to ask you that. That's a little off the subject.

Rod, did you want to ask anything?

ASSEMBLYMAN FRELINGHUYSEN: I just had a question. People are being placed under some guise, I assume, in facilities by psychiatrists and others. In what sort of facilities are they being placed in? Are they being placed in facilities that treat alcoholics, substance abusers? What are the normal settings? There must be something out there which provides for placement. Would you comment on that? And what percentage of the individuals are we talking about here that you see, in a general sense, have substance abuse tied into their condition? Why can't you, in fact, use those DRG categories and don't you, in fact, use some of those DRG categories to cover the medical costs?

DR. VIDETTI: The payment for DRG category is usually for the main illness. If someone comes in with a substance abuse problem that is what the hospital would be reimbursed for. There are many good programs for substance abuse in general hospitals. There are many outpatient substance abuse programs that do a very good job. But I-- The overlap between psychiatric diagnosis and substance abuse, there are large number of patients who have substance abuse who only have substance abuse when their mania is rampant. During their depressed phase they wouldn't think of drinking and the minute they become manic they might go into alcohol abuse. There are patients who have come under the same umbrella of substance abuse you have an addictive personality who would also have in their genes or in the genetic loading for their family depressive illnesses, schizo-affective illnesses, as well as the manic depressive illnesses. So that yes, at one phase of the illness you might be able to hospitalize them for mania or another point for depression and still have an addictive personality someplace in the setting. I don't know if I'm answering--

ASSEMBLYMAN FRELINGHUYSEN: I'm not sure you are. I'm a little bit confused here. You have-- There are a number of

individuals that are mentally ill that you gentlemen look after that must be placed in some setting and I want to know what means you use to get placement, whether it is in private or public setting. Which DRG group or which mechanism do you use to assure placement? I think it's relevant to our discussion.

DR. VIDETTI: Yeah, well the majority of the people, if they're--

ASSEMBLYMAN FRELINGHUYSEN: If there's a limit on the number of DRGs that cover the mentally ill then I assume that there's enough ingenuity out there that people have come up with ways to utilize other DRG categories.

D R. W I L L I A M N A D E L: Well, there are other -- there are specific DRG categories for substance abuse, for alcohol abuse, for alcohol dependence, for organic mental syndromes associated with either alcohol or drug dependence. So people who have those problems can be, you know, appropriately assigned those DRGs. But I'm not sure that's your question. Were you asking about--

ASSEMBLYMAN FRELINGHUYSEN: No, it is. Actually it is. I think I-- I'm not sure I want to say it three times, but I will. Are you using any of those categories now as professionals for placement?

DR. NADEL: Could you clarify what you mean by placement, please?

ASSEMBLYMAN FRELINGHUYSEN: Placement in a private or a hospital or any other setting.

DR. NADEL: By diagnosis. Sure, I mean, by diagnosis. If someone needs, for example, 28 day stay in an alcohol rehab unit because their basic problem is alcohol dependence, they might be evaluated at the hospital and affiliated with and referred to an ARU. Or they might be referred to a couple of intensive outpatient alcoholism programs that are in Union County. So we think diagnostically and we try to get someone to the appropriate resource for their illness. If it happens to be one that's psychiatric and is appropriately treated in a

psychiatry unit, we'll, you know, refer them there; when it's appropriately treated at some other kind of facility we'll refer them there. As Dr. Videtti was saying, one of the problems is some of the facilities have bars to entrance of an economic nature that make them inaccessible except for those people who are fortunate enough to have a good amount of money personally or good insurance policies based on where they work.

ASSEMBLYMAN FRELINGHUYSEN: I think I hear what you're saying relative to the need to expand the number of DRGs for the mentally ill, but I'm saying that in the absence of that occurring, then obviously some other categories are being used.

DR. VIDETTI: We're willing and we've offered to revamp the system, to work as a task force with the State to set up new categories which would allow for fair treatment for these patients, fair return for-- You can't keep treating patients on a losing basis in a hospital. But yes, they will be treated and they are being treated now.

ASSEMBLYMAN FRELINGHUYSEN: Okay. Thank you. Mr. Chairman, thank you.

ASSEMBLYMAN COLBURN: Thank you. Yes, Dr. Nadel.

DR. NADEL: I just wanted to distribute some testimony. It's an outline.

ASSEMBLYMAN COLBURN: Thank you.

DR. NADEL: You may note that my testimony was first given-- This is an outline of testimony that was first given June 5, 1985 before a similar committee or a committee with a similar name. The problems haven't changed and I don't think the proposed solutions have changed either, so I just merely took the liberty of changing the date.

I come here as Chairman of the Legislative Committee of the New Jersey Psychiatric Association, and I am presently Chief of Psychiatry at Muhlenberg Hospital in Union County. I am also have a private practice in psychiatry. In former professional careers I was Deputy Commissioner of Mental Health for New York City, that included alcoholism and mental retardation at the time

as responsibilities. I was also formerly Medical Director and Chief Executive Officer at Fair Oaks Hospital in Summit, New Jersey before coming to Muhlenberg so I'm familiar with a variety of systems, public, for-profit, and not-for-profit general hospitals that obtain in terms of looking at psychiatric care. I'm certified in psychiatry and also certified in administered psychiatry.

At present my job after Dr. Rubin and Dr. Videtti have outlined some of the issues and problems for you, illustrating them with some case vignettes, is to propose some solutions. Now, unlike Dr. Videtti, I am not going to go along with anything that's infeasible. We have some of that now in a DRG system that discriminates against patients with psychiatric diagnoses and I think it's about time that this should end.

I would like something reasonable, something like a level playing field that Dr. Weiner referred to in his earlier comments regarding the study that was done by the Harvard/MIT group. And I do hope with a new kind of Committee, new Chairman, and Health Commissioner that perhaps the DRG system can be evaluated neutrally and its weak points, as well as its strong points, identified. I think one of the real weak points is its discrimination against psychiatric patients, who could be anyone with a psychiatric diagnosis. Unfortunately this discrimination is part and parcel, probably, of large discrimination, to address a prior question. But is most pointed, as we have the data in the DRG system.

Now because of the inappropriateness of the DRG system for psychiatric diagnoses, HCFA, in all its wisdom, has excluded psychiatric diagnoses from its Medicare reimbursement system, its Medicare DRG system. It did so initially for a three year period and then recently this year has extended that for another two to three years. This was not based on whim but it was based on a sense of studies, one done by the American Psychiatric Association of over a 1.5 million discharges of patients with psychiatric diagnoses. So very clearly the DRG system did not

measure the intensity of care needed nor the resources allocated for the care of the patients. These were things that we were saying last year and since then we've had this study from the American Psychiatric Association, a similar study from the National Association of Private Psychiatric Hospitals, and studies such as the MIT/Harvard study which did call the DRGs for psychiatry the most heterogenous and troublesome. They could probably go into detail by what they meant, but I think it is accurate to say that they meant that they really did not do the job that the DRG system theoretically was to do.

And once it does not do that job, it creates certain chance of profits or losses. If you keep a patient for a short number of days you can generate a profit if you then commit them to a hospital. And this has been more the case for general hospitals that do not have organized psychiatric units than in general hospitals that do have psychiatric units.

The proposal in terms of solution is basically to exclude psychiatric units in general hospitals, or patients admitted to them, from the DRG system, in a similar fashion that Federal Medicare administers by HCFA does. And we have a bill prepared for introduction in the Assembly, and actually, Dr. Colburn, we would like your advice in terms of how to proceed, whether you think the introduction of that bill at this time is the best way to go, and perhaps have you review it with someone who will sponsor it.

ASSEMBLYMAN COLBURN: I think we ought to see the bill and take a look at it.

DR. NADEL: I'll give you a copy of the draft.

ASSEMBLYMAN COLBURN: Fine.

DR. NADEL: We think it's quite important because psychiatric patients, typically, have very few patients advocating for them. They do not make good advocates themselves. Back when I was City Commissioner it was very easy to get 10,000 patients of mentally retarded -- 10,000 parents of mentally retarded individuals with whistles parading around City Hall. It

was also comparatively easy to get the alcoholism folk to lobby for a department budget because they saw the cost benefits in terms of industry in returning someone who has had a problem of alcoholism to the workplace.

But the psychiatric patients were very loath to stand up. Their families sometimes were inappropriately guilty that they had someone with a psychiatric illness in their family and so they were not as ready as the parents of someone who was mentally retarded to stand up and be forthright about getting services. So it's really left to the providers in this case, psychiatrists, nurses, social workers, to argue for improved services. Of course, this is called self-serving by some, but they refuse to look at the facts.

There's been discrimination right down the line that's now been continued in the DRG system. The DRG system as developed did not have psychiatric diagnoses and the people who developed it at Yale felt that they should not be included in the New Jersey plan. Because Yale-- Because the New Jersey plan had to be comprehensive the psychiatric diagnoses were, as was indicated, sort of an add on to the whole system without sufficient experience. What was a DRG experiment very quickly, without evaluation, became the law of the land in New Jersey for hospital reimbursement. We moved very quickly from an experimental stage where the results were not announced to being the way all hospitals were reimbursed. This was particularly unfortunate in the case of the psychiatric DRGs.

And finally, the Health Department did agree to meet with some psychiatrists. In testimony last year the Health Department characterized that one meeting as adequate consultation with professional groups, including psychiatrists. We say that one meeting at which most of the psychiatrists disagreed with what the Health Department was trying to do with the DRGs because they did not fit clinical practice and patient care, and then the Health Department and went along and they ignored what the psychiatrist said. We did not feel that that

was adequate consultation, and still do not. As I say, I hope with a new Commissioner and new people in place that this can be addressed.

Finally, the Health Department did on a June 5, 1985 meeting where the testimony was originally presented, did say that it was going to get a task force together. Now, that task force hasn't yet been gotten together. We did meet, fortunately, with two of the Assistant Commissioners, Ms. Goldschmidt and Ms. Grant-Davis (phonetic spellings) in June as the General Hospital Committee of New Jersey Psychiatric Association. Meeting with them to go over the problems with the DRG. There are problems both in DRG construction and with DRB reimbursement, and they advised us to handle those separately and also were quite willing to have us work with them, and I hope this time the Health Department upper echelon will be willing to take a fresh look and move forward with the thorough going review of the DRG system because it is terribly poor public policy in New Jersey. What it does is that it favors the hospitals outside the DRG system, which are private, for-profit in some instances, and whose fees are quite considerable. One hospital has extended its length of stay in the last five years from 30 to 52 days and its fees have gone from $300 to $1000 a day. This is outside-- This is by virtue of the fact that the SHARE system only covers part of the payers, as was alluded to by former speakers before you today.

I think that a level playing field should be established and everyone should have to operate with the same kinds of rules for reimbursement as well as regulations governing the use of seclusion and other details of psychiatric care.

I have no further testimony and would like to comment on a few of the points that were made by prior speakers, if I might. In one case it was said that there has been no adverse effects on patient care due to the DRG system. This is a point that was made first by the people from MIT and Harvard.

ASSEMBLYMAN COLBURN: After they said that you couldn't measure it anyhow.

DR. NADEL: Right. But there are some things that you can measure and there's some things that we suggest that the Health Department measure last year. One of those was recidivism, i.e. patients who are repeatedly admitted to hospitals. And what happens when you have an unfortunately short stay is that person may be inadequately treated. It may be safe to allow that person to go home, particularly if they have a family and a support system, but it may not be comfortable for the patient, it may not be wise, it may not be the best medical care. It may be safe because you can be assured that the patient's family will bring them back should they decompensate, once again, in a short period of time.

To my knowledge the Health Department has not yet done a study of recidivism and I think it's the only entity that may have access to the data. I don't know that the data exists even, but I think it certainly would be worth a pilot project for them to do this. Also, the nature of the patient has changed in terms of the general hospital serving more and more and increasingly chronic long-term illness as State and county facilities do not do that job any longer. And nationwide there's been a tremendous shift in terms of where psychiatric patients are served. They used to be predominately served in the public sector in large state institutions. The majority of patients are now served in general hospital units throughout the country, and this is certainly the case in New Jersey. You have fewer people in the State facilities and they're staying for long periods of time. In some cases you have two populations. As the other doctors alluded to, diagnosis in psychiatry does not equilibrate with length of stay. It's not like a fractured hip; someone can be a schizophrenic and require 20 years of hospitalization. Someone can be a schizophrenic and require 10, 15 days of hospitalization before they go back to work for a bank, or a major corporation, or in their law practice or medical practice. Diagnosis does not really correlate with the severity of illness or the kinds of resources and treatment appropriate.

ASSEMBLYMAN COLBURN: Thank you. On your handout, number one and number two are alternatives, one to the other, is that—

DR. NADEL: Yes. The first alternative is vastly preferred and that is—

ASSEMBLYMAN COLBURN: And number two would be your second choice.

DR. NADEL: Right, and it could not be the present DRG system in New Jersey but rather one that's modified for many of the clinical modifiers that Doctors Rubin and Videtti alluded to.

ASSEMBLYMAN COLBURN: Well, then, three, four, five and six would be some modifiers?

DR. NADEL: Yes, you see—

ASSEMBLYMAN COLBURN: Okay. I just wanted to—

DR. NADEL: There are no modifiers allowed in the psychiatric DRGs.

ASSEMBLYMAN COLBURN: I realize that. I just wanted to be sure what it meant.

DR. NADEL: Yeah.

ASSEMBLYMAN COLBURN: So maybe three, four, five and six ought to be— Oh, I see, okay. Those aren't major three, four and five, those are minor three, four, five and six, aren't they? Sub— You have big two and then B and then one, two, three, four, five, six under that.

DR. NADEL: Right.

ASSEMBLYMAN COLBURN: Okay. I got mixed up. That's fine.

Do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: Yes, I do. I found all of your comments fascinating and to a certain extent stimulating. I think one of the things that, of course, you've recognized is that the level of advocacy is not traditionally been there, as you pointed out, for those that are developmentally disabled. I think the level of advocacy is growing, I think in large part due to the families and those interested in the mentally ill, groups

of physicians such as yourselves -- psychiatrists and others.

I think a lot of the problem exists because of jurisdictional, shall we say, responsibilities between the Department of Health, in this case, the overseer for DRGs and the Department of Human Services. I'm not sure we're going to resolve that today.

But I wondered if you would just comment briefly on, and make some distinctions on your ability as a psychiatric association, your comments on services relative to children and adolescents the State provides, DRG related or not, versus adults who seem to get, shall we say, more attention than their younger counterparts. I know it's difficult to do it in a short period of time, but I think it's relevant to our discussion.

DR. NADEL: Okay.

ASSEMBLYMAN FRELINGHUYSEN: If it is relevant to our discussion.

DR. NADEL: Well, I think the problem has been with the DRG system it's been impossible for hospitals to expand their services. In other words-- And, in fact, one of the other things that has been done in view of the DRG system is not that inadequate individual care has been rendered, but whole programs have been cut. I know of a program in your home county at a hospital that intervened with adolescents, actually. It was an outpatient adolescent program intervening so that they would not progress towards the severity of illness that would require hospitalization. That program, which was basically psychologists, three social workers, was cut because psychiatry became a money loser. Now, not all psychiatric departments were as fortunate as Dr. Videtti's and could only have 52% occupancy and break even. But other hospitals-- Psychiatry could, you know, break even or even be in the black a little bit for hospital administrators. When the DRG system came into being the black became red and the psychiatry programs, whole programs were cut. In other instances not an identified program such as that, but personnel were cut in occupational therapy, group therapy or

the units, social work which provided for discharge planning and family therapy conferences and nursing staff. So that the clinical -- the individual patient care was not inappropriate it, there was just less of it, and that can also be gotten if people are frank. We've been trying, and we have gotten letters from chiefs of psychiatry in three different counties at well-known and well-regarded hospitals with good psychiatric units documenting how, in their instances, programs were cut which made it impossible to deliver care to certain numbers of people. And that's another way that administrations and doctors deal with the difficulty of the DRG system. You just don't have a program. This is particularly true in adolescents which have traditionally been underserved in this State, both in the State sector and in general hospitals and in private psychiatric hospitals.

If the Health Department and its State Health Coordinating Committee allows for the expansion of beds in a way that for-profit corporations outside of the State of New Jersey can participate, I'm sure there will be an expansion of beds in whatever sector of beds the Health Department allows because these beds are outside the DRG system. Indeed, there are 12 to 16 certificates of need pending development of final regulations because there is a great deal of profit that can be made in the health care system in New Jersey if you're in mental health and if you advertise so you get yourself out of having to accept Blue Cross, Blue Shield, Medicare, and Medicaid patients. One of the hospitals in New Jersey has the highest rate of commercial payers of any hospital in the country.

ASSEMBLYMAN COLBURN: Thank you. Mr. Alexander, are you still in the room? I was going to ask you to testify next. I think you come from the town in which I was born, Orange. He represents the New Jersey Federation of Senior Citizens.

N I C K A L E X A N D E R: My name is Nick Alexander. I'm the President of the New Jersey Federation of Senior Citizens.

I have only a brief testimony to offer and it has to do with the people that somehow you folks have not paid any

attention, and that's the consumer. There's nobody here from the consumer end of it. That means the people that get in the hospital and have to pay the bill. The problem with DRG is that it places a patient in a group for payment. I'll give you two classic examples. I had a letter from a member of our association from Glassboro and he said that he went for treatment for an ingrown toenail and he was shocked when he got the bill. The bill was $1500 for a toenail. Now he said two years previous to DRG he had a toenail removed and that cost him $75. So the DRG, according to this example, is really not doing the job. Now the hospitals are pleased. They're as happy as a hog drinking swill because what happens is they're using an average to cover their expenses and if they can get the patient out soon enough to have some money, that goes into a surplus fund. Now, again, the patient suffers for that.

I had a man come down to my house over Fourth of July weekend. He had to go down to Florida to bring his father home. Now, his father was active until he was told that the father was beginning to mentally slip a little bit and that he needed some care. So during the process of driving back, and it took him 42 hours of straight driving from Florida to get down to Gibbstown, he finally got the patient into a hospital and they told him in three days he'd have to be out in the street because based upon his diagnosis that they couldn't keep him any longer. Now my advice, if it wasn't for the fact that the son felt upset about this, would have been this: Let the hospital put the patient out in the street and then we'll take that case from thereon.

Now something has got to be done. I mean you've created a monster. You've created a monster in this way. In business you know darn well that the traffic pays for your expenses and determines if you're doing the business properly. It determines how much you should charge for your goods. You don't compete merely on products in business, you compete upon services or quality of goods that you offer. Now this is determined on the volume that you have. Now, if you reduce the

volume in the hospitals, in effect what you're doing is you're increasing the cost to the patient because the hospital eventually has to require more money. Let's face it, they're not going to be able to provide the services if you're going to create legislation that, in effect, denies them the volume that they need to take care of the needs.

Now, I'm not suggesting that the patient that should be out of the hospital in three days should stay 15 days. But by the same token, there is evidence, a great deal of evidence that the patients are being put out entirely too rapidly, out of the hospitals. They're coming back to the hospitals. They're also coming to the hospitals and the next trip is to the morgue. And this is what has to be addressed. You've got to address yourself to the system -- that when you reduce the volume in the hospital, that of necessity increase the price.

The other thing is why should a person with, let's say, $75 ailment pay because he's in this diagnostic related group, he has to pay $1500 for a toenail removal. Thank you.

ASSEMBLYMAN COLBURN: Thanks very much. Just a minute. Maybe want to ask you a question. Roo?

ASSEMBLYMAN FRELINGHUYSEN: Excellent.

ASSEMBLYMAN COLBURN: I just, I appreciate what you're saying. I don't know that anybody here are the ones, at least up here, are the ones who imposed the system on you.

MR. ALEXANDER: Oh, I know that.

ASSEMBLYMAN COLBURN: Because frankly when it started, if you were here at the beginning, it looked to me like a way to start the administrators fighting with the physicians. Apparently that didn't happen. But I know, I've heard some stories like you have about the $6000 broken wrist and things like that. So I really appreciate your point of view and I think the next witness might share some of your feelings about this.

MR. ALEXANDER: Let me just go on a little further on that. The problem has been created not so much by doctors and hospitals. I've been 35 years in the hospital field and I've

retired now and so I know a little of the background of what's going on in the hospital. I was in an executive position so it wasn't that I heard from say the porter dishwasher or what have you. I've been on top of these things. And while it's true there has been at one time, and I'm going back to 1950 I guess, to where you had a situation of again patient days. Now you've been in the hospital yourself so you know what we mean when we say patient days. Now if you don't have the patient days you are not able to meet your daily obligations and this is the way the administrator determines whether he is either breaking even, losing money or making money, one or the other. And this is the problem and I think this is the area that mostly should concern a group such as yours, that when you review all this testimony that you've heard, that I don't think there is that much of hospital and doctor shenanigans, as it is that a situation is created by legislative bodies that in effect they created conditions where the hospitals are not making money so they have to increase the money -- the rates. Thank you.

ASSEMBLYMAN COLBURN: Thanks a lot. Dr. Primich, you've waited long and patiently. Good afternoon.

D R. F R A N K J. P R I M I C H: Good afternoon. I've waited even longer than you think. I've been ten years waiting for this evaluation of the DRGs.

New Jersey's innovative method of reimbursement has been characterized by a gross lack of foresight, and an appalling lack of integrity or accuracy in official proclamations regarding results as the program evolved.

The Department of Health's unsubstantiated contentions of cost savings and improved quality of care have been widely publicized. Objections and questions raised originally by individuals like myself and later by the Medical Society of New Jersey have gone essentially unanswered. The majority of major players in this charade, for a variety of self-serving reasons, either openly supported the program or withheld justifiable criticism.

Patients, with the most to lose, had no direct nor knowledgeable input other than through their physicians. And we doctors, ironically, were the only ones whose testimony was discounted as self-serving because of our objections to over regulation.

New Jersey Public Law 1978 Chapter 83 is finally being shown to have been an ill-conceived and ill-advised piece of legislation. If we are to intelligently pursue a solution to our current problems, that concession must be made. To waste valuable time trying to rearrange the deck chairs on this ill-fated Titanic rather than give the order to abandon ship in an orderly fashion will only increase the eventual toll.

Any constructive discussion must be preceded by a review of the misconceptions and deceptions that got us into this mess. First was the benign and deceitful introduction of this lethal system as a limited, voluntary, experiment. This served to render moot the well-warranted concerns of those of us who have now been proven prophetic. To all intents and purposes DRGs have been none of the above.

Limitations have been few. They have consisted of exclusion of a small number of specialty institutions wherein DRGs are obviously inappropriate. Volunteerism disappeared after ten hard-pressed hospitals asked to be included among the 26 institutions selected for what was to have been the pilot study in 1980. Experiment is probably the most misused of the three words unless the people of New Jersey are to be considered guinea pigs to be used by the Federal government without their informed consent.

At long last we are supposedly here to evaluate this experiment. All the evidence that I am aware of indicates that DRGs have added nothing but confusion, complexity, and additional costs. For anyone to properly judge DRGs it is imperative that there be an awareness of the common misconceptions that prevail.

Most references to the New Jersey rate-setting system designate the entire process as DRGs. That generalization alone

has been responsible for supporting comments from presumably knowledgeable individuals and organizations which in no way endorse the actual DRG process.

Let me give you a few examples. Commercial insurers: Since the equal billings provisions of Chapter 83 gave them a competitive edge, vis-a-vis Blue Cross, lobbyed strongly for its passage and want it to continue. Hence they offer little objection to the inequities of the DRGs and repeatedly express their high opinion of New Jersey's DRGs.

Hospitals administrators, particularly those with a high indigency census, benefit tremendously from the uncompensated costs allowed by Chapter 83. Therefore they extoll the virtues of DRGs. Questioned directly regarding comparison of the actual billing process with the prior SHARE system, I have yet to find an administrator who would not admit that DRGs are costlier and more cumbersome.

Bureaucrats entrusted with administering the program try to avoid public panic through reassuring statements. Instead of being forthright they look for scapegoats to account for the failure. Governor Kean, pitifully misguided by his advisors, missed the golden opportunity to hang this albatros around the neck of Brendan Byrne. Worse still, he has highly recommended our program to the other governors. With his growing national prominence it seems unlikely that he would want to face the embarrassment of the needed turnaround. His opponents might consider giving him a little prod. The underserved and overcharged patients can ill afford to wait.

The excuse for introducing DRGs was that the prior SHARE process would not fulfill the Medicare waiver requirement for innovation. Without the Medicare waiver the very basic all-payer concept upon which Chapter 83 was structured could not be implemented. If that is true then the impending loss of the waiver should mean the end of Chapter 83 as we have come to know it.

Where do we go from here? It seems to me that the

three major provisions of Chapter 83 must be considered separately lest we repeat the current confusion.

Equal billing sounds nice and fair but in reality creates as many inequities as it resolves. Since deregulation at this time is a pipe dream, let me suggest my second best proposal: Have the Rate Setting Commission simply establish maximum rates. In the current competitive atmosphere mutally agreeable discounts might lead to the desired goal of cost containment.

Uncompensated costs which covertly raise the rates of all-payers should be recognized as welfare costs. If they are deemed a true societal responsibility they should be paid for out of governmental revenue. If food stamps are not paid for by a tax on food and the cost of housing the homeless is not added to real estate taxes, why should the ill and injured bear the additional burden of paying for health care welfare costs?

DRGs, our primary concern, must be evaluated from two standpoints: cost and impact upon quality and availability of care. It is my considered opinion that DRGs lose on all counts.

Costs of computer hardware and software, additional high-priced personnel and time consuming orientation and education have been more than the exaggerated unsupported claims of savings. The MIT and Harvard studies, at a cost of $700,000 to the Robert Wood Johnson Foundation, support my gratuitous early testimony contending that the prior SHARE system was simpler and more economical.

Quality of care has suffered under the present program. This is not to say that it would not be diminished in any rigid regulatory program. However, it is patently dishonest to deny that reality. The clearest example that I can cite is the situation wherein an expensive antibiotic "A" is known to be 90% effective in treating a specific infection. A cheaper antibiotic "B" is 60% effective. If the patient is given "B" by a cost-conscious provider you don't need a medical degree to comprehend the lesser quality involved.

It is generally accepted that a significant increase in the rate of readmission is an indication of inadequate original treatment. This seemingly scientific measure was inexcusably used by the Department of Health several years ago to give undeserved credibility to their quality claims. What they did was to have a costly regional PSRO review of a huge number of charts to determine how often readmission occurred within seven days of discharge. Since those figures fell within generally accepted norms it was contended that this should lay to rest any concerns about the quality of care being administered under DRGs.

That study gave no consideration to the innumerable other factors involved in evaluating quality of care. Of greater significance was the fact that this superficial study totally ignored the cases readmitted after eight or more days, those who died before they could return, and those who were so disheartened by their original stay that they either went elsewhere or totally lost faith in the health care establishment. My rebuttal to those false conclusions in the press and media, as well as direct confrontations with Commissioner Goldstein, did result in an apparent discrediting of the study.

Lo and behold, at a recent public hearing before the State Senate Committee on Aging in Long Branch, that study was again cited, not only by the Department of Health, but by the New Jersey Hospital Association and the PRO of New Jersey as proof positive that there were no quicker and sicker discharges in New Jersey. This might be happening in the other 49 states, but all three claimed that they were unaware of a single case of premature discharge.

I'm familiar with the term stonewalling, but this is ridiculous. It will border on the unbelievable when I tell you that the format of that hearing was to essentially alternate organizational witnesses with often pitiful old folks who recited their personal horror stories. If such whitewashes are tolerated we might just as well give up any hope of correction.

New Jersey has been guilty of gross misrepresentation

regarding DRGs. We are largely responsible for the premature ill-advised extension of the concept to national Medicare reimbursement. It would represent a giant step on the road back to sanity and integrity if we would unmask and discard DRGs.

There are those who will tell you that the flaws in DRGs can be corrected. I'm here to tell you that they are irreparable because the basic concept is illogical. Tinkering and modification are of no more value than redecorating the upper floors of a building with a faulty foundation. Eventually it will crumble. Others will tell you to consult with the bespectacled, bewhiskered 30 year old Ph.D.s who concocted this catastrophe. Maybe they will have better luck with their next guesstimate.

Common sense should tell you that any system will be subject to the frailties of human nature such as greed and avarice. These problems can be reasonably controlled through vigilance.

There are probably better approaches to rate setting than SHARE, but in the absence of a proven alternative my recommendation is to return to that method before the bookkeepers familiar with it reach the age of Alzheimerism.

Whatever you decide, please consult with the practicing physicians before, instead of after the fact.

I have tried to keep this presentation of an extremely complex issue brief. I would be more than happy to expand upon my accusations and recommendations if you will simply ask. Thank you.

ASSEMBLYMAN COLBURN: Thank you, Doctor. Well, we have somebody who is not only more erudite than I, but more candid.

Rod, would you like to ask anything?

ASSEMBLYMAN FRELINGHUYSEN: No. It's interesting.

DR. PRIMICH: For some reason legislators never want to ask questions.

ASSEMBLYMAN COLBURN: What do you see as happening to the people who are discharged under the-- Of course, you know,

the DRG system is not the only thing that is responsible for shorter length of stays. I think the PRO-- Are they not equally responsible?

DR. PRIMICH: Well, again, this is another cost inefficient method. The PROs are rejecting any number of things basically not on the basis of inadequate care so much as inadequate chart keeping, inadequate bookkeeping. To my knowledge at the last count more than 50% of the claims that they rejected or held back on have been reversed on simple application of the facts in the case. Now this-- The doctors we can fairly say are guilty of inadequate bookkeeping. In other words, this may well reflect cases where doctors have spent adequate time in making diagnosis, in prescribing for patients but didn't write a progress note and therefore on this basis the claims can be rejected. So for many of these things it's not--

I don't want to pretend for a moment that I focus all of my anger and ire at the Legislator, the hospitals, the Department of Health, PRO. I have been equally critical, even more so, of my colleagues over the years for many reasons; often because they just would not take the time and effort to meet the criteria that I feel are necessary for the good practice of medicine. Everybody cops out on quality of care. My contention is that it's difficult to define, but I can certainly tell you what good quality is, what mediocre quality is, and what poor quality is, and that's the only thing that's important is to be able to make that differentiation. And if people refuse to even give consideration to making those kind of decisions on the basis of the fact that you supposedly do not have rigid criteria-- But the more rigid the criteria, the less logic there is. The only person who can honestly make a judgment as far as quality of care is that forgotten person the gentleman who was just here was worrying about, the patient.

In other words, this whole concept of third party payers, whether they be insurance companies, governments or anybody else, what do they know about whether that patient was

adequately cared for? If that patient, as in the old days, was paying their own bill, they would have a lot of questions to ask about the money that we spend, as to how wisely we spend it and whether some of these esoteric tests and procedures that we do are cost-effective. If you're paying for it, you want to know. If somebody else is paying for it open up the floodgates: I'll take all the treatment I can get

ASSEMBLYMAN COLBURN: But dropping DRGs doesn't really necessarily answer the whole problem, does it, as far as you're concerned?

DR. PRIMICH: Well, if we were to have the courage to say the DRGs were not a very bright way of establishing hospital costs and hospital reimbursement. Not costs because DRGs, if you have computer capability will give you some rather interesting and probably beneficial information as far as cost accounting is concerned, but it is an absolutely ridiculous way to pay for hospital reimbursement. What you are doing-- In other words, the premise that these people use all the time -- and I wouldn't want to defend the other side on this issue -- is that hospitals are a bunch of thieves. On this basis they have come up with this system that is supposedly going to reward hospitals for more efficiency. Now, if you tell me that somebody is a thief and I'm going to come up with a system to reward them for efficiency, the thing that strikes me is now about this thief taking advantage of inefficiency? If you can make paper diagnoses and give as little service as possible you come up with the greatest bottom line in the world. Now the basic premise in the first place was not right. In other words, there is thievery within the hospital organization, but I would say with the possible exception of myself, anybody who accuses them of that, are bigger thieves than they are. So on that basis, as I say, the system does not reward efficiency. That's a crock. We've gotten into--

The PROs to me have been put in the position of bounty hunters. They've gotten into this ridiculous thing now where they want, full blast, nothing but cost containment. That was

their whole mission, meanwhile paying lip service to quality of care, which was a joke.

Now when people realized what they were doing and there were demands that they involve themselves in quality, they're involved over their heads. This is not peer review. You've got a general practitioner or a nurse making a judgment as to whether a neurosurgeon is operating appropriately and giving the proper care to his patients. It's asinine. They can't do it. But the point is that if you want to control the bottom line, you've got to have rules, much as I hate regulations. And whether it be direct peer review in organizations which, for many years we had, and as long as the thing came, the bottom financial line came out within reason, the voluntary peer review that we did on ourselves was acceptable to the community. And then as things started to get a little bit out of hand one way or another, then came first the voluntary and the mandatory and the mixed. The mixed one is where the voluntary peer reviewers were to be inspected periodically and if they looked like they were doing a pretty good job they would have periodic extension of the power to police themselves. And then sort of dribbled on down and then now again even with the current PRO system there is some contingency there for in certain institutions for all intent and purposes everybody is doing their own utilization review now and it's being pretty much spot checked by the PROs.

But if this is done, and this is why when you get into a relative simple system that pays on a per diem basis, and if you have a police force to look in there and simply check out what cases by whatever criteria you want to use don't belong in a hospital in the first place. You throw those out and which cases were the cases kept needlessly beyond the time that they should have been discharged, that can be an absolute cutoff. We're talking in terms of round numbers -- of "X" number of dollars per day. That's a very clear and precise way of controlling costs.

Now, the other thing we just sort of barely touched on here, and it was a wonderful term that I thought should have been

making the headlines by now, and it's what's known as the no-care zone. That is with these patients where we expedite discharge so that marginally you're discharging them, perhaps, a day or a half a day or 3/8ths of a day depending on your statistics, sooner than you might otherwise to some type of intermediate or skilled nursing care, some sort of step-down from the acute care facility, whose services they really no longer need, to independently care for themselves. Everybody talks about hey, throw them out there. That's a no man's land. There isn't any structure and I think you yourself mentioned the example that when they do structure this thing it's going to be horribly expensive because if you make three steps, every step will have its own bureaucracy to run it, every step will have its own entrepreneurs setting up the system and making arrangements. And the poor little visiting nurse will still be getting underpaid for her expert care, while the entrepreneur who is running the thing and the bureaucrats who are processing the papers that he's sending in, will all be making a delightful living. That's what I think we have to focus before we push these people out, that there is someplace for them to go. And I don't think that these proposals that are being made are particularly logical. They'll bankrupt us all and if anybody gets serious down in Washington and stops those printing presses they'll just-- I mean the only way it's being paid for now is out of deficit spending.

ASSEMBLYMAN COLBURN: Okay. Thanks very much. Let's see, is Josephine Sienkiewicz still available?

J O S E P H I N E S I E N K I E W I C Z: Yes.

ASSEMBLYMAN COLBURN: Boy, you have been patient.

Mr. Frelinghuysen is particularly sensitive about his stomach, as usual.

ASSEMBLYMAN FRELINGHUYSEN: That's not for the record.

ASSEMBLYMAN COLBURN: That ought to really grab the headlines I think.

MS. SIENKIEWICZ: Please tell me if you can hear me

because I've been told in the past my voice tends to get low.

ASSEMBLYMAN COLBURN: We can hear you here. I'm not sure about how this thing works throughout.

MS. SIENKIEWICZ: Okay. My name is Josephine Sienkiewicz. I'm the Director of he Home Health Care Division of Mercer Street Friends Center here in Trenton. We're a nonprofit organization that provides visiting nurse and home health care to the residents of Mercer County. I myself am a registered nurse and I hold a masters degree in Nursing Administration and I've specialized in community health nursing.

Friends Home Health Care is a Medicare certified and licensed home health agency in the State of New Jersey. I'm explaining this as my testimony today will address the effects of the DRGs on the health care system specifically as it relates to home care. Home Health Care typically provides part-time intermittent skilled nursing care by a registered nurse or physical therapist, speech therapist, or occupational therapist under physician's orders. When these services are provided home care services of a home health aide, who provides basic personal care such as a bath, food preparation, some light meals, light housekeeping duties, and assistance with ADL, activities of daily living, or social worker may also be provided. Home Health Care generally does not cover full-time nursing care.

In 1984, 68% of referrals to home care in New Jersey, and again I'm speaking about certified home health agencies, were specifically related to a patient's hospital stay. Therefore, I feel that it is appropriate to consider home care in the greater context of the DRGs' effect on health care.

It's been pointed out here today, as well as studies by the Senate and the House Committee on Aging, that the DRG system has resulted in a shorter length of stay for hospitalized patients. The acute care setting has realized a cost savings. What we have to remember, though, is this translates into some patients being discharged quicker and sicker, as has been termed here. And they still need health care.

Home care is utilized at this point in time and associated costs of health care have begun to rise as a result of a larger volume of people now using home care. Home care agencies have experienced an increased demand for service as well as an increased complexity of care.

A study by the Health Care Financing Administration found a 37% increase in hospital discharges to home care. Highly technical care as well as 24-hour seven day a week service has become the rule now rather than the exception. I was a visiting nurse myself around 17 years ago. The most complex patient then was perhaps a complicated sterile wound dressing referred when the condition had stabilized in the hospital, or an injection, or perhaps a catheter change. Service was basically provided during the week, Monday through Friday. Weekend service was rare. Now my nurses are administering IV medications at home, caring for Hickman catheters which are threaded directly into the heart for life sustaining medication or nourishment, caring for fresh surgical wounds, working with terminally ill hospice patients, and pronouncing death so that patients can die with dignity at home. Our practice has significantly changed.

Our technology has increased and home care has responded to enable people to remain at home and be cared for safely and in a qualitative way. This can't be done, however, without qualified professional people and without adequate training and supervision. Costs have risen. They've had to rise.

Home care is still a cost effective alternative to hospital care and the quicker and sicker discharge of patients means that the home care demand is increasing as an alternative to institutional care, especially in the elderly population. Many elderly experiencing hospitalization with early discharge are going home to be cared for by an equally elderly and often frail spouse. They want to be home and they expect their needs to be taken care of by the visiting nurse and other appropriate professionals and paraprofessionals such as the aides. They

expect that Medicare will cover these costs. What a shock it is, though, for them to learn, however, that Medicare does not cover all of their needs. Through the Health Care Financing Administration's use of a series of new regulations, guidelines, stringent interpretations, and actions the curtailment of the home health benefit is being realized.

Thus at a time when there is a documented increase in the use and need for home care brought about partially through an attempt to decrease costs by placing limits on hospital care through the DRGs, there is blatant action by the Health Care Financing Administration to curtail the Medicare home health benefit citing this very increase in service use as a justification for developing these new regulations.

Home health agencies are suffering under new lower cost limits, mandatory cuts in cost based reimbursement under Gramm-Rudman, and that is -- I'm going to digress for a minute. We are paid in home care on a retrospective, not a prospective system. We charge, our charges must be above our costs and at the end of the year there's settlement with Medicare so that we are only paid what it actually costs us to provide the service. What the Gramm-Ruoman did was make a mandatory cut in that cost so that no matter what our cost was, it was reduced.

ASSEMBLYMAN COLBURN: By a percentage?

MS. SIENKIEWICZ: By a percentage. It was one percent in March and it was due to-- I don't know what's happening now, but it was going to be an additional 2% in October.

ASSEMBLYMAN COLBURN: I see.

MS. SIENKIEWICZ: Restrictive interpretations in patient care requirements were also affected. Delays in processing and paying claims, and what is worse, that we're seeing it become more and more difficult to provide the quality and quantity of service that people need.

I'd like to share a few examples. I know it's difficult to measure quality as has been said here, but I think only through some of these anecdotes can we really see what is

happening to the patient out there.

Mrs. K. was a 65 year old woman with cancer who was hospitalized to have a Hickman catheter surgically implanted in order that chemotherapy could be given to treat her active cancer. She came home to be cared for by her daughter. The daughter had to be taught to care for this catheter which required daily sterile dressing change and an injection of Heparin to prevent clotting at the tube site. Mrs. K. was very weak and had to be taken by car with help one time a week to the doctor for her chemotherapy treatments. These cannot be given at home. And also to be evaluated for radiation therapy. We provided nursing visits to teach the daughter how to care for her mother and to observe and monitor Mrs. K.'s condition. This family refused a home health aide because Mrs. K's daughter assisted her mother with her bath and Medicare would not pay for the homemaking activities alone. Medicare subsequently denied this patient's nursing visits as she was felt to be not homebound. She died two months later.

Mrs. G. is a 55 year old patient diagnosed with severe respiratory and heart problems. She lives alone and had been walking and independent until the illness resulted in her hospitalization. Upon discharge to home care she was basically bed and chairbound, required continuous oxygen and was unable to dress or wash herself without severe breathing problems. Periodic nursing and daily home health aide service was provided. In addition, this patient developed a bedsore that required daily care. The home health aide visits, in excess of three times per week which was for a duration of two hours each time, was denied as it was felt this patient was able to use a walker to get to the chair and therefore the additional two time per week aide visits were only supportive.

Mrs. C. is a 71 year old patient with cancer of the colon and had a previous history of polio. Prior to her hospitalization she was independent in all her activities. Bed rest and the cancer treatments had caused her to lose

significant strength in all of her extremities. A total of four physical therapy visits were provided to treat her loss of function, increase her muscle strength through therapeutic exercise, and instruct her in ambulating with a walker and a cane. At the end of the four visits she was again independent. This period of time covered about a three week period. All visits were denied as Medicare felt the loss of function was not specific to her diagnosis.

A final case is Mr. S., an 81 year old patient hospitalized with heart failure and diabetes. He was hospitalized for five days and was sent home totally dependent on his family. He was bedbound and required skilled nursing, physical therapy, and home health aide assistance at home. Prior to the hospital stay he had been independently ambulating and managed all his own care. The nurse monitored his heart condition and the therapist helped the family set up a safe exercise program and taught him the use of the walker to help him begin care for himself again. Two weeks after admission to home care this patient was readmitted to the hospital. Medicare denied these home physical therapy visits as not medically reasonable or necessary.

These are some examples that you can see that while the DRGs are causing many ill and impaired elderly to be discharged sooner from the hospital, these same individuals are also being denied needed home care benefits.

This hearing's purpose is to examine the DRG reimbursement system on hospital costs and the quality of care. I charge that the issue is larger than just hospital care. The quality that we as Americans have come to expect as our right is in jeopardy unless we provide a continuum of care through our health care system. One action on one part by necessity affects the other. You cannot limit one area and squeeze those same people into another while at the same time decreasing the services to that area also.

Another factor to consider is the cost to the patient

because in order to cover their care they are spending more and more dollars of their own to provide supportive care for themselves at home.

In my agency I have data that shows that over the last two years our readmission rate of patients going back into the hospital has increased by 15%. In addition, 12% of the cases referred to us that we could not provide service for were due to rehospitalization within 24 hours or death.

The increasing restrictions on home care services means that individuals are receiving less than optimum care at a time when they are increasingly in need of greater levels of care than before. I urge this Committee to consider patients' needs for home care when examining the issues of the DRGs' impact on the quality of care and the need to consider the continuum of care -- not just that in the acute care institutions.

ASSEMBLYMAN COLBURN: Thanks a lot. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: Eloquent testimony. I would be interested in looking at your statistics. I think that would be valuable to us.

MS. SIENKIEWICZ: I'd be glad to send them to you. They are readmissions, though, based upon our reason for discharge. I don't have-- We don't carry statistics in what period of time those readmissions occurred. But the fact that it increased so much was what I thought was significant.

ASSEMBLYMAN COLBURN: Do those statistics go anywhere?

MS. SIENKIEWICZ: The State Health Department has a -- compiles the statistics from us on a yearly basis so they do have all -- from all of the entire agencies in New Jersey.

ASSEMBLYMAN COLBURN: Do they? Okay, thank you. I guess I wanted to say, which I guess I hadn't said before, that I really thought for years that anecdotal evidence was something to be respected and it's looked upon with considerable disfavor in the medical journals. But in my own practice many years ago I discovered something that wasn't known about something called ACTH that it produced an initial diuresis when you gave it, and I

learned that out in a cabin in West Virginia. So you know, there are times when this anecdotal evidence really does mean something.

I watch these statistics from highly academic places and sometimes they'll say -- and even the FDA -- and they'll say that 80% of something happens, or 90%. Well, what happens to other 10 or 20%? Gosh, the people who are taking care of the patients have to work with the 10 and 20% and when you're faced with a tough situation it doesn't help you that 80% happened the other way. You're in that 10% and you're really up against it, you know. So what do you do? So anecdotes are okay with me.

MS. SIENKIEWICZ: The other thing, too, that I find that as my nurses are going out and seeing sicker and sicker patients they're becoming frustrated in that they can't give the quality of care that they feel they should be giving to the patients.

ASSEMBLYMAN COLBURN: Oh, sure. Yes.

MS. SIENKIEWICZ: And the paperwork burden has become tremendous through all the different regulations that are being imposed.

ASSEMBLYMAN COLBURN: When I looked into this question of home health care costs right after Medicare came in I think the agencies -- and this was, you know, almost 20 years ago -- said that they figured 20 minutes travel time, 20 minutes paperwork time and 20 minutes with the patient for an hour's charge. Has the paperwork part of that changed at all?

MS. SIENKIEWICZ: A good 27% of my nurses time is spent on non-essential patient care, and that I count as the paperwork.

ASSEMBLYMAN COLBURN: As the paperwork, okay. So it might have gone up a little bit.

MS. SIENKIEWICZ: That's a significant amount. They spend about 20 minutes driving. They spend on an average now of 45 minutes to an hour with the patient. The time with patients has increased significantly.

ASSEMBLYMAN COLBURN: How about that?

MS. SIENKIEWICZ: And an admission takes at least an hour and a half to write up.

ASSEMBLYMAN COLBURN: You mean the first visit to somebody's home?

MS. SIENKIEWICZ: The first visit takes an hour and a half in addition to that patient time to write up. Subsequently the paperwork is probably reduced to 20 minutes to half an hour per patient, but that's significant.

ASSEMBLYMAN COLBURN: If anybody ever has any good suggestions about how the paperwork might be reduced, I'd sure be happy to receive it.

MS. SIENKIEWICZ: We would like to make some.

ASSEMBLYMAN COLBURN: I've been asking agencies, and as a matter of fact I've got a bill in the back of my mind that might address this thing. But I really would like to hear from people how we could reduce the paperwork and sometimes when we ask, I've found that agencies and hospitals and groups are afraid to protest the paperwork for fear that they'll be punished by the folks that are generating the stuff.

And I remember when I was with the National Association of Counties, I was on a health committee and we had a Federal -- I have to call her bureaucrat -- come before one of our committees and she told us that in the course of some pilot program they didn't quite know what reports to ask for, so they asked for everything that they could think of for a couple of years just to be sure they covered everything. I thought that was a terrible admission to make publically. But, you know, that's an example of how it all works.

Thanks. Thanks again.

MS. SIENKIEWICZ: Thank you very much.

ASSEMBLYMAN COLBURN: I appreciate it. Now for those survivors here-- I guess Mr. Kurtz has given up. Ruth Strickland and Bernadette Countrymen. Are you together by chance, the two of you?

R U T H S T R I C K L A N D: I'm here. Sort of, but not

exactly.

ASSEMBLYMAN COLBURN: Okay. Do you want to come together? Does it make a difference? You would rather just come alone.

MS. STRICKLAND: I'll come alone because I'm speaking for myself.

ASSEMBLYMAN COLBURN: Okay. You're Ruth Strickland, right?

MS. STRICKLAND: Right. Mr. Chairman, members of the Committee, thank for allowing me the opportunity--

MR. ALEXANDER: Would you speak into the speaker so we can hear it?

MS. STRICKLAND: Okay.

MR. PRICE (Committee Aide): That's not for amplification. It's just for the hearing unit to record.

ASSEMBLYMAN COLBURN: I'm sorry. This is just a recorder. It's not an amplifier, so it's a function of--

MS. STRICKLAND: I'll speak louder.

ASSEMBLYMAN COLBURN: --where you're sitting and the person's voice--

MR. ALEXANDER: I should have kept my mouth shut.

ASSEMBLYMAN COLBURN: No, that's all right. I'm sorry.

MS. STRICKLAND: Mr. Chairman, members of the Committee, thank you for allowing me the opportunity to present this testimony on behalf of myself and my colleagues. My name is Ruth Strickland. I'm a registered nurse. I've worked as a staff nurse on a medical-surgical unit at Riverview Medical Center in Red Bank, New Jersey for ten years. I've been in nursing practice for 20 years, with 90% of that time spent in acute care hospital settings involved with daily bedside nursing care. I'm addressing this issue strictly from the basis of being a bedside nurse.

While some may feel that the DRG system has contained costs, I would like to say that if this has occurred it has been to the detriment of the patient, his family, and their nurse.

Since the advent of DRGs I've seen a monumental increase in job dissatisfaction and much greater stress experienced by staff nurses. Nurses are leaving the profession to seek job environments that provide better pay and that are less physically, mentally, and emotionally demanding. To add to this problem is the fact that nursing school enrollment is declining yearly, due in part to the myriad business and industrial opportunities now available to women.

Today patients are admitted to the hospital much sicker and in need of more complex nursing care. In addition, due to the high utilization and demand for intensive care beds, patients are often transferred to medical-surgical units from the intensive care units while still requiring intensive nursing care. This has required medical-surgical nurses to learn and implement technology and care that prior to this was available only in an ICU setting. I've included a bar graph to support my statement about increased patient acuity at Riverview over the last three years. This data was compiled by using a patient classification system widely accepted and validated in the nursing community. You'll find it attached to the end of my testimony.

One of the most important roles of a nurse is to function as a teacher. She must teach the patient and family general health restoration and maintenance, and explained detailed and often complex discharge plans for home care. If this is done effectively it's been shown to reduce readmissions for the same problem. For patient education to be effective, the patient must feel physically and emotionally ready. If he's experiencing physical discomfort such as post-operative pain or emotional distress such as having just been told he has diabetes or cancer, he certainly won't be motivated or receptive to learning. However, with the current shortened hospital stay of patients we must often begin teaching before the patient is ready. We must also teach the patient and family more complex care than ever before. If the patient and family haven't had the

time to learn the care needed, this places an additional burden on community health resources and may contribute to a possible readmission for the same problem.

An illustration of the pressure on nursing personnel and patients due to shortened hospital stays is also to be seen in the area of maternal-child health care. First time inexperienced mothers and their newborns babies are often sent home the second day after delivery whereas in the past they stayed three to four days. These mothers frequently lack the knowledge base and ability to care for their babies. This has the potential for extreme maternal frustration that could precipitate a cycle of mental or physical child abuse or long term health problems for the child.

With the decrease in the dollars that a hospital has to spend, cuts have been made in support services such as housekeeping, transportation, dietary, and pharmacy. For the nurse to provide and maintain a safe and therapeutic environment for her patient she must often pick up the slack by assuming extra non-nursing duties. For example, if pharmacy has no one to deliver a medication, a nurse must become the messenger, leaving her unit and her patients. If a housekeeper is not available on a unit because he may be covering several units, the nurse must mop up spills. If x-ray has no patient transporter the nurse must take the patient to the x-ray department.

To summarize, I would like to state that in the last five years I have found it increasingly difficult to practice the kind of nursing that I aspire to and that my patients have a right to expect. I believe this has resulted, if not directly, then indirectly from the implementation of DRGs. DRGs have impacted on me by causing staffing cuts, increased patient assignments involving more acutely ill patients, decreased length of hospital stays necessitating intense patient and family teaching at an inappropriate time. I feel DRGs have robbed me of the opportunity to provide as much emotional support for my patients and their families as they need and deserve. I also

feel that in selected cases, an additional one to two days in the hospital would be most beneficial to all. The patient and family would be comfortable and confident with home care. There would be decreasing usage of community resources, decreasing need for skilled care nursing home beds, and decreasing hospital readmission for the same problems.

Thank you for allowing me to present this viewpoint. Does anybody have any questions?

ASSEMBLYMAN COLBURN: Thank you. Mr. Frelinghuysen?

ASSEMBLYMAN FRELINGHUYSEN: The only comment I didn't see in your remarks and your colleagues' previously, is evening and weekends is another--

MS. STRICKLAND: Well, nurses traditionally have worked erratic schedules, erratic hours, and weekends and holidays.

ASSEMBLYMAN FRELINGHUYSEN: That even make it worse and accentuates the problem.

MS. STRICKLAND: Yes, staffing is even shorter during those times.

ASSEMBLYMAN FRELINGHUYSEN: Thank you.

ASSEMBLYMAN COLBURN: Did you find that when you went into nursing that you had the idea that you were going to take care of patients?

MS. STRICKLAND: Uh, yes.

ASSEMBLYMAN COLBURN: And later on you found out that you were taking too much care of papers?

MS. STRICKLAND: There's been a tremendous increase in paperwork, documentation, that type of thing.

ASSEMBLYMAN COLBURN: That probably happens as much because of the PROs as the DRGs, do you think, the paperwork part of it?

MS. STRICKLAND: Yes.

ASSEMBLYMAN COLBURN: From what I've seen the nurses' notes are really extensive and I always read them and I learn a lot from them. But they have these silly things like some poor soul comes in with a heart attack and they say, "what are your

treatment goals?" You know, it's kind of ridiculous to have to write all those down. I guess we all should-- I was thinking they ought to have some way of phrasing it, we're going to go through goal A, B, C, and D and then not have to write it all out. But it seems to be there in the chart. I suppose if it's not somebody comes along and says, "You did it wrong."

MS. STRICKLAND: Well, if we don't document certain aspects of the patient care then part of that can be disallowed by PRO.

ASSEMBLYMAN COLBURN: I was the first dermatologist in Ancora when it opened about 1957 and the psychiatrist there used to closet themselves with 150 charts and write notes on them and the patients were out around, you know, in the great big rooms. And these notes would say doing well or same or status quo--

MS. STRICKLAND: Very complex, detailed notes, right?

ASSEMBLYMAN COLBURN: And then the inspectors come around and look at all those notes, say, "Boy, that fellow is really keeping up with those patients."

Thanks a lot.

MS. STRICKLAND: Thank you.

ASSEMBLYMAN COLBURN: Well, let's see. Bernadette Countryman.

B E R N A D E T T E C O U N T R Y M A N: That's correct.

ASSEMBLYMAN COLBURN: You're from the Society for Nursing Service Administrators of New Jersey.

MS. COUNTRYMAN: That's correct. Thank you for bearing with us today. It's been very long. Thank you very much for the opportunity.

ASSEMBLYMAN COLBURN: Gosh, I think you're the one that has borne with us.

MS. COUNTRYMAN: No, it's been very interesting. I'd just like to comment on one of your questions to the previous witness. One of the reasons for extensive documentation is not just a DRG issue, but has to do with the legality of nursing practice--

ASSEMBLYMAN COLBURN: That's true.

MS. COUNTRYMAN: --and JCAH requirements and Department of Health requirements. So that has added to the burden over the years.

As you stated, I'm Executive Director for the Society of Nursing Service Administrators. The members of our organization are the administrators of the acute care -- nursing administrators in acute care hospitals throughout the State primarily.

The issue of quality care is a particular concern to nursing administrators and this is the issue I'll address myself to today. Since the broad inception of the DRG system in New Jersey, significant changes have taken place in the manner in which consumers are processed through the health care system. The consumer now enters the hospital not a few days prior to surgery or for tests, but rather on the morning of major surgery or in a state of acute illness. During their hospital stay patients are more aware than ever before of their rights as health care consumers. At the other end of the hospital stay patients receive medical discharge when barely entering an early convalescence. These changes in the patterns of hospitalization have been a direct result of the DRG trim point dictates.

The results of this trend, coupled with a reimbursement system that fails to specifically cost out nursing, have given rise to several issues of concern to us. While hospitals are generally experiencing a declining census, we are seeing a sharp increase in patient acuity levels. I've heard many witnesses say that today. Patients who in 1982 were cared for in intensive care units would now be cared for on med-surg units. This necessitates maintaining a highly skilled professional nursing staff who remain competent in the face of ever increasing and ever changing technology and who are readily able to respond to the increasing demands to provide quality in health care delivery.

The use of lower cost ancillary nursing staff has

become inefficient because of the previously stated need for RN intensive time. In some cases this has resulted in the conversion of nurses aide and licensed practical nurse positions to RN positions. A result has been the loss of employment opportunities in those job categories. In addition, these positions are not converted one for one so that fewer actual nursing personnel are the end result.

Nursing support services in the areas of staff development and patient education, while vital in maintaining staff competency and referral sources, have often been the first to be cut in this time of decreasing dollars for nursing, based on a reimbursement system that fails to recognize the specific needs of nursing.

There are those patients whose conditions do not allow a timely discharge within the trim points and whose diagnosis does not readily allow reclassification within the system. This issue of outliers has caused nursing departments considerable concern because of the enormous cost to our already straining budgets.

Case in point: Recently a woman in her mid-60s was admitted to an intensive care unit in a northern New Jersey hospital. She did not have cancer and she was not considered to be terminally ill. Her care included ventilator support, nasogastric feedings, and hemodialysis. In addition, a pacemaker was implanted. She remained in that ICU conscious and alert until her death seven months later. She was, on the basis of diagnosis, an outlier. The actual cost of her care during that time was $300,000. Reimbursement for her care was $50,000. I would guess that did not cover the nursing of a one to one or one to two ratio for seven months around the clock.

The legal and ethical issues of nursing practice, both on an individual and department basis, are challenged in the present economic climate. Nursing has historically been the profession who guided the patient's return to wellness after medical treatment for an acute illness. It is a source of great

frustration that we are often unable to ease this transition for the patient and that because of a lack of appropriate reimbursement for such vital services as hospice, home care, and convalescent beds, nursing departments are put in the position of processing medical discharges for patients who are psychosocially unready. These are the patients who are at high risk for recidivism.

I would just like to say that we've heard that discussed in various ways this morning, but that really is a great disadvantage to the consumer. While there is no problem, as Dr. Colburn said earlier, in readmitting a patient from the hospital's point of view, there is a real problem with doing that from the patient's point of view.

It is of little wonder that we are failing to recruit bright young men and women into our profession as witnessed by the now declining enrollment in New Jersey's nursing schools. It is of great concern that we are losing many of our profession's best because hospitals and specifically nursing departments are struggling to provide a climate conducive to excellence in nursing practice.

In summation, the nursing administrators of New Jersey's hospitals feel that under the present DRG reimbursement system our goal of excellence in quality has given way, at times, to an uneasy acceptance of mediocrity. The goals of the Society and our continued commitment to the public will continue to encourage us to meet this challenge. We welcome any positive change that may result from your review of the inequities within the DRG reimbursement system.

Mr. Chairman, I'd just like to add to that my colleague, Barbara Wright testified earlier and addressed many of these same issues. There has been some discussion of methods to cost out nursing and just for your information, there is a current evaluation conducted by the Department of Health with New Jersey's hospitals concerning costing out of nursing service. That should be available throughout the Department of Health. It

would supply recent information regarding the impact of the proposed system called RIMS.

ASSEMBLYMAN COLBURN: Rims?

MS. COUNTRYMAN: R-I-M-S.

ASSEMBLYMAN COLBURN: What's it stand for?

MS. COUNTRYMAN: Relative intensity measures.

ASSEMBLYMAN COLBURN: Okay. Thank you.

MS. COUNTRYMAN: That can be obtained from Faith Goldschmidt at the Department of Health. Thank you, Mr. Chairman.

ASSEMBLYMAN COLBURN: Thanks a lot. Just a second. Rodney, do you have any questions?

ASSEMBLYMAN FRELINGHUYSEN: I was interested in your third point, your third concern. Nursing support services in the area of staff development and patient education. You're basically talking about continuing education for nurses within the hospital setting and any other opportunities.

MS. COUNTRYMAN: Yes, that has been a pattern that's been established within nursing departments to have clinical specialists, primarily master prepared nurses for the most part, who have an area of specialization. Their role is usually two-fold. It's to update staff on changes taking place in treatment methodologies and it's also for patient referral. If a patient has a specific problem that maybe is not within the bounds of nursing practice, of ordinary practice, they can be a resource. So that's one of the things. It's difficult to-- I think it's very difficult to justify those type of cuts, but, in fact, they have happened in some places.

ASSEMBLYMAN FRELINGHUYSEN: Mr. Chairman, one other question related to that. Are some hospitals doing this and doing a better job of it than others, such that there is a model, there are models that are being promoted?

MS. COUNTRYMAN: There are, yes.

ASSEMBLYMAN FRELINGHUYSEN: In other words one could say out in the affluent areas they can do this sort of thing.

But are there models of staff development that are--

MS. COUNTRYMAN: Yeah, I would not say that--

ASSEMBLYMAN FRELINGHUYSEN: --geographic?

MS. COUNTRYMAN: I would not say that that has necessarily been in the more affluent areas. Some of the inner-city hospitals, because of the different type of funding that they receive and grant fundings that they often receive, can also use these models. But it has primarily been the hospitals maybe with the best administration who found ways to keep these services. Yes, some hospitals have been able to manage that and I think it is just a matter of having a supportive chief executive officer and financial officer and nursing leadership within that department that's committed to quality of care. They are the people who have been able to maintain those.

ASSEMBLYMAN COLBURN: Thanks a lot.

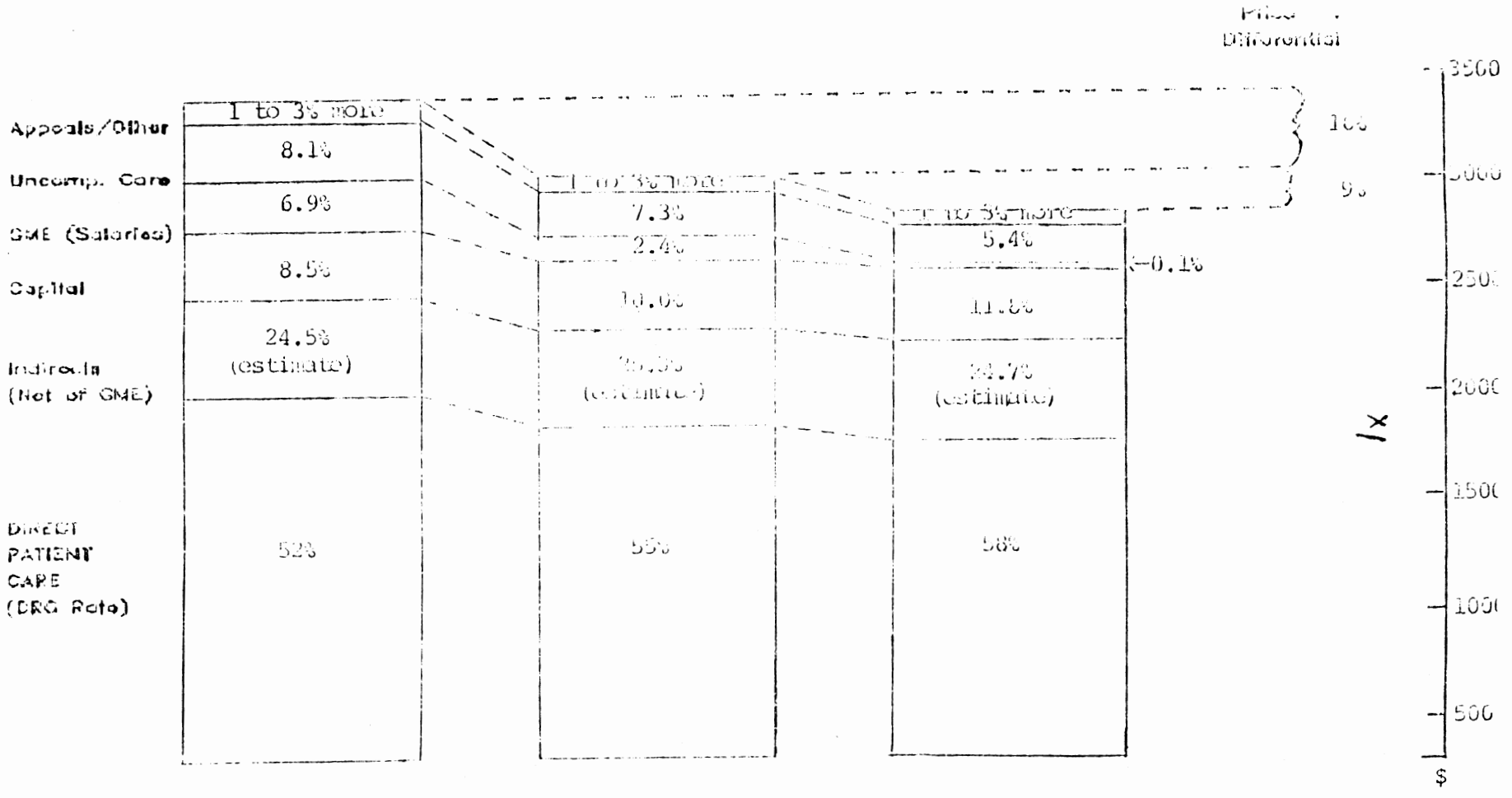
MS. COUNTRYMAN: Thank you.

ASSEMBLYMAN COLBURN: We've finished our list, haven't we? Anybody who hasn't been called on or would anybody like to say anything from the audience? The survivors should certainly have that prerogative. Well, I want to thank you all for coming. You know, I guess a lot of these meetings have to do with the fact that the health care system in the country is said to take up too much of the gross national product. And I thought that it wouldn't be inappropriate someday if we just looked upon our legal system and found out what percentage of the gross national product that is taking from the county courthouses, to the judges, to the attorneys when you hire -- when you get into a case you don't only have one lawyer, you have at least two and sometimes more, and I'm telling you, it takes up a lot of money. So I just think maybe we'll take that one on next. (laughter)

(HEARING CONCLUDED)

APPENDIX

TYPICAL DRG PRICE STRUCTURE BY PEER GROUP



SOURCE: 1985 PAYOR WORKING PAPERS USING 15 HIGH VOLUME DRGS (10/85)

HAROLD L. COLBURN, JR.
Chairman
NICHOLAS R. FELICE
Vice-Chairman
RODNEY P. FRELINGHUYSEN
THOMAS J. DEVERIN
GEORGE J. OTLOWSKI

New Jersey State Legislature
ASSEMBLY HEALTH AND HUMAN
RESOURCES COMMITTEE
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ATTACHED IS A COPY OF A SUMMARY OF THE HARVARD-MIT RESEARCH TEAM'S STUDY OF NEW JERSEY'S DRG HOSPITAL REIMBURSEMENT SYSTEM, WHICH WILL APPEAR AS AN ARTICLE IN THIS SUMMER'S EDITION OF THE JOURNAL, HEALTH AFFAIRS. THE SUMMARY WAS PROVIDED TO THE HEALTH AND HUMAN RESOURCES COMMITTEE THROUGH THE COURTESY OF THE NEW JERSEY HOSPITAL ASSOCIATION. NONE OF THE MARKS OR COMMENTS CONTAINED ON THE ATTACHED COPY WERE MADE BY ANYONE ASSOCIATED WITH THE COMMITTEE.

2x

MASSACHUSETTS INSTITUTE OF TECHNOLOGY
Laboratory for Health Care Studies
Cambridge, Massachusetts 02139

Project Summary

AN EVALUATION OF THE DIAGNOSIS-RELATED GROUP METHOD FOR REIMBURSING HOSPITALS IN NEW JERSEY

(Sponsored by the Robert Wood Johnson Foundation)

Introduction

We have just completed a comprehensive evaluation of the Diagnosis-Related Group (DRG) method for setting hospital rates as applied in New Jersey. With DRGs, fixed prices are established in advance for hospital services, based on patient diagnosis, and paid regardless of the actual costs hospitals incur in providing these services. Because hospitals are allowed to retain the difference between their costs and the fixed prices, they supposedly have incentive to become efficient managers of resources.

New Jersey adopted the DRG method for setting rates in 1980 as part of a major reform of hospital reimbursement. The reform had several objectives in addition to that of controlling hospital costs. The enabling legislation mandated that the reimbursements be sufficient to assure the financial stability of hospitals and to provide access to care for uninsured patients. The rate regulations were to be applied to all those who financed care so as to guarantee fair competition among insurers. The specific methodology for calculating rates was left to the Department of Health to select.

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Approach

The evaluation combined statistical analysis with extensive field interviews and was directed toward understanding overall system impacts as well as specific hospital effects of reimbursement changes. The statistical data were derived from American Hospital Association surveys for 1971-1983, hospital cost reports and the billing record system. (The Department phased in DRGs beginning in 1980; the earlier years provide comparisons with unregulated experience and that for a previous rate setting arrangement called SHARE.) Interviews were conducted with New Jersey and federal officials (a federal waiver was required for New Jersey's reform and in 1983 the federal government adopted DRGs for its Medicare program nationally), insurers, employers, and with physicians and administrators at 16 hospitals, distributed by size, location, ownership, and management reputation.

Findings

Overall the experience under the reform seems quite successful. Costs were kept in line when compared with previous results and those achieved in the region and nationally. The financial stability of the hospitals was maintained with important improvements noticeable for inner-city facilities. Reimbursement for hospital care for the poor is significantly better in New Jersey than it is in most of the United States. Insurers, employers, and hospital administrators seem generally satisfied with reimbursement arrangements and results.

The cost experience was in line with the trend established by the SHARE system. Under DRGs, length of stays declined (SHARE paid on a per diem basis encouraging longer stays) as did cost per admission. More substantial savings were not achieved because the admissions rate increased to offset the decline in length of stay.

DRGs did not lead to significant changes in management styles or hospital efficiency. It was thought that DRGs would force major changes in physician practice and in the use of hospital resources.

They did not have this effect because of several factors. Reimbursement rates in New Jersey were not especially stringent. Moreover, much of the reimbursement was actually cost related rather than fixed priced. Finally, DRGs proved to be rather awkward devices for categorizing illness, physician behavior, and hospital activity.

Conclusions

New Jersey achieved the goals mandated in the reform of its hospital reimbursement arrangements. The all-payer system of rate regulation assures access to care for the poor and equity among insurers. The rates established permitted deficit-threatened, inner-city hospitals to improve their financial condition. These results are especially impressive when compared with the likely experience in other states under the federal Medicare program. What controls costs is the overall cap on hospital expenditures which was part of the prospective payment reform New Jersey adopted. Although useful for recognizing variation in case mix, DRGs are an unduly complicated way of calculating hospital rates.

Harvey M. Sapolsky, Principal Investigator

Professor of Public Policy and Organization
Massachusetts Institute of Technology

William C. Hsiao, Co-Principal Investigator

Professor of Economics and Health Policy
Harvard School of Public Health

Sanford L. Weiner, Project Manager

Research Associate, Whitaker College
Massachusetts Institute of Technology

July 11, 1986

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The New Jersey
Coalition For the Protection Of Vulnerable Adults
P.O. Box 936, Somerville, New Jersey 08876

PUBLIC TESTIMONY

ASSEMBLY HEALTH & HUMAN RESOURCES COMMITTEE

July 14, 1986

Good morning. My name is Cornelia Thum, and I am Chairperson of the New Jersey Coalition for the Protection of Vulnerable Adults and I am also the Director of the Somerset County Board of Social Services.

Thank you for the opportunity to present testimony at this public hearing and to present our organization's perspective on the effect of the DRG system on quality of care in New Jersey.

The Coalition is comprised of predominantly persons who represent agencies dealing with adults at risk. Such organizations as Offices on Aging, County Welfare Agencies and Boards of Social Services, senior advocacy groups, mental health professionals, etc.. comprise the membership.

All of these persons have personally or professionally encountered problems created by the DRG. One member commented that "the System has created an emergency worse than before the person went into the hospital". From our view, the DRG creates the following problems:

1) Discharge planning for the patient often involves the need for follow up Home Health Care. That care is not always available, either by virtue of a lack of community resources or because of the

inability of the patient to pay for the needed care. There are often several days gap in coverage between when the service is needed upon the patient's discharge and when the Home Care service can begin. We have noticed that many discharges take place on a Friday or a week-end; whether this is a result of DRG or not, the result is no possibility of care at home until the next week.

Another situation involving appropriate discharge planning is when a patient needs nursing home placement. Often a bed is not immediately available, and the hospital must discharge the patient. The only recourse is to send the patient home, even without adequate resources at home to manage the person.

If and when home care can be arranged, often the least trained and skilled individual is left with attending to the needs of a person who needs some continued skilled care. The home health agencies are expected to work miracles in maintaining a person at home.

2) This issue of cost containment in the hospitals as a reason for DRG is quite fascinating. If one looks at the cost of care at home for persons who if allowed to remain in the hospital until fully recuperated would not require such extensive care, I believe there would be enlightening information.

3) If appropriate care is not available at home, a person in some hospitals may remain beyond the prescribed DRG time - this however causes a financial drain on the hospital for the unreimbursed stays. It's clear that not too many hospitals are in a financial position to do that.

4) The DRG seems to also affect admissions. Several instances of patients who could benefit from hospital admission were denied same because they did not seem to fit a DRG category. A situation of an elderly man was mentioned, who had become aphasic and whose behavior had changed rapidly over a few days period of time ultimately turned out to have a brain tumor which was detected after several attempts to have him admitted to the hospital had failed.

5) One final problem. Many instances of increased Protective Service Hotline calls have been noted by the agencies who have such a service. The calls are being made by the patient or family who are trying to cope with the physical and medical needs at hand.

I'm confident that the Legislature can take some action to resolve this very difficult dilemna and look forward to cooperating in any way in this endeavor.

Thank you for this opportunity to testify.

Cornelia Thum
Chairperson

New Jersey
Business & Industry
Association

102 West State Street • Trenton, New Jersey 08608 • 609-393-7707

July 21, 1986

Mr. David Price
Office of Legislative Services
State House Annex
CN 068
Trenton, NJ 08625

Dear Mr. Price:

Because of time limitations, New Jersey Business and Industry Association was unable to submit testimony at the July 14 Assembly Health and Human Resources Committee Public Hearing on the DRG Hospital Reimbursement System.

However, we are pleased to submit our testimony to the members of the Committee as well as to the Committee Aide for incorporation into the hearing record.

It was surprising to observe that none of the organizations or individuals that testified acknowledged that a contributing factor to the apparent success of the DRG system is the involvement of business in the reimbursement process. The business community, as opposed to the general taxpayer or state government, has accepted the responsibility for contributing financially to a significant segment of the uncompensated hospital care burden.

NJBIA urges that the Legislature not add to this burden. We hope that you will oppose the "add-on" concept as proposed in Senator Codey's S-2024.

Sincerely,

Lester Kurtz

Lester Kurtz
Assistant Vice President

jk

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New Jersey
Business & Industry
Association

102 West State Street • Trenton, New Jersey 08608 • 609-393-7707

Statement

of the

New Jersey Business and Industry Association

to the

New Jersey Assembly Health and Human Resources Committee

Public Hearing

on

Effect of DRG System on Hospital Costs

19x

July 18, 1986

New Jersey Business and Industry Association, the largest Association of employers in the State, takes this opportunity to bring to the attention of this legislative committee the effect of the New Jersey Diagnosis Related Group system on employer health care cost-containment efforts. NJBIA is of the opinion that each special interest group evaluates the DRG system from a different prospective. Hospitals, Physicians, Insurance Carriers, and Employers each may evaluate the effect of the DRG system differently. NJBIA is fully aware of the fact that business's view may be somewhat narrowed.

Pre-DRG

NJBIA believes that the legislators should be aware of the situation that led up to the DRG System. Prior to 1978, New Jersey hospitals were experiencing a growth in bad debts, primarily urban hospitals. The bad debts, in part, were the result of uncompensated hospital care provided to indigent individuals who did not have health insurance or inadequate health insurance. Usually, the budgets of municipalities and counties provided contributions to support hospitals within their boundaries. As a result, hospitals were inadequately reimbursed for services they provided individuals receiving public assistance, or partial insurance coverage. As a general rule, a hospital's per diem charge did not look to the users (patients) of hospital services to recover uncompensated hospital care. Hospitals looked to local government for funds to meet their operating losses. Also, certain insurance carriers received a volume discount on hospital charges, further contributing to the financial problem.

Enter DRG

The DRG concept was created to overcome the financial problems hospitals were experiencing at the time. Each DRG rate would include a percentage mark-up for uncompensated care to the indigent and uncollected bad debts. Government was very supportive of this new concept. Local government was off the hook; no longer would hospitals look to local government for an annual contribution to supplement their budget. In effect, each DRG rate had built into it, on average, 7% to reimburse the hospitals for uncompensated care.

The Legislature should bear in mind that group health insurance programs for employees, and in many cases dependents, are paid for by employers. Thus, business is of the opinion that, through their insurance carriers, they are the largest single source of hospital income. They pay the major cost of group health insurance premiums.

Cost Shifts to Business

One of the results of the new DRG system was to shift the responsibility for a large portion of indigent care from local government to business. Business did not fully understand the new system and did not voice unified opposition.

In the early days of the new system there were a number of complaints from business about excessive charges. But, as the system gained experience and adjustments were made, business objections subsided. Business, as a whole, accepted this social (welfare) responsibility as a corporate responsibility.

Corporate Assessment

Businesses that can afford the employee staff or consultants for health care cost-containment purposes have found the DRG system to be workable. Businesses and hospitals are better able to resolve their disagreements over charges, and other issues.

It appears that the DRG system created economic incentives for hospitals to encourage efficiency and contain health care expenditures. The system has, in the opinion of business, enabled hospitals to become efficient managers of their resources. Hospitals in New Jersey are in a stronger position to monitor and direct physician resources to contain treatment costs.

It should be noted that hospital per diem costs today are below the national average, but they were also below the national average prior to the DRG system being operative.

Conclusion

NJBIA would like to urge the Legislature not to embrace the concept of shifting a social or taxpayer responsibility for indigent care over to the private-business sector by "add-ons" to the DRG rate. This concept is incorporated in a Senate bill, which may be considered shortly by this committee.

NJHA NEW JERSEY HOSPITAL ASSOCIATION

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Princeton, New Jersey 08543-0001

Louis P. Scibetta FACHE
President

TESTIMONY OF CRAIG A. BECKER

VICE PRESIDENT FOR GOVERNMENT RELATIONS

NEW JERSEY HOSPITAL ASSOCIATION

BEFORE THE

ASSEMBLY HEALTH AND HUMAN RESOURCES COMMITTEE

22x

TRENTON, NEW JERSEY

JULY 14, 1986

Good day, I am Craig Becker, Vice President for Government Relations for New Jersey Hospital Association. Thank you for the opportunity to address the Committee on the Harvard/MIT study on "The Lessons of the New Jersey DRG Payment System."

Let me begin by expressing our appreciation to the authors of the report for pointing out that New Jersey's unique all-payer system has not only been effective in holding down costs significantly below national and regional rates, but it has been singularly effective in paying of uncompensated care. Nowhere in the nation will you find as comprehensive and successful a system as ours in providing access to care for all, regardless of their ability to pay.

We also applaud the report for indirectly taking the Federal Government to task for not paying their fair share of uncompensated care. Medicare, through the Prospective Payment System, has avoided its responsibility by dropping the uncompensated care problem squarely on the States, hospitals and payers. Some states do a better job than others in providing access to care for all, but none do it as well as New Jersey.

There are several other points raised by the report which we find significant. We wholeheartedly concur with the Report's findings when it noted:

1. Administrators do not view their hospitals as businesses per se with product lines. The DRG system was not viewed by the Administrators as a tool to manage this business.

2. Administrators responded to budget restraints not by persuading physicians to become "more resource conscious," but rather by cutting non-patient care areas, such as adminisstrative overhead, inventories and even refinancing of high priced debt.

3. Administrators found cost savings through doing most of the preadmission testing on an outpaitent basis. In addition, outpatient surgery has become an accepted and effective way of reducing admissions and overall costs.

4. Administrators do not use DRGs as a tool to pressure physicians to change their practice patterns. Hospitals recognize physicians as primarily their customers. Basically ,hospitals provide the workshop for the physician and, as a result, have little control over the practice of medicine.

5. Clinical services were given highest priority and were the <u>last areas to suffer cuts</u>. Administrators were primarily concerned with maintaining quality care and took budget restraints out of other departments.

Addressing the last issue, that of quality care, New Jersey hospitals are working hard to assure that patient care is still the number one concern. However, because of recent cutbacks by the Federal Government, tied in with restraints put in on hospital revenues by the State for the last decade, it is getting more difficult to ensure that quality of care is not affected. We cannot restrict hospital revenues without expecting levels of treatment to suffer.

In conclusion, there can be no doubt that the DRG system coupled with Charpter 83, the all-payer system, has held New Jersey's hospital costs down as compared with the rest of the nation and the region. For the five year period ending in 1984, New Jersey ranked 48th out of 50 states in rate of increase in hospital costs. In 1984, New Jersey patients paid $338 less per hospital visit than the average acute care patient paid nationwide. By accepting the DRG all payer system, hospitals have been assured of fiscal solvency, including payment for uncompensated care.

To date, as the report notes, hospitals have cut from ancillary services in order to meet the budget demands of this system. If the State and Federal Government continue to severely restrict hospitals' inflation factors, then services to patients and quality care will suffer. As an industry, we are determined to maintain our 24-hour-a-day, seven-days-a-week service to the residents of New Jersey. We must be extremely careful that we don't cut so deep as to cripple our state's health care delivery system.

OUTLINE OF TESTIMONY BY KENNETH J. RUBIN, M.D.

July 14, 1986

A. President-Elect, New Jersey Psychiatric Association;

B. Member, General Hospital Psychiatry Committee, New Jersey Psychiatric Association;

C. Attending, Monmouth Medical Center, Long Branch, New Jersey;

D. Medical Director, Inpatient Psychiatric Unit, Monmouth Medical Center, Long Branch, New Jersey;

E. Chairman, Psychiatric Quality Assurance Committee, Monmouth Medical Center, Long Branch, NJ;

F. Private Practice, Long Branch, NJ.

I. THE CLINICAL TREATMENT OF CONDITIONS IS COMPROMISED BY THE LENGTH OF STAY REQUIREMENT AND CONSTRAINTS.

II. DRG'S ARE DISCRIMINATORY AGAINST THE MENTALLY ILL BECAUSE COMORBID CONDITIONS ARE NOT INCLUDED IN REIMBURSEMENT AND DO NOT INCREASE REIMBURSEMENT TO THE HOSPITALS.

III. MALPRACTICE HAS BEEN MANDATED WITH INADEQUATE LENGTH OF STAY FOR AN ADEQUATE TREATMENT IN THE VARIETY OF MENTAL ILLNESSES.

IV. THE DRG'S ARE NOT INDICATIVE OF INTENSITY OF TREATMENT REQUIRED OR THE ALLOCATION OF RESOURCES NEEDED TO TREAT THE THE PATIENT.

V. THE DRG'S ARE A REIMBURSEMENT MECHANISM THAT IS HIDDEN IN MEDICAL TERMINOLOGY.

VI. THE DRG'S FOR PSYCHIATRIC DIAGNOSES DO NOT HAVE LENGTH OF STAYS WHICH APPROXIMATE A NORMAL CURVE WHICH IS WHAT THE DRG'S ARE PREDICATED UPON.

VII. THE DRG'S ARE NOT APPLIED TO ALL OR MOST PSYCHIATRIC PROVIDERS AS HAS BEEN DONE WITH MEDICAL-SURGICAL ILLNESSES SO THEY FAVOR THE USE OF PRIVATE, FREESTANDING HOSPITALS FOR PROFIT OR NOT FOR PROFIT.

Testimony of the New Jersey Psychiatric Association General Hospital Committee, ~~June 5, 1985~~ 7/14/86, William R. Nadel, M.D.

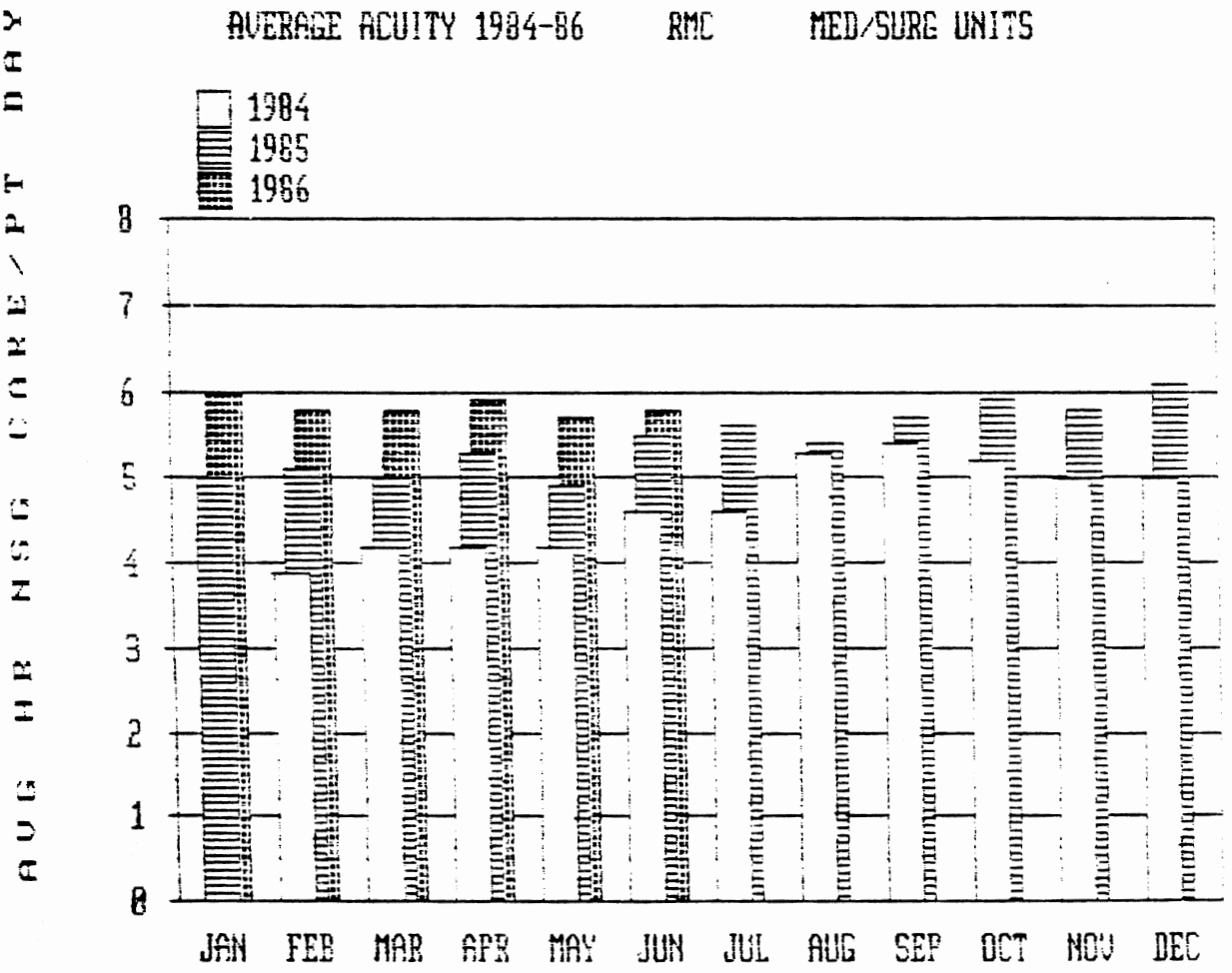
Solutions for the deleterious effects of the New Jersey DRG reimbursement system on the mentally ill and services to them:

1. Exclude services rendered to psychiatric patients in general hospital psychiatric units until the methodology can be developed which adequately deals with these diagnoses.
   a) the present system discriminates against patients with a primary diagnosis of a mental illness and is not only inequitable but probably unconstitutional.
   b) the Federal government in it's Medicare DRG reimbursement system has excluded psychiatric units in general hospitals until a methodology can be developed to handle the psychiatric diagnoses and treatment within the DRG reimbursement system, acknowledging that this is not the case at present.
   c) patients with psychiatric diagnoses at some hospitals are reimbursed under the DRG system and in other hospitals under the Share system so that in psychiatry the system is inequitable to patients and hospitals depending on where they happen to be located.
2. Extend a modified DRG reimbursement system to all psychiatric units or hospitals treating mentally ill patients excluding Federal, State or County sponsored units or hospitals unless they elect to be included in this reimbursement system.
   a) this system would treat patients and hospitals in all parts of the state equitably without regard to accidents of location or socio-economic status.
   b) modifications should include:
      1. reimbursement acknowledgement of co-morbid conditions, both medical and psychiatric.
      2. reimbursement should make allowance for stay on medical/surgical units which may be necessitated by the psychiatric illness i.e. time in an intensive care unit

or cardiac telemetry unit following suicide attempts which may result in lacerations, fractures or overdoses with serious medical/surgical sequelae.

3. chronicity of illness must also be taken into account as typically those with chronic illness require more time than others with the same diagnosis when the illness is not chronic.
4. number of prior hospitalizations and/or duration of hospitalizations must be taken into account. Some people do not benefit from repeated brief hospitalizations and require a longer length of stay, having demonstrated the inadequacy of brief hospitalization for them.
5. severity of functional disability DSM IV
6. severity of psychosocial stressors and sufficiency of family and other support systems. DSM IV

9, negotiated daily rate - c C.B.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