PUBLIC HEARING

before

ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

on

DRG HOSPITAL REIMBURSEMENT SYSTEM AND STATE WAIVER FOR MEDICARE

VOLUME II

Held:
December 20, 1984
Perth Amboy City Hall
Perth Amboy, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman George J. Otlowski, Chairman
Assemblyman Paul Cuprowski

ALSO PRESENT:

David Price, Research Associate
Office of Legislative Services
Aide, Assembly Corrections, Health
and Human Services Committee

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ASSEMBLYMAN GEORGE J. OTLOWSKI (Chairman): We are now going to call this hearing to order. Mr. Price, the absentees include Assemblyman Visotcky, Assemblyman Haytaian, and Assemblyman Felice, although Mr. Felice indicated that he was going to be here. Seated on my right is Assemblyman Paul Cuprowski. This hearing is one of a series of hearings to be held. The next hearing will be held in Jersey City next Friday, December 28, at the County Administration Building. It will start at 10:30 a.m.

Now, before we start, I just want to point out that the purpose of this hearing is to examine the DRG system of hospital rate setting in New Jersey, and the various questions related to the future of the system and the future of our State's hospital system. The hearing will run the whole gamut to determine if there are changes we have to make, if the system is working, and how well it is working; also, if it is not working, why it isn't working and what kind of substitutes there should be. The hearing, of course, is a very broad hearing, and it may or may not result in legislation. It all depends on what is brought out. The record will be reviewed by the Committee. Undoubtedly, the Committee will then make suggestions. In the meantime, the staff will meet with anyone who has any particular suggestions. The staff will also review the record before it comes to the Committee, so they can make recommendations to the Committee based upon the record.

How will the hospitals cope if the State does not receive a new waiver? This is one of the problems. As a matter of fact, it could be a very costly problem, because the costs would immediately shift to the homeowners and to the counties, the way it was operated before. This is unthinkable and unbearable. As a matter of fact, I am sure the Legislature would never tolerate that.

We are talking, too, about a $3 billion industry that services seven and a half million people. So, we're talking about a great program here with many, many ramifications. I just wanted to make these things known. The Committee has no fixed ideas; we have a completely open mind, and we want everyone to be aware of that.

We have also pointed out at these hearings that if you have written testimony, we want eight copies. Also, if you have written testimony and you submit the eight copies, we usually do not have that read, since the contents of the testimony become a part of the record, and that is sufficient. I wanted to make that generally known. If someone has a written statement and wants to summarize that written statement, he or she will be permitted to do so. Or, a Committee member may have a question he wants to ask you about your written statement. So, that is the nature of the hearing and that is the way it is going to be held.

First we are going to hear Deputy Commissioner Charles Pierce, Jr. of the New Jersey Department of Health. Is he here?

FROM AUDIENCE: He's downstairs on the phone.

ASSEMBLYMAN OTLOWSKI: He's downstairs on the phone, okay. Then we are going to hear from Jean R. Marshall, First Vice President, New Jersey State Nurses Association. Ms. Marshall, do you have copies of your written statement?

JEAN R. MARSHALL, R.N.: Yes, I do. Good morning, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: Good morning. Ms. Marshall, will you please give us your name and the organization you represent for the record?

MS. MARSHALL: We will shorten our statement.

ASSEMBLYMAN OTLOWSKI: No, what I want you to do-- You've submitted the written statement. For the purpose of this hearing, just summarize, please. All right?

MS. MARSHALL: Fine. Chairman Otlowski, am Jean Marshall; I am First Vice President of the New Jersey State Nurses Association. I am an Enterostomal Therapist; also, I am a graduate of Perth Amboy General Hospital School of Nursing, and I did want to say that.

I am speaking on behalf of the 6,000-member Association. We appreciate the opportunity to present this testimony on New Jersey's hospital payment system, the DRGs. To my right is Barbara Wright, our Executive Director.

NJSNA has closly monitored the State's DRG system. As an association, we actively participate as members of the Commissioner of

Health's Nursing Advisory Committee. In addition, we comment regularly at public meetings of the Health Care Administration Board and the Hospital Rate Setting Commission.

Further, our knowledge has been greatly enhanced through our members who are staff nurses and managers. They are integral players in the system seven days a week, 24 hours a day. As the largest nurses' union in the State, many of the contracts we negotiate are impacted by the DRG payment system.

My comments, which I will shorten, will address the DRG system in general and its impact on nursing in particular.

NJSNA strongly endorses the continuation of a prospective rate-setting system which includes all payers and provides for uncompensated/charity care. We recognize that these elements are hallmarks of S-446, and we support their continuation. Therefore, we support the Department of Health's waiver application for a three-year extension.

We have all witnessed the success New Jersey's rate-setting and reimbursement methodology have had on reducing hospital costs and placing us among the least costly states in the nation. Nevertheless, we know that the ways in which we as health professionals practice may have a greater impact on health care cost containment than addressing hospital costs alone.

For example, variations in health care practices create patient volume and can also increase the complexity of DRGs. Therefore, the addition of surgery in a DRG computation increases its costliness. Exercising the option for hospital versus ambulatory care for a patient increases costs. Many of these costs will be controlled by third-party payers through such measures as requiring a second physician's opinion, or introducing a co-payment or deductible for hospital care where there are community alternatives. Since variations in practice do not necessarily yield better patient outcomes, monitoring practice patterns through peer review mechanisms with a cost efficiency dimension become a social necessity for professionals.

ASSEMBLYMAN OTLOWSKI: Would you do me a favor, Ms. Marshall, because we have your whole statement, would you please go to your summary on the last page?

MS. MARSHALL: Right. In summary, the New Jersey State Nurses Association supports the Diagnostic Related Groups methodology for prospective determination of hospital costs. We appeal to the Legislature to hold firm in its convictions and to the communities of interest to be supportive through this inevitable and predictable period of development and refinement. We have created an approach which is pace-setting, better, and promises to become more perfect with time and perseverance.

Thank you for the opportunity.

ASSEMBLYMAN OTLOWSKI: Thank you very much. Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: I don't have any questions at this point, Assemblyman Otlowski, but I certainly appreciate the Nurses Association being represented here to give their opinion. I think it is important that we know the opinions of doctors, nurses, and administrators. Thank you very much.

ASSEMBLYMAN OTLOWSKI: Your Association represents 6,000 nurses throughout the State?

MS. MARSHALL: Yes, throughout the State of New Jersey. Also, I am on the Cabinet on Nursing Practice for the American Nurses Association, which has 220,000 members.

ASSEMBLYMAN OTLOWSKI: Are most of your nurses part of the whole hospital system of the State of New Jersey? Are you representing most of the hospitals in the State?

MS. MARSHALL: Oh, yes, we have members in the State community.

BARBARA WRIGHT: May I respond, Assemblyman Otlowski?

ASSEMBLYMAN OTLOWSKI: Would you tell us who you are, please?

MS. WRIGHT: My name is Barbara Wright; I am the Executive Director. I think your question might have been directed to our collective bargaining activity. We do not represent all of the hospitals in the State of New Jersey. There are very few nurses who are under contract in this State, either in acute care or in other kinds of health care facilities. We are the largest nurses union in New Jersey, and we do represent nurses in a number of hospitals in the State. However, many nurses are not under contract.

ASSEMBLYMAN OTLOWSKI: But, geographically, are you--

MS. WRIGHT: (interrupting) Our Association represents from Sussex County to Cape May, from Middlesex County to Hunterdon County. May I make a comment, Assemblyman Otlowski?

ASSEMBLYMAN OTLOWSKI: Surely.

MS. WRIGHT: I think one of the things Ms. Marshall did not have an opportunity to highlight, but which we think is particularly different from some of the testimony which will come before you -- and I know you will see when you have a chance to read our testimony -- is the whole focus of nursing as a cost center in hospital rate setting. Nurses' charges have been lumped into the patients' bills. For that reason it has been extremely difficult to determine what the cost of nursing is. Nursing often subsidizes other kinds of hospital costs. We think the work that has been done in New Jersey, and it has been done with regard to this -- the DRG waiver -- as part of the research-- A nursing allocation statistic has been researched and is being developed. We will probably be one of the first states in the country to develop it at this level. We think this allocation statistic will tell us a great deal about having nursing resources applied based on patient need. We think strongly that a patient with a hernia repair may need less care than a patient with a myocardial infarction.

ASSEMBLYMAN OTLOWSKI: Are you saying that the nurses' services are a part of the bill?

MS. WRIGHT: They are part of the bill, but up until this point they have been part of the room and board charges. So, when you look at a patient's bill and the room and board charges, you cannot determine professional nursing practice needs. They are lumped into that. One of the things the project did when--

ASSEMBLYMAN OTLOWSKI: (interrupting) What would you do differently?

MS. WRIGHT: Well, what we are trying to do is work with the Department of Health in measuring these nursing costs, to separate the costs out. As you move toward cost containment, the more you can identify each of the cost centers.

ASSEMBLYMAN OTLOWSKI: Are you suggesting methods?

MS. WRIGHT: Yes. We're saying in our testimony that one of the methods that was researched as part of the HCFA waiver-- There was a half a million dollars as part of the grant from the late 1970s, in which New Jersey led the country in looking at nursing costs. We continue to lead the country in this area. Two states have gotten ahead of us. The State of Maine has already legislated nursing costs on patients' bills. We are not sure that is the way we would go, but we do know that the State of Maine is moving in that direction as of July, 1985. In Connecticut, St. Raphael's Hospital has nursing on patients' bills, as does Phoenix, Arizona. This is not a legislative issue.

ASSEMBLYMAN OTLOWSKI: The State of Connecticut shows the cost of nursing on the bill?

MS. WRIGHT: Yes, on a patient's bill. We are not saying that is the way we want to go. We don't know that the patient bill is important. The real issue we studied in New Jersey was trying to separate nursing costs from room and board charges.

ASSEMBLYMAN OTLOWSKI: In your written testimony, do you show how it works in Connecticut?

MS. WRIGHT: No, we don't know how it works. It has just been initiated and reported in the literature. What we do--

ASSEMBLYMAN OTLOWSKI: (interrupting) Could we have an additional memorandum from you to show us how it works in Connecticut?

MS. WRIGHT: Surely. In addition to that, we will give you information on how it works in New Jersey. We kept our comments very general here just because we wanted to alert you to this issue. We think it is an important one.

ASSEMBLYMAN OTLOWSKI: In an addendum to your written testimony, will you cover both of those aspects -- how it is done in Connecticut and how the nursing costs are shown there, and how it is done in New Jersey? Will you give us that?

MS. WRIGHT: We are evolving a method in New Jersey, but we will update you on where we are in that. I think Assemblyman Cuprowski wanted to ask something.

ASSEMBLYMAN CUPROWSKI: Mr. Chairman, through you, just before you leave, since the subject has been brought up, are you referring to the relative intensity measures?

MS. WRIGHT: The relative intensity measure of nursing resource use. We call them RIMs.

ASSEMBLYMAN CUPROWSKI: Am I correct in understanding that there are no conclusive studies throughout the United States at this point relative to RIMs?

MS. WRIGHT: We have developed the most comprehensive work that has been done on this so far in New Jersey. We know that there are some other parts of the country-- At Yale, New Haven, where John Thompson is working -- and he developed the DRG -- they are taking some of the tools we developed in New Jersey and moving on with them. So, there is no state we know of that is more advanced. We see some of them taking our materials and running with them, so I am not saying we are going to be the first to really implement the system. St. Luke's in Phoenix is another place where the work was done.

ASSEMBLYMAN CUPROWSKI: Thank you.

MS. WRIGHT: Assemblyman Otlowski, there is one other point we think is extremely critical to bring to your attention. The nursing salaries in New Jersey, as they were established in the DRG rate-- As we studied this issue very comprehensively, we found that they are built on a very inadequate revenue base. Regarding the certified revenue year on which the DRG was struck originally, we believe at that time that nursing salaries were inappropriately low. We just need to let the Legislature know that we continue to find this a serious problem in the State when attempting to adequately not only recruit, but to meet the needs of patients on intense patient care.

ASSEMBLYMAN OTLOWSKI: Let us have your supplementary statement so we will get the benefit of what you are saying.

MS. WRIGHT: Okay, that is a different issue. The nursing salary is our other point.

ASSEMBLYMAN OTLOWSKI: Right, but that is for another forum, another day. Okay?

MS. WRIGHT: Good. Thank you very much. We appreciate the opportunity.

ASSEMBLYMAN OTLOWSKI: Thank you very much. May we have Mr. Charles Pierce, Deputy Commissioner of the New Jersey Department of Health? Commissioner, do you want to identify yourself for the purpose of the record, please?

DEPUTY COMMISSIONER CHARLES PIERCE, JR.: Certainly. Thank you, Assemblyman Otlowski. I am Charles Pierce, Deputy Commissioner of the New Jersey Department of Health. On my right is Ted Seamans, my associate in the Department. Mr. Seamans is going to be able to stay on throughout the hearing. If questions are raised by other panel members, he will be able to provide additional information.

ASSEMBLYMAN OTLOWSKI: That's Mr. Seamans?

DEPUTY COMMISSIONER PIERCE: Correct.

ASSEMBLYMAN OTLOWSKI: Do you have a written statement?

DEPUTY COMMISSIONER PIERCE: I do not have a written statement.

ASSEMBLYMAN OTLOWSKI: Oh, that's great. Why don't you just develop your position briefly, and if we have any questions we will direct them to you. Then Mr. Seamans is going to remain so we can talk to him toward the conclusion of the hearing to see if there is anything that has to be cleared up or if we have any questions to be answered.

DEPUTY COMMISSIONER PIERCE: Yes, Mr. Seamans will stay on. I really wanted just to spend a short amount of time with you to bring you up to date on the negotiations on the waiver, which I thought was of greatest interest to you.

I understand there is an article in this morning's New York Times which reports that President Reagan has agreed to continue the New Jersey waiver despite some reservations by some Federal officials, and that there will be firm monitoring conditions appended to our waiver approval.

ASSEMBLYMAN OTLOWSKI: Incidentally, in that connection, I have received informal word that the Federal government has approved the waiver.

DEPUTY COMMISSIONER PIERCE: That is at about the level where we are, as well.

ASSEMBLYMAN OTLOWSKI: That is informal; there is supposed to be a confirmation communication.

DEPUTY COMMISSIONER PIERCE: We have not received it as yet. What I want to share with you is kind of the outcome and the flavor of the discussion which was held last week between the Governor and Secretary Heckler. I accompanied the Governor, along with several others. I want to tell you first that in terms of the waiver itself, not a single red flag was put up. That is the reason the Governor was so optimistic as a result of the particular session, and why we think we will get an approval. The point that was raised over and over again by the Federal officials was that they want assurances from New Jersey that we will be able to respond to any downward change that they will make in PPS. That is what they call their Medicare prospective payment system. They have every intention of what they call "recalibrating" the rates, making them lower. There are nationwide reports of drops in admissions. They think that this should qualify for a reduction in the payment system.

I think that addresses a point which you are going to hear later today about how much New Jersey would have received under the Medicare waiver, but I believe that in reality those were projections based on an assumption that there would be no change. That is not a valid assumption in the health care field at all.

I want to tell you our thinking. What we have told the Federal officials verbally in terms of how we can respond is, one, if you make a change in your rates, what we will do is immediately model. We will forecast what kind of an impact that would make on New Jersey. Our assumption is that initially any changes they may make will probably have a minimal impact, but if at some point out in the future our savings are down here and their payments are up there, and they start to come down and we feel we are getting dangerously close, we will then propose a set of regulations to our Health Care Administration Board. Then we will model those out and take what we feel is the appropriate action on the regulations. The way they change is not necessarily, and probably not likely to be, the same way that we would change. They will probably do something very broad; there is an economic factor. They said, "Suppose we reduce the economic factor 2%, what would you do?" We made a quick calculation; that is a $60 million

impact on New Jersey. Our savings are probably still below that. We would do nothing, and I think that is one of the benefits of our system. We are able to work with these resources as they best fit New Jersey, not having to respond to all that is going on nationally.

The second point we reminded the Federal officials about was that the 1985 rates are all set. When they are talking about changes -- although certainly Congress could change this -- they are really talking about what is going to happen in 1986 and 1987. We feel there is plenty of time to take corrective action if it is necessary.

The other point we are going to try to develop is, on the hospital reconciliation-- At the end of the year, we reconcile hospitals' actual experience, because we give rates on the assumption that their volume number of patients is going to be "X" or "Y," whatever they have submitted. If that is changed, there is a change in the rate at the end of the year which flows into the following year. We are going to try to do that on a much more frequent basis, semiannually or, if possible, on a quarterly basis. That will keep everybody up to speed and will prevent a kind of unhealthy lag which we have allowed to creep into the system due to limited resources.

I would like to shift and tell you they have told us there are two technical problems. That doesn't sound bad, but when you're talking about a $3 billion industry, a technical problem could eventually become a major problem. One is conformance with the State Medicaid plan. Commissioner Albanese and his staff have worked very closely with us. We feel that there is no problem. However, what it means is, we are dealing with an entirely different division in the Federal government. There is probably going to be a time lag while we bring them on board to understand how our system sets the rates for all payers, including Medicaid. We do not believe, other than timing, that that presents any problem at all.

We feel that the other technical problem is largely the Federal government catching up with us We filed a waiver and it is for both outpatient and inpatient. When they were midway into their negotiation, they said, "We want you to separate inpatient and outpatient. At the moment, we are only going to talk about the big

dollars on the inpatient side." Formally, on Monday, we submitted an outpatient waiver. We believe we are even going to save money there because we control the charges a hospital places on its patients on the outpatient side. Medicare does not. They are still under their old system of whatever is customary and usual, which can be highly inflationary.

This was one of the critical points that the Governor made in his presentation to Secretary Heckler. He said that the two are interlocked, because if you don't have the two, an inner-city hospital that has an emergency patient knows it is not going to get uncompensated care if it stays on the outpatient side, and now has an incentive to admit the patient. That is not the kind of incentive we want.

In addition, I think there is some potential danger for the Medicare patient who would now be subject to uncontrolled charges if we did not have the ability to control the outpatient charges. Verbally they said, "We understand and we are sympathetic with that," but that remains a technical problem that has not yet been resolved.

I have just one final point. I think we are always going to have a difference of opinion with the Federal officials. Essentially, I perceive them as seeing themselves as running an insurance program. They are concerned for their beneficiaries; they are also concerned about the Hospital Trust Fund. These are their two main concerns: How do we protect our dollars and how do we protect our beneficiaries? Our system in New Jersey, as you have just heard -- and, as I know you all know very well -- is a hospital rate-setting system. We are concerned about efficiency in the hospitals; we are concerned that an efficient hospital be financially solvent; we are concerned with uncompensated care; and, we are concerned with equity among all payers. Those are a lot of issues which the Federal government, under its mandate, is just not concerned about. That is why we are going to have a difference of view from now on.

That ends my update on the status of the waiver.

ASSEMBLYMAN OTLOWSKI: Thank you. As this thing with the Federal government develops, and as you are working out some of these

technical differences you're talking about, when you have something substantial, will you let us know so we can get you back again for the record?

DEPUTY COMMISSIONER PIERCE: Absolutely.

ASSEMBLYMAN OTLOWSKI: Would you do that, please?

DEPUTY COMMISSIONER PIERCE: Yes. I will make sure that Ted Seamans stays in touch with Dave Price and that we relay whatever finally comes down as quickly as we can.

ASSEMBLYMAN OTLOWSKI: Good. Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Mr. Pierce, I certainly appreciate the Department of Health being represented here to give us an update. I think that is very commendable of the Department.

I have one specific question. In view of the reports, and the newspaper articles this morning especially, does that mean that the expected waiver approval only applies to inpatients? What happens to the inpatient study, if you will? Is that going to be held in abeyance?

ASSEMBLYMAN OTLOWSKI: You mean the outpatient.

ASSEMBLYMAN CUPROWSKI: Yes, the outpatient.

DEPUTY COMMISSIONER PIERCE: The way the approval would come through right now is only for the inpatient, which is the big dollar side. It will not say, "You are approved for the outpatient."

ASSEMBLYMAN CUPROWSKI: Okay, so the outpatient is going to be--

DEPUTY COMMISSIONER PIERCE: (interrupting) That is why there is going to be a delay on that. Actually what we did was, we essentially took the information that was in the original document, extracted it, and put it into a separate document. So, they really don't have new material to review. I think they may have wanted to do that just for their own purposes. However, they really don't have new additional information. It was all filed originally.

ASSEMBLYMAN CUPROWSKI: Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much. Mr. Seamans, you are going to stay around?

MR. SEAMANS: I will remain, yes sir.

ASSEMBLYMAN OTLOWSKI: Thank you again.

DEPUTY COMMISSIONER PIERCE: Thank you very much, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: Dr. Frank Primich? Doctor, we have your written statement. Would you like to comment additionally on that?

FRANK J. PRIMICH, M.D.: Yes, I would like to comment on quite a few things. First and foremost -- since we talked with the nurses in numbers -- I am here as more than an individual. I am here representing 9,000 physicians, the members of the Medical Society of New Jersey. Physicians' notoriously organized medicine never seems to be able to agree on much of anything. One of the few things we have had any unanimity on in New Jersey has been our final conclusion that DRGs are not a good system. The policy of the Medical Society of New Jersey is that we disapprove of the concept, and that we are pledged to lead the fight against the continuation or extension of this program. I think it is important to understand that this is not just me. I am the spokesperson, for now, trying to get across why we feel this way.

Unfortunately, had our position been publicized three weeks ago at the original hearing, perhaps the outcome might not have been the same. This, again, has been painted by everyone as something desperately needed in New Jersey. It almost seems pointless right now for me to give you what I had proposed. I sat through the original hearing. I listened to you asking very intelligent questions and getting deflections and non-answers to them, questions as to what the prerogatives were, was there an alternate approach to this should the waiver be lost -- all of this. There were many things which could have been suggested. Lou Scibetta from the New Jersey Hospital Association, in his written testimony, gave you two or three things. In my statement, there are a number of things. But, what is most important to me is that we are going along here proclaiming this wonderful system, which I personally predict will result in the destruction of the best health care system this country -- or the world -- has ever known. Foolishly, because it has this label hung on it about New Jersey, it is sort of like we have to take pride in it. Well, we have a few things in New Jersey that we are not particularly proud of, and

normally we try to avoid them. We have a lot of things in New Jersey that justify pride, and I think that one of them, hopefully, is that our legislative bodies are able to look at both sides of a situation and then, with the necessary information, make some intelligent judgments as to where we are and where we are going.

Originally, the hearing was supposed to be to evaluate the DRGs. There are a number of things here that are constantly misquoted.

ASSEMBLYMAN OTLOWSKI: Doctor, wait just a moment.

DR. PRIMICH: Yes, sir.

ASSEMBLYMAN OTLOWSKI: That is the purpose of this hearing. There will be many hearings before we take a position. As a matter of fact, this is the second hearing in the series. There may be three more hearings after this. When we have concluded all the hearings, we will then review the record and will make a judgment. We will then determine whether legislation will be passed. So, the fact of the matter is, nothing is permanent. Nothing is permanent; only God in his heaven is permanent. Everything else changes daily. There is nothing that is cast in stone here.

DR. PRIMICH: I know that, but the point I am trying to make is, had this been openly and adequately discussed three weeks ago, the current course, which apparently is already accomplished-- I scanned The New York Times in a hurry this morning because I didn't know how long it was going to take me to get down here. I missed the article -- wherever it was stashed away -- that supposedly the waiver has been cleared. I fully expected that from the way things were proceeding, because of the fact that what was presented to the people in Washington was essentially a one-sided thing. We had a big problem, we wanted this, and we needed it.

ASSEMBLYMAN OTLOWSKI: Excuse me, doctor, just so that the record is clear. I think what the Governor wanted to do there -- and he has undoubtedly accomplished it -- was to get the waiver extended until we could come up with some kind of a system that would be better, or that would equal this system. As I said, nothing is cast in stone. Frankly, I want to commend the Governor. I think he was wise in doing this because if this thing had collapsed, the cost would have shifted immediately to the counties, as I have outlined.

The purpose of this hearing is to look at this question from a very broad perspective. Now, obviously you feel that it doesn't work. That is going to be considered. As a matter of fact, what I would suggest-- The record is open; your written testimony will be in there. If you have additional facts to show that this is not suitable, this doesn't work, this is no good for New Jersey, this is no good for the doctors, this is no good for the people, let's get it in the record.

DR. PRIMICH: Fine. What I am trying to explain, and I find it very difficult-- I have been known to blow my whole approach to things when I try over and over and over again to state a case with examples, and with everything else, and someone doesn't listen. I have pledged that I will try to remain calm; I will try one more time. I have spent five years on this, sir.

ASSEMBLYMAN OTLOWSKI: Doctor, if the record is going to be lucid, I suggest that you remain calm and get what you want to say into the record.

DR. PRIMICH: If I may. There is no logic to your presumption that this would be shifted to the counties. That is one way to pay for it; however, there are many other ways. Apparently we have money floating around in New Jersey that the Legislature hasn't been able to figure out what to do with. The surplus is from the Casino Fund and the State budget itself. These moneys could be used to shore up any shortfall in this thing temporarily while adequate and proper methods are figured out on how to get out of this system.

You heard the nurses here a little while ago. They are concerned about what is happening to nursing care. I think I am more concerned than they are, because they seem to think this is a wonderful system if only you can program higher pay for nurses into it. What is happening in this system is that since there are forced economies, there are tremendous costs simply for the regulations, the people who have to do the bookkeeping, and so on. When you add these costs to a hospital budget, you have to take something away. What is being taken away, in my eyes, is nursing care. We are losing nurses through attrition who aren't rehired. In a few cases, I have actually heard of

them being fired for economic reasons. But, with that, you get into the whole element of the cost of hospital supplies -- medications and devices that are used. In the interest of economy, things that are cheaper, and as is usually stated "almost as good"-- Now, anything that is almost as good as something else, to me, rather simply represents a diminished quality.

We have heard all sorts of stories from the Department of Health about their check into the quality of care. Believe me when I tell you that up until this point it has been all but nonexistent. There was one study done that did not answer any of the questions it was designed to answer, and it was passed off to the public as a reassurance that the medical community's concerns were absolutely without foundation. Now, the Commissioner of Health and I have gone round and round with this. He constantly says, "Show me one documented case." Everytime I give him one documented case, he says, "But, that is one in seven million; that has no significance." It is extremely difficult to document a case where a patient has been given inadequate and inappropriate care. This sets up a whole structure for a legal case where you need absolute evidence. It is just not within the realm of most people outside the judiciary to be able to get the documentation. However, the reality is there. People are aware of what is happening.

My big hope was that if we did not get the waiver -- all right? -- then we would make an adjustment to the financial problem for the moment, and would then, once and for all, admit that the New Jersey DRG system has been artificially proclaimed a great success. According to the Department of Health, we have saved HCFA money. According to HCFA, we have cost HCFA money. Who are we to believe? We have asked and asked for appropriate figures. We have never gotten them. We have gotten comparisons of apples and oranges. The rate of increase in New Jersey was less than in other states. New Jersey, before this system was introduced, was forty-eighth on that list because of prior regulations. So, when you compare that-- We asked for comparisons in the beginning part of this program, when only a few hospitals were on DRGs, comparing the DRG hospitals with those which were not on DRGs.

It is my contention that the hospitals in New Jersey which weren't on DRGs did better. Their rate of increase was less than those which were on DRGs. The argument on their side of it is, "Well, if we ever got those figures out in the open, they probably would show that, but those are supposedly start-up costs." We constantly have start-up costs, but we never catch up to the start-up costs.

So, there is a lot to be wished for that if, number one, we didn't get the waiver, and number two, New Jersey denied that DRGs were the greatest thing since sliced bread. This would cut the very foundation out from under the Federal program, which has nothing to recommend it except the false claims of success in New Jersey. So, perhaps then everyone could go back to a rational way of trying to solve the problem. What happened basically in the Medicare Trust Fund was that more was promised. In other words, it was an open-ended thing where everyone would have the highest quality health care. It is impossible to fund that volume and that quality of care. Literally and actuarially you cannot do it. Therefore, it was a false promise.

If we once have some honest acceptance of that fact, then we can go on. There are many, many factors that affect the cost of health care. It is not to be accomplished by simply putting a fixed amount, by saying, "This is what we will pay for such and such." One of the biggest misinterpretations of all is the concept that this system fosters efficiency. Ideally and theoretically, almost anything works out very nicely. This is what it should do. However, if you understand that what we are talking about is the bottom line, the dollar, there is no easier way to save money than by not giving the service which is bought. In other words, an inferior product at the same rate or remuneration is going to give you a very, very efficient operation. Technically, it can be done without illegal measures. It's immoral, it's indecent, it's unethical, but the assumption here is that the whole health care provision establishment is some type of a criminal group which is out to fleece the public, and the public must be protected by "big brother." Now, if that is true, you are giving them a license to steal. You're saying, "Here, all you need is a paper diagnosis." I can diagnose you or anyone else here as

having almost any-- The thing that comes through over and over again is that we are trying to alter a system without getting at the basic causes of the problem.

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me. In your written testimony, and in the testimony which you have just given, you've criticized the system, and I find no fault with that. However, you do not make any suggestions for an alternate system. I was hoping that since you say you represent the Medical Society, that they would have a plan which would be equal or better than the present plan.

DR. PRIMICH: Yes, sir, I do. It's in my written testimony.

ASSEMBLYMAN OTLOWSKI: The only thing I see here is the criticism you have of the present plan and some of the unacceptable things about the present plan. However, there is no plan submitted which shows an overall approach to this, shows how it would be financed, or shows how it would be operated. There is no such thing in your written statement.

DR. PRIMICH: Sir, that is for a very simple reason. To do this is extremely elaborate. I could dream up a number of things that I might think would be an improvement. However, what I am recommending, sir, is the system we already had, the share method of hospital reimbursement. It doesn't have to be explained. I certainly hope the people in the Department of Health know what it was. They were the ones who were running it. This is worse than that. So, a step in the right direction is a step-- If you are off track, if you are lost, it is nice to get back on the road and then figure out where you're going. It sounds simple when I say it fast, but literally what I am telling you is that what I recommended in that written testimony-- A number of times I made reference to the share system as the prior system which was effective in cost containment and so on. What is confused here is Chapter 83, which had a noble intention, and the DRGs, which are a stupid method of hospital reimbursement. Reference was made earlier to John Thompson, the man who created this thing. It was intended as a cost-accounting thing, not as a reimbursement. He was quoted as saying that what the government is doing with his system will screw it up. He didn't know quite how, but he was sure it would. And, I'm here to tell you he was absolutely right. They have screwed it up.

ASSEMBLYMAN OTLOWSKI: All right, good. Thank you very much, doctor. Assemblyman Cuprowski, do you have any questions?

ASSEMBLYMAN CUPROWSKI: I do have a couple of quick questions. The share system is a cost plus system. Is that correct?

DR. PRIMICH: The share system is basically a system of allowable costs. Now, this is another thing that is thrown around so loosely in the media, the concept that prior to governmental intervention there was some sort of a blank check. No hospital I ever knew, no doctor I ever knew got a blank check for anything. In other words, what you speak of as reasonable and allowable costs-- Under the share system, rates were negotiated basically for Blue Cross, which was the major insurer in the State, and from those rates that were established, rates were set for Medicare and Medicaid payments. Now, this could have been very easily accommodated to the all payer system and so on. Again, that system was based upon averages or past performance, or the expectancy of what the medical needs would be. This was to relatively simplify it. It accumulated all the costs it took to run a hospital, divided that by the anticipated number of so-called patient days, and came up with a per diem figure. This figure, in turn, was to be paid per day.

Now, that system had one horrible flaw in it for those who wanted to rip off the thing. All you had to do was keep people on the marginal end, when they were basically well enough to go home, for "X" number of additional days, and you would be paid full rates for those days. That is where, since the hospital industry fails to police itself, I, who hate regulation, conceed. Yes, you need regulators here. You need people to look at the end line on that per diem type of payment and disallow those days when there wasn't anything meaningful or necessary done for the patient. With just that much regulation, you could have contained that system and you would have had a simple system that worked. Instead, we have a system that has all sorts of discrepancies as. There is no individualization of this whatsoever to the patient.

ASSEMBLYMAN CUPROWSKI: Very quickly, has the New Jersey Medical Society done any studies, to your knowledge, as to the effects of DRGs?

DR. PRIMICH: The New Jersey Medical Society has repeatedly asked the Department of Health for the figures so we could do a study.

ASSEMBLYMAN CUPROWSKI: But, you haven't gotten them?

DR. PRIMICH: We never got the figures. We have asked them for evidence of what they have done. The important thing here is the question of the quality of care. Through the whole initial phase of this thing, all the stress was on utilization. They were looking for unnecessary utilization. In other words, nowhere was there anyone checking on patients who were discharged too soon. This little study they did on readmissions is an absolute joke to anyone who understands what the factors are. People who were discharged, if they were discharged inappropriately, would more than likely not let themselves be readmitted to the same hospital within seven days, if they could help it. If they happened to die before they got back in, that statistic was never mentioned anywhere. In other words, we have all of these gruesome possibilities. We have not accused anyone of doing this; we have raised the question that it is possible.

ASSEMBLYMAN OTLOWSKI: But, doctor, the question Assemblyman Cuprowski is asking is, does the New Jersey Medical Society have a position? Are they making any specific recommendations? That is the question he asked. We don't have anything from them on that in the record.

DR. PRIMICH: This has been stated repeatedly. I'm sure it is in my testimony. The position of the Medical Society of New Jersey is that we disapprove of the concept of DRGs and that we recommend--

ASSEMBLYMAN OTLOWSKI: (interrupting) That is the official position of the Medical Society of New Jersey?

DR. PRIMICH: Yes, that is the official position.

ASSEMBLYMAN OTLOWSKI: All right. Doctor, thank you very, very much. May we just go on because we have many, many people we want to hear from.

DR. PRIMICH: I'm sure you do. There are a number of things I wanted to address, but I thank you for the time you have given me to the extent possible. My beeper went off a little while ago. I am going to answer the phone, and if it isn't anything vital, I intend to

come back and sit through the rest of this hearing. I would like to offer you my expertise -- which I promise you is equal to that of anyone in the Department of Health -- should there be any adverse comments regarding the system and you want substantiation of the facts.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

DR. PRIMICH: Thank you.

ASSEMBLYMAN OTLOWSKI: Mr. Craig Becker wants to add to the testimony for the New Jersey Hospital Association. Mr. Becker, would you please identify yourself and your organization for the record? What date was your original testimony given?

CRAIG BECKER: It was at the last hearing; it was the testimony of my boss, Mr. Lou Scibetta, President of the Association.

ASSEMBLYMAN OTLOWSKI: Did he submit written testimony?

MR. BECKER: Yes, he did.

ASSEMBLYMAN OTLOWSKI: What did you want to add to that?

MR. BECKER: Primarily, I just wanted to let you know that the Association has been studying alternatives should we lose the waiver and, also, in terms of a long-term approach to the entire question, at least as far as the funding of indigent care is concerned. In a short-term should the waiver be lost, we believe that at least the moneys that would be lost, or would be maldistributed, could be taken care of through what we call a "Medicare carve-out." It would be just changing the rates and it would require some movement by the Rate Setting Commission. This would take care of the short-term problem; however, it would create another problem, in that in many of our high indigent care hospitals the rates would go sky-high, would be out of sight, and would not be competitive.

ASSEMBLYMAN OTLOWSKI: Who would bear that cost?

MR. BECKER: It would still be the hospitals. It is just a question--

ASSEMBLYMAN OTLOWSKI: (interrupting) But, the hospitals couldn't bear that cost because--

MR. BECKER: (interrupting) In the long run, no, they could not.

ASSEMBLYMAN OTLOWSKI: They would have to close their doors. They are not equipped to carry that kind of cost.

MR. BECKER: We feel they could do it for about six months, but that would be about the outward limit.

ASSEMBLYMAN OTLOWSKI: Where would you get the costs after the six months?

MR. BECKER: Well, the second aspect we are looking at is an indigent care pool which would basically take the moneys that are being maldistributed and put them into a pool that would be run either by the Department of Health or the Department of Human Services. Then, this money would be used to pay for all uncompensated care throughout the State. This would take care of the problem, at least the maldistribution, and the problem with the high rates for our inner-city or at least our high indigent care hospitals.

Again, we have just been looking at it in terms of concepts. I have given Ms. Simon some preliminary information that we have been looking at. It is certainly not fleshed out; it hasn't even been discussed preliminarily with the Department of Health. But, the Hospital Association felt this was an issue that we couldn't just sit back and wait for the Department of Health to act on. We feel that even with the waiver, three years down the road at a minimum, we are going to be facing the same problem, and we don't want to do that.

ASSEMBLYMAN OTLOWSKI: Speaking as the Chairman of this Committee, I would like to encourage you to work that up even further and in greater detail, to be ready in the event that down the line we are shot off the ramparts. I think we have to be ready for all possible alternatives, ready with other systems and other plans.

MR. BECKER: That is the way we feel too, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: Will you do that?

MR. BECKER: I certainly will.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much. Your comments were an important addition to the testimony.

MR. BECKER: Thank you.

ASSEMBLYMAN CUPROWSKI: Excuse me, Craig. I'm not sure if I heard the first alternative. I don't know if I picked it up correctly. Is it Medicare value?

MR. BECKER: It's "carve out." We call it a Medicare carve-out, which basically means that--

ASSEMBLYMAN CUPROWSKI: Carve out? I think I'm missing it somehow.

MR. BECKER: Okay. If I may explain it in layman's terms, a carve out-- You have to understand, I have a very bad cold; working for hospitals, you pick these up. But, with the Medicare carve-out what is going to happen is, some hospitals in the State are going to be getting more Medicare dollars than they would have under our system. Basically what you would do is leave those Medicare dollars alone, not touch those, but you would change the other rates, the Blue Cross, the Blue Shield, the commercial carriers, to equal the same amount of moneys that the hospital would have gotten. In other words, if a hospital's approved budget is $50 million, that is what it is. And, if they had gotten 20 million Medicare dollars under our present system and that, let's say, shot up to $25 million, then the Rate Setting Commission would have to adjust the other rates by $5 million -- the Blue Cross, the Blue Shield, the commercial carriers.

That is what we mean by a Medicare carve-out. Again, that is just a quick fix. It is certainly no long-term solution. It would put our high indigent care hospitals into a tremendous, tremendous disadvantage, to the point where we would be concerned about their financial solvency.

ASSEMBLYMAN OTLOWSKI: Al right?

ASSEMBLYMAN CUPROWSK : Yes, thank you, Mr. Chairman.

ASSEMBLYMAN OTLOWSK : Thank you very, very much, Mr. Becker. Is Thomas Romeo, Chairman, Legislative Committee, Healthcare Financial Management Association, New Jersey Chapter, here? (affirmative response) Did you submit written testimony?

THOMAS J. ROMEO: Yes, I did.

ASSEMBLYMAN OTLOWSKI: Do you want to supplement that with your comments?

MR. ROMEO: Yes. My name is Thomas Romeo. I am with the Healthcare Financial Management Association. We are a national organization, but we represent about 600 members in New Jersey. We come from all institutions throughout the State, and we also have lawyers, accountants, consultants, and other health care related professionals.

ASSEMBLYMAN OTLOWSKI: You represent 600 institutions? Are they hospitals?

MR. ROMEO: No, we have 600 members, individual members. They represent all of the institutions.

ASSEMBLYMAN OTLOWSKI: Just for the purpose of clearing this up, the individual members represent what -- hospitals, doctors, nurses, or what?

MR. ROMEO: No. Primarily, hospitals, financial people, accountants who work with hospitals, consultants who work with hospitals, nursing homes, a variety of health care related organizations.

ASSEMBLYMAN OTLOWSKI: All right.

MR. ROMEO: Mostly in the financial area. You have my written testimony, and I don't want to repeat that. But, I think there are two important issues. The DRG system has worked, but its most glaring failure has been its lack of prospectivity. We constantly have to adjust things retroactively. This causes a great deal of problems -- I have outlined those in the testimony -- for all hospitals. It also--

ASSEMBLYMAN OTLOWSKI: (interrupting) In your original testimony, do you outline the problem?

MR. ROMEO: Yes, I do.

ASSEMBLYMAN OTLOWSKI: Did you suggest ways it could be corrected?

MR. ROMEO: Well, how you can correct it is a complex issue, but the basic thing is that we are given figures from the State when these things are done in advance. If we are given a factor for a rate increase and we are given 5%, it can't be adjusted two years down the road. We have to know that we have 5% for wages. In addition, there are items the Department just doesn't get to on a timely basis, so they get to the 1984 regulations in 1986.

ASSEMBLYMAN OTLOWSKI How could that be corrected?

MR. ROMEO: I cannot speak for the Department. They are going to have to work on this more closely themselves.

ASSEMBLYMAN OTLOWSKI: You're just calling the problem to their attention?

MR. ROMEO: That's right.

ASSEMBLYMAN OTLOWSKI: And, you're asking for a solution.

MR. ROMEO: That's right. Okay? The second thing I would like to mention, which I brought up in my written testimony, is that we are 11 days away from the end of the year and it was very nice to hear that we have a decision about the Medicare waiver. And, whether you like the waiver or not, I am glad to hear that we know what we are going to do in 11 days. I think it is ridiculous that we have to wait for the Federal government to tell us what to do, and then have to come up with some kind of a hurried-up plan in order to know what we are going to do next year.

I think we should start now to get the people together -- as was mentioned by the New Jersey Hospital Association -- the Department, the Rate Setting Commission, and the Legislature. There are laws involved -- Chapter 83 -- that should be addressed. I'm not so sure that some of the things which were suggested can be done. It is an all payer system; that is on the records. I don't know whether you can shift costs under that carve-out method. I am not an attorney, but I think that all of the parties should be looking at this and looking at it now because, even though the waiver has been approved, someday it will go away and, if it is approved for three years, it is my understanding that that waiver can be terminated at any time the Federal government feels it is paying more under that system.

So, those are the two points I wanted to make. Maybe you would like to read my summary here.

ASSEMBLYMAN OTLOWSKI: Yes, but you're suggesting now that the Department of Health, the Hospital Association, and--

MR. ROMEO: (interrupting) The Rate Setting Commission.

ASSEMBLYMAN OTLOWSKI: (continuing) ...the Rate Setting Commission get together immediately and start working up a plan that will fit New Jersey and fit the situation, which could change at almost any time.

MR. ROMEO: That's right. In conclusion, I think we should truly establish a prospective payment system which will provide the hospitals with financial statements that present the most accurate

picture of the hospitals' year's operation on which to base financial planning and sound management decisions. I think we should recognize reasonable technological advances so that New Jersey does not fall behind other states in this area. I think we should incorporate the Certificate of Need process with the rate-setting process. We should rethink how uncompensated care should be financed other than by--

ASSEMBLYMAN OTLOWSKI: (interrupting) How would you connect the rate setting with the Certificate of Need?

MR. ROMEO: Well, right now you can be granted a Certificate of Need, and the Rate Setting Commission may not give you the dollars to carry that project forward. Someway, those two functions have to be coordinated so that if you are given the approval to buy a CAT scanner, you have to have the money in your rates to operate it. It doesn't seem reasonable that you can do one without the other. We have been witnessing that problem since the beginning of the system.

Finally, as I said before, consider now other alternatives to the waiver, rather than to react to the Federal government. That is all I have to say. If you have any questions, I will be happy to answer them.

ASSEMBLYMAN OTLOWSKI: I just want to say this: I think some of the suggestions you made have merit, particularly the coordinated effort you suggested. If our staff people have any further questions and call on you, would you be ready to meet with them and make suggestions to them?

MR. ROMEO: Certainly.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski, do you have any questions?

ASSEMBLYMAN CUPROWSKI: No, thank you. However, I think Mr. Romeo makes a very good point. The Rate Setting Commission and the Certificate of Need process should work a lot more closely, hand in hand. It is nice to say, "Yes, you get a Certificate of Need to buy an expensive piece of equipment, but now you figure out how to pay for it." We know it is not going to be calculated into the rates and so forth. I think he has a good point in that regard.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much.

MR. ROMEO: Thank you.

ASSEMBLYMAN OTLOWSKI: May we hear from Mr. Leo Brach of the New Jersey AFL-CIO, please? Will you give us your name and the organization you represent for the record?

LEO BRACH: Yes. My name is Leo Brach. I am the Health Plans Adviser for the New Jersey State AFL-CIO. Collaterally, I am a public member of the Health Care Administration Board of the State of New Jersey; I am also on the Board of Pharmacy.

ASSEMBLYMAN OTLOWSKI: Mr. Brach, you've submitted written testimony which will be part of the record. Are you going to summarize that now?

MR. BRACH: Yes, I would like to summarize my written statement. First of all, I would like to say this about DRGs: The New Jersey State AFL-CIO is in favor of them; it is in favor of the rate-setting provisions because of the fact that we understand fully if it were not for the DRGs and the waiver, about 40% of the hospitals in the State of New Jersey would be forced to close because of financial considerations. This would certainly affect the public's health tremendously.

I have listened to many statements from professionals, and there is a great deal of concern about the methodology. However, very little has been said about the affordability of health care, whether it is good or bad. As I listened to Dr. Primich my ears twitched. The medical profession has been telling us about their concern for health care, and I don't disregard that. Still, in spite of their particular concern, health care costs have risen within the past decade about a hundred billion dollars, from $300 billion nationally to $400 billion before the decade is even over.

During the course of my work in the health care industry, I served as the Administrator of the Operating Engineers' Health, Welfare, and Pension Fund, one of the largest union funds in the country. I was on the paying end, and I spent many sleepless nights trying to interpret why, because of similar types of diagnostics, there were tremendous differences as far as payments were concerned. This was caused by the fact that the hospitals at that particular time would call the administrator's office to find out what our parameters were as

far as coverages were concerned. The billing would be geared to that particular coverage. If it happened to be a contract with lesser coverage, they geared up to that, but not based on the actual cost.

At this particular point, I would like to inject my past experience. I am a professional accountant. I taught accountancy at the Treasury Department and at Seton Hall. I am fully aware of the figures and what different systems reflect. I know what a bottom line truly is without the so-called manipulating aspects that can affect the particular bottom line. I like the DRG system; I was a proponent, and still am, because of the fact that it sort of parallels the Unit Cost Accounting System which industry throughout the world uses. The Unit Cost Accounting System enables an identification of all elements of cost directly attributable to a particular product. This type of system provides for the evaluation of costs, and the determination of the necessity of such costs to the production and eventual sale of the product.

This is what DRG does. It takes the services directly related to the actual cure or alleviation of the particular illness, nothing else but, and places that within the confinement. Heretofore, the accounting systems, as far as hospitals were concerned, were purely warehouse accounting systems, motel accounting systems, where they were concerned with space and the cost of that particular space. They would go ahead and spread it out whether there would be 30 patients in the hospital, or 500 patients, and it would be apportioned according to space situations.

DRG prevents that particular type of approach whether this related cost applies to a particular diagnosis, and simply applies the particular costs involved in the cure or treatment of that particular patient. Now, this is quite an accomplishment, because for years no one could actually find out what type of efforts were expended on behalf of the patient with the thought in mind of alleviating the particular illness for which he was confined. DRG does that. There are different things we can criticize in it, and I bring that out in my testimony. DRG, in order to get off the ground, and in order to allow the implementation of the several states that had the foresight to take

advantage of it, took a survey of hundreds of hospitals. This was done by a group at Yale University. They went through the different diagnostics, the different costs of the elements involved in the treatment of a particular diagnosis, and averaged situations out. There was very little consideration, probably, as to the methodology used in that particular treatment. In one hospital you probably would have gotten Cadillac treatment -- roses or pansies with all of your meals, etc. In another hospital you would get the complete essentials. This was all averaged out so they would have a rate to start with.

I bring out in my testimony that I hope the DRGs in the future will take these situations into consideration about whether something is absolutely essential or not. All of us know today that if you are admitted into a hospital, you are admitted under specific hospital rules. Whether or not you need certain tests, you have to go through those tests because the hospital does that. And, of course, the administration of the hospital wants that because it gives them an opportunity to sell many of their tests, many of the technologies that have been introduced, whether or not that particular technology is essential to the treatment of that particular patient. Those are the things that we have to strip in order to make sure that the DRG conforms with what industry knows as the Unit Cost System.

Now, with the Unit Cost System, once you establish the direct elements involved in either the production or treatment of the particular ailment, then you can make the essential modifications based upon your particular economy, etc. The waiver in the State of New Jersey did that. It provided for the so-called economic differences and indexes and added that onto the DRG in order to make sure that the hospital would be sustained. If it weren't for that, we would have -- as I mentioned before -- 40% of the hospitals really closing their doors.

At the beginning, the DRGs were a landmark approach to hospital cost containment. However, there were many misconceptions. The first misconception was that it was a panacea for the containment of total health care costs, which it was not. It was simply directed

to hospital care. I hope that in the future, in order to control costs and make them more affordable, it will be applied to other segments, such as doctors' fees, different laboratories, prescriptions, dentistry, etc. But, it is a start. It has been very effective in this particular State, and I hope it will continue in its particular effectiveness.

I sit back as an individual who represents people who pay for this particular type of service and medicine, as I said good or bad, which is becoming unaffordable. In fact, in many cases it is unaffordable, not only to the employee, but to the employer. There has been a movement in the so-called cost containment on the part of employers and, also, on the part of our national Administration, to say, "Well, we can contain this cost," but what have they been doing? They have been spreading the cost, taking away, saying, "Well, listen Mr. User, Mr. Patient, you pay part of this." Sure, that takes that part off their backs, but it puts it on the backs of the ordinary worker and the ordinary patient. This is what we are against. We are against true cost containment; we are for quality care at reasonable cost, not a diminishing of any particular services to our workers, to the public, or to the indigent.

Much as been said about the Rate Setting Commission. The reason we are in favor of it is because for a long time several of the large providers in this State legislatively were permitted to go ahead and negotiate with hospitals. However, with that particular permission, because they were quasi-public corporations, they did not have to meet all of the costs of hospitals. One thing they did not meet the cost of was the uncompensated care or indigent care. So, those of us who were in the so-called self-administered plans paid that. The people in private plans paid that. But, the two organizations that had the benefits of a quasi-public structure had an advantage of anywhere from 20% to 25% because they did not cover all of the costs.

The DRG system, which is related to your rate setting, equalizes every provider, every payer. They must share the costs of all of the services of the hospital.

ASSEMBLYMAN OTLOWSKI: Mr. Brach, you have been very, very helpful. As a matter of fact, I just want to commend you for the logical presentation of your extemporaneous comments, which have added to your written testimony. I think you have been very, very helpful to this Committee, and I want to personally commend you for that.

Assemblyman Cuprowski, do you have any questions?

ASSEMBLYMAN CUPROWSKI: No, I think you have said it very well.

MR. BRACH: After listening to Dr. Primich, I have no ax to grind with him, except that I think the public is finally recognizing what Hippocrates said years ago, "Physician, heal thyself." In this instance, this is what the public is doing today because they are curing themselves, since they are paying for it. Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much.

ASSEMBLYMAN CUPROWSKI: Thank you, Mr. Brach.

ASSEMBLYMAN OTLOWSKI: May we now have Dr. William Nadel, New Jersey Psychiatric Association? Doctor, will you please give us your name and the organization you represent? Also, please point out whether or not you are representing them officially, all right?

WILLIAM NADEL, M.D.: Yes, I will. I am Dr. William Nadel; I am representing the New Jersey Psychiatric Association as its official spokesperson at this hearing. I am Chief of Psychiatry at Muhlenberg Hospital in Plainfield, and I am in private practice in Union County.

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me. Have you submitted written testimony?

DR. NADEL: No, I have not submitted written testimony.

ASSEMBLYMAN OTLOWSKI: All right.

DR. NADEL: I would like to express my gratitude, and the organization's gratitude for your having a continuing series of hearings, since the first hearing was only a partial view of what has happened with the DRG system in this State. I have had some experience in the public sector, having been Deputy Commissioner of Mental Health, Mental Retardation, and Alcoholism Services for New York City before returning to my home State. I think the DRG system in psychiatry is very poor public policy. I hope to outline that quite specifically.

I feel I am speaking also as an advocate for the mentally ill. As you probably know, the mentally ill do not advocate very forcefully for themselves because of the stigma of mental illness. I think this is one reason historically why psychiatric care for the mentally ill has not been the top priority for the public--

ASSEMBLYMAN OTLOWSKI: (interrupting) Are you going to point out how psychiatry fits or does not fit under the DRG system?

DR. NADEL: Yes, I am.

ASSEMBLYMAN OTLOWSKI: Good, great.

DR. NADEL: I would say that I have general, theoretical, logical, and practical problems with the DRG system as a whole. However, I would like to address that in a separate letter to the Committee.

ASSEMBLYMAN OTLOWSKI: Excuse me, doctor. Are you also going to develop positive recommendations about the way you think the DRG should go with psychiatry? Are you going to do that?

DR. NADEL: Yes, I have some recommendations in that regard. I don't want to use the time I have here before the Committee to address the general problems with the DRG which affect all health care delivery. But I would like to focus on the specific role it plays in terms of diminishing the care for the psychiatrically disabled and ill, and focus on the specific problems for psychiatry with this system.

In the first place, for psychiatry, the DRGs for the psychiatric diagnoses do not correlate with the intensity of care required or the resources needed to render that care. Most of the psychiatric diagnoses under the DRG system are in Category 430. Of the psychiatric diagnoses, one-third of them are regarded as outlyers under the DRG system. What that means is that there is not enough experience with these diagnoses in the State, that the stay is too short or too long, that the people leave AMA, or that they are clinical outlyers. In other words, they do not fit in the system. There was one analysis done of the initial group of 26 hospitals under the DRG system by an analyst in the State Hospital Association. This demonstrated that the psychiatric diagnoses do not fit a normal distribution. The theory behind the DRG system assumes a normal distribution. The distribution

for psychiatric diagnoses was rectangular, bimodal, long tales, long beginnings, but only one of the 12 approximated a normal curve. There was a public meeting at which this data was presented, and the Health Commissioner at the time, who took a system from Yale and brought it to New Jersey, changed what it was about to do, did not listen to the author of the system who said that it was inappropriate -- Mr. Thompson has been referred to before -- and then declared the experiment a success without any analysis. She simply called the data a lie. "This analysis must be a lie and the person doing it must be a liar." It caused some consternation because this gentleman was not a liar, and the numbers didn't lie. The numbers didn't fit with the theory, and the theory was inapplicable to these diagnoses--

ASSEMBLYMAN OTLOWSKI: (interrupting) Doctor, are you saying that the DRG does not fit the psychiatric approach to treatment and payment?

DR. NADEL: I'm saying that the DRG analysis and system are inappropriate for psychiatry. The Federal government, whatever its ultimate wisdom or non-wisdom, has seen fit to exempt psychiatric diagnoses from its Medicare until further study is done, because they recognize that there is a real problem in trying to plot a DRG system in psychiatry. One problem is that the system for psychiatric care is quite different than the system for general medical/surgical care. In other words, the DRG system applies when you include all of the players.

ASSEMBLYMAN OTLOWSKI: Doctor, if the Federal government cannot find a way to cover it under Medicare-- If the Federal government cannot find a way, a manner, a system, an approach, or a program to cover it under Medicare, how are we doing to do it with DRGs?

DR. NADEL: Well, what I'm saying is, the Federal government has exempted the psychiatric diagnoses from its Medicare DRG policy. As it studies the problem, it recognizes that there is a serious problem in trying to use this system with psychiatric diagnoses.

ASSEMBLYMAN OTLOWSKI: Are you saying the system will never fit psychiatry?

DR. NADEL: I wouldn't go that far. I think there are problems, but I think those problems can be addressed. What is outstanding is, this State and the State Department of Health did not do it.

ASSEMBLYMAN OTLOWSKI: How can some of these problems be addressed under DRG?

DR. NADEL: Well, first of all, it would help if the DRGs were recast, so that they would more closely approximate the intensity of care needed and the amount of resources that would have to be allocated to treat the people with disorders. Unfortunately, in psychiatry, diagnosis does not indicate the intensity of resources needed. In other words, if you have a fractured arm and the bone does not protrude, you are in one DRG; if the bone does protrude, you are in another DRG. That's fine; that is a difference that makes a difference in terms of, you know, antibiotics, troubles with infection, likelihood of healing -- all of those things. In psychiatry you have a diagnosis, let's say, of paranoid schizophrenia. Now, that person may be out of the hospital in three days; that person may require three months in a hospital, or three weeks in a hospital. And, the medical diagnosis doesn't make the difference. So, the system is poorly cast as it stands to reimburse for psychiatric care.

Furthermore, the psychiatric service system, as I said, is quite different than the general medical/surgical system. You have all the players, all the general hospitals in the State in the DRG system for medical/surgical care. In psychiatry, you do not have all the players. You don't have the State hospitals; you don't have the county hospitals; and, you don't have the freestanding facilities, such as the Rutgers Community Mental Health Centers here in Middlesex County, or Princeton House, which is two miles from the main hospital at Princeton -- the Princeton Medical Center -- but is not included. You are not including the private hospitals, either the not-for-profit hospitals or the one for-profit private specialty hospital in the State. It is no accident that these hospitals were exempted from the DRG system. The private for-profit hospital was suing Joanne Finley and Pat Harris. The day before that suit was brought into court,

specialty hospitals were exempted from the DRG system because the State Health Department and HEW knew it would lose that suit, due to the fact that the DRG system is unconstitutional on grounds I don't really want to get into because those are general, not specific.

The DRG system, though, as it has been implemented in New Jersey, discriminates against the mentally ill in very many ways. It also fosters a shifting of care to the more expensive, private hospitals not under the DRG system.

ASSEMBLYMAN OTLOWSKI: Doctor, I think you have made a good case as far as you have gone. Now, obviously the case you have made shows that psychiatry does not come under the umbrella of the DRG system. You have shown that in the testimony you have given. Now, how could you bring it under the umbrella when you say that this system cannot measure the kind of treatment that psychiatry dispenses? If there is no measuring rod, as there is with a broken arm, or a broken leg, using your example, what kind of a measuring rod would you use?

DR. NADEL: One of the factors you have to consider in doing this in terms of psychiatry diagnoses would be chronicity, how long someone has been in a hospital, or how many repeated episodes of hospitalization someone had. That in a rough way, can correlate with the period of time of supervised care someone will need, but that is not in the DRG system. What the DRG system really does is lump two-thirds of the patients who are not outyers in one DRG. So, it doesn't separate out as people who would propose that sort of system would have it. It doesn't separate out patients; it lumps them.

ASSEMBLYMAN OTLOWSKI: Doctor, let me develop this, because I think before we leave this area, we have to have some understanding of where we're going. You have led me to believe with your testimony that there is no way of measuring psychiatric treatment that would fit under the DRG. Am I correct about that?

DR. NADEL: Well, I said as it is presently done, okay? What I am suggesting is that other parameters have to be introduced to a DRG system to make it appropriate for--

ASSEMBLYMAN OTLOWSKI: (Interrupting) Could those parameters be spelled out?

DR. NADEL: I believe so, but I have to say a DRG system that only affects one portion of the psychiatric service system unbalances that system and has problems in it. It forces patients -- the poor, the working poor, the people who do not have million-dollar health insurance and can't afford a private psychiatric hospital -- into county and State hospitals because the general hospitals are going to go out of the psychiatric service business, given the way the DRG system penalizes psychiatric services.

ASSEMBLYMAN OTLOWSKI: Doctor, there is a related question. Could the DRG system afford psychiatric coverage, since the whole question, as you put it, is so cumbersome? To use your own words, there is no special way you can pinpoint a psychiatric illness.

DR. NADEL: But, I didn't say there isn't a way to pinpoint a psychiatric illness, sir. I may have been misunderstood, or I may not have put it clearly. What I'm saying is, the way the DRG system is set up, it does not do that. It is doable, and the American Psychiatric Association is doing it.

ASSEMBLYMAN OTLOWSKI: Let me ask you this question: Is there a possibility of submitting a plan that would fit under DRG, a detailed plan, showing how it would fit, showing at least estimated costs, showing that it is possible economically, that it is possible from a health point of view, that it is workable, and that it could fit under this system? Could that be done?

DR. NADEL: Not without the cooperation of the Health Department, which has been singularly uncooperative and insensitive to physician input in general, and psychiatric input specifically. It did not have psychiatrists reviewing the DRGs before they started the DRG system. Because of the outcry about that, they had an advisory committee--

ASSEMBLYMAN OTLOWSKI: (interrupting) I just want to say that this, in my opinion, is so important. Frankly, this whole business you are talking about is so important that I would like to treat this just a little differently. What I would like to do is set a separate hearing on this subject alone. As a matter of fact, I would like to give you and your associates an opportunity to develop a

program that could be considered by this Committee. We would then ask the Health Department and some of our other departments to evaluate that system to determine how it would fit in.

Now, what I would like to do is give you an opportunity to really develop comprehensive testimony -- in-depth testimony -- with the kind of people who would help you to put this together when we call you to testify and present such a program. Would you accept that?

DR. NADEL: Certainly; we would love to accept that. However, we would also like to make a few recommendations specifically for current operations, because this will take time and, as I said, will involve the cooperation of a Department that hasn't been--

ASSEMBLYMAN OTLOWSKI: (interrupting) But, the other thing stands, because I think the problem of mental health in this State-- We're having problems with the people we're treating in our mental institutions and a problem with the kind of money we are paying there. Some of our hospitals do not have the kind of programs they should have. Then, as you pointed out, the coverage isn't there. I think that has to be treated separately; I would like to do that and give you the opportunity to go into that in-depth.

DR. NADEL: Certainly. One point would be that the DRG system, or the reimbursement system should be uniform for all categories of hospitals.

ASSEMBLYMAN OTLOWSKI: All right, but in the meantime, let's hear what you have to say in your current remarks.

DR. NADEL: Okay. The DRG system has penalties in it for good clinical care of psychiatric patients. For example, the DRG for depression does not give one enough time to try a course of antidepressant medication in a supervised way. It takes three to four weeks before you can say a certain kind of medication is not the treatment for this individual, has failed to help him with his depression, and switch to another one. By that time, this person is way outside the length of stay. What is happening in hospitals is that lengths of stay are being looked at; doctors are being identified; their average length of stay is being identified; and, the theoretical cost to the hospital of these doctors' lengths of stay are being made

public knowledge, not the doctors' names, but every doctor knows his own number. If Doctor 100 hears that he has cost the hospital $40,000, he knows he should alter his behavior or the hospital might not look kindly upon him.

Psychiatric services in hospitals have been cut back, and are being cut back every month. This is a real problem. You don't have a chance, for example, to treat a depressed person with medication; you don't have a chance to treat him with ECT within the period of time for the DRG.

ASSEMBLYMAN OTLOWSKI: You're talking about a heck of a big problem that confronts this State and which, as a matter of fact, confronts many of the states. These are the people who are walking the streets; these are the people who are living on the street; these are the people who may be stacked away in some nursing home and forgotten. As I said, I would like to go into that separately, because I think it is related to the total problem of health. I would like to treat that at a separate hearing.

DR. NADEL: Surely.

ASSEMBLYMAN OTLOWSKI: Let's just go to your immediate suggestions with the system as it is now, and what we can do with it as you see it.

DR. NADEL: For 1985, I think the only thing to be done is to treat all psychiatric diagnoses as outlyers and reimburse on the basis of cost. This is not just cost willy-nilly, but this is a Health Department approved kind of cost.

ASSEMBLYMAN OTLOWSKI: Would that be a fixed cost, doctor? Would it be the actual cost?

DR. NADEL: It is the actual cost as determined by a negotiation between the hospital and the Health Department. In other words, outlyers are currently being reimbursed. Hospitals are being reimbursed for outlyers on the basis of cost.

ASSEMBLYMAN OTLOWSKI: How would you do it? What are you suggesting?

DR. NADEL: Well, that is what I am suggesting, that they be reimbursed on the basis of cost.

ASSEMBLYMAN OTLOWSKI: But, you're saying hospitals are unhappy with that, aren't you?

DR. NADEL: Hospitals are happy with the DRG system, partly because the State maladministered the share system so egregiously that hospitals didn't know until three or four years later what their budgets would be for a year. It was an untenable position for hospital administrators. Then there was the indigent care cost question. And, there was a reason for hospital administrtion to go along with the DRG system. Psychiatry services only constitute 2% to 10% of the services in a hospital, and the hospital administrator gets great advantage for the other 90% to 98% of his hospital.

ASSEMBLYMAN OTLOWSKI: Doctor, again I just want to say I would like to treat this whole question separately. And, when it is being treated separately at a hearing, I would want to alert the hospitals to be prepared to address this question. I would want to alert the Health Department to address this question. And, I would like you to come in with a specific plan.

DR. NADEL: Another thing that needs to be done is that the State Health Department and the State Department of Human Services have to develop consistent -- not contradictory -- policies. The State Health Department is trying to reduce the length of stay in hospitals and psychiatric services. The State Department of Human Services is trying to get community hospitals to care for the chronically mentally ill who used to be cared for in State institutions. The chronically mentally ill have a longer length of stay for the same diagnosis as someone who is not chronically mentally ill. In other words, a functioning paranoid schizophrenic who is a very able attorney or doctor, well medicated, may have a break because of some life circumstance, and require hospitalization for one to three weeks. That person is a very different person than the chronically mentally ill person with the same paranoid schizophrenic diagnosis who has been in a State facility for 10 years, and is now in something like the Park Hotel in Plainfield -- a 200-bed not officially titled State facility, but a 200-bed former hotel popuated by 190 former long-term State hospital people. When that person decompensates with the same

diagnosis, that person requires a longer length of stay. His whole pattern of illness is different. His whole ability to return to a functioning life is different. The whole family and social support system that the well-functioning doctor or lawyer who happens to be schizophrenic has is not available to these individuals. So, their time in hospital is much longer, and the kind of care they need is somewhat different.

But, what's happening is, Human Services is telling psychiatrists and psychiatric services in general hospitals to go one way, and the Health Department is telling them to go the other way. Now, ultimately the patient is the loser. Psychiatrists are not going to lose much; the hospitals are not going to lose much; the patients are going to be the ones who are hurt most. And this is what happens time after time as government policies are inconsistent, incoherent, and contradictory.

ASSEMBLYMAN OTLOWSKI: Doctor, again you're presenting a tremendous problem here that I think has to be approached separately. That is why we are going to hold a separate hearing. We will probably devote a whole day just to this subject. I just want you to be ready when we do that.

DR. NADEL: Okay, I'll be ready. What has to be done is to take into account the complexity of the issues. This hasn't been done, and the Health Department has not used its own advisory committee.

ASSEMBLYMAN OTLOWSKI: Doctor, just this: I don't want you to feel that I'm cutting you off, but I am. (laughter)

DR. NADEL: I hear you.

ASSEMBLYMAN OTLOWSKI: The truth of the matter is, I want to give you a better opportunity, a better forum, and we are going to do that, as I said. We will conduct a special hearing related to this subject, and we will devote a whole day to it. Okay?

DR. NADEL: I am very appreciative of that. I hope we will have some instant remedy, because psychiatric services are disappearing from general hospitals as we sit here and talk, and that will continue.

ASSEMBLYMAN OTLOWSKI: Doctor, I don't know of any instant remedy; that is the purpose of this hearing. Maybe we can find one.

But, in any event, I just want you to know that I appreciate your appearance; I appreciate your testimony; and, I appreciate your concern, because this is one of the real troublesome problems of our time. I don't want you to feel that you are being brushed off. As a matter of fact, you are getting something that no one else is getting; you're getting a full day for this. All right?

DR. NADEL: Okay, thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much. May we have James Reilly, please? I'll tell you what we are going to do. We are going to hear Mr. Reilly. Mr. Reilly is submitting his testimony, and we will see how long his comments are going to be. We're not talking about reading your testimony; we are going to see how long your comments are going to be. Then it has been suggested that we break for lunch, and I will give you the names of a number of good restaurants, all friends of mine. (laughter) Then we'll come back. All right?

Mr. Reilly, will you please tell us your name and the name of the organization you represent in an official capacity?

JAMES D. REILLY: Yes, I will, Mr. Chairman. My name is Jim Reilly. I am the Fund Administrator for a self-funding group, the Steamfitters Welfare Fund, Local 475, Newark. Currently, I am the Administrator of the Fund's assets. I realize lunch has been called, so I will keep my remarks very brief.

Basically, we found some problems with the DRG system which we have discussed with the State from time to time. I just want to thank the Chairman and the Committee members for giving us the opportunity to develop some of these problems.

I guess the concept is good, but there is something unpopular in my statement that I am going to say right off the bat, if I may. I think one problem I can see at face value is really the indigent care. We realize it is a broad social problem, but it seems, at least in a small fund such as ours, that we are being forced to share an unfair burden of that cost. Since it is a broad-based problem, it may be better addressed by some other form of payment. We really think that New Jersey has the finest quality hospitals in the country. I'm speaking as--

ASSEMBLYMAN OTLOWSKI: (interrupting) Are you saying that the indigent care thing is a burden on the whole system?

MR. REILLY: Yes, that is my observation. Again, you have to take it as my observation only.

ASSEMBLYMAN OTLOWSKI: Do you deal with that in your written statement?

MR. REILLY: Yes, I do.

ASSEMBLYMAN OTLOWSKI: Just develop that for a moment.

MR. REILLY: Well, let's take the price per case for example. Again, this is not my area of expertise; my opinion only comes from looking through the system. I see a pattern developing where when the DRG system was implemented, the idea was that if a hospital got a "windfall" profit, the following year the DRG rate per case would be somewhat lower, and the overall system would benefit from it. However, they also have the indirect costs going to the markup factor. I show in an exhibit here where the DRG costs remain kind of static, but this markup factor goes from approximately 1.5 to almost twice the DRG bill. Included in this indirect cost is the indigent care, and that is sort of the crux of my observation. I won't even call it a direct comment, but I did document it somewhat.

One of the problems we have as a self-funded group-- Granted it is an all payer system, but we are impacted severely by either excessive DRGs or erroneous DRGs. I document that further. But, we do not have the averaging effect of a Prudential or a Blue Cross. We like to think that we have been doing this for 30 years in an expert--

ASSEMBLYMAN OTLOWSKI: (interrupting) You're carrying--

MR. REILLY: (interrupting) We are directly self-funded.

ASSEMBLYMAN OTLOWSKI: You're self-funded?

MR. REILLY: Yes, sir. When we get an excessive DRG in its initial stages-- Everyone has a horror story, so I will get this one right out; it is sort of an attention grabber. It was Beth Israel Hospital in Newark; I'll mention the name. A daughter of one of our participants went into the hospital, spent an overnight stay, and the itemized costs were $630.00. She had a diagnostic problem. A kidney problem was diagnosed with an ultrasound treatment. There was no

treatment given for the disease. We received a bill in our office for $8,500.00. Well, in trying to make this DRG system work, when we looked there, that particular DRG which I document in my submitted material, was a nephronic syndrome with a surgical procedure. We appealed it as an erroneous DRG because there was no surgery performed. This is where the "Alice in Wonderland" concept comes in. When we went in there, fortunately enough for the Fund, the young lady, who was a nursing student, also appealed it because it was excessive. We payed what we thought was the appropriate DRG, which was about $4,000.00. I forget the exact figure, but it is in here. On face value, that was excessive as well.

To make a long story short, when we went through the appeal process we were told that the encodement was correct, and that because the sound waves penetrated the body it was an evasive procedure. I said, "When you tap someone and listen with a stethoscope, that is an evasive procedure too." But, they upheld the encodement, and I said, "Well, that is not what it reads." They said, "You're looking at the English descripter, you know; run it through your grouper." I said, "Well, I don't have a grouper; I am the grouper." To make a long story short, we were fortunate enough that the PSRO did rule that it was an excessive charge and we were billed itemized costs. We did get a refund on it. I have documented a series of things here in the material I am submitting. At this point what we have done -- and I see a member of the State DRG Committee here-- Because we are self-funded payers, we depend heavily on contributions for the payment of benefits. We also cover our retirees; we have 300 retirees. We cover them in full. This is the point I was getting at with the indigent care. If we were forced to pay excessive DRGs continuously, since we don't have the averaging effect of a Blue Cross or a Prudential, where we might get a balancing effect, we would probably have to cut back our coverage. One area we would have to cut back would be the retirees, because there are no contributions coming in on their behalf. We just felt that if a man or woman labored 30 years in the industry, we would try to extend all possible medical care. I have one example of a person who is being billed $4,000.00 more than itemized costs. We, as

a fund, and I document this, are paying-- In cases which we feel are excessive DRGs, we don't want to withhold payment to the hospital, and we immediately pay the itemized costs times the payer factor, which is usually about 105%, or 5% over the bill. Then we advise our participant that he has the right of appeal. Under ordinary circumstances in the appeal process, the billing is suspended until the adjudicating body, in this case the PSRO, rules whether or not it is excessive. In this particular instance, the fellow called me yesterday. He received a summons, even though he has an appeal in process. It's Jersey Shore Medical Center; I have that in here too. It is a $4,000.00 bill. The man is 64 years old; he has an invalid wife -- that is who the bill was for -- and he is being asked to appear before a judge to answer this charge, even though an appeal process has been registered.

This kind of summarizes a lot of my statement. It is a very lengthy thing, but I tried to document the background of our Fund. I put in some of our experiences with excessive charges. I put in some of my general observations of some of the problems.

ASSEMBLYMAN OTLOWSKI: In this testimony, did you indicate how we could possibly cope with excessive charges?

MR. REILLY: Well, I didn't, and for this reason: I heard you ask that question before, Mr. Chairman, and quite frankly the flyer I received from Mr. Price, who was kind enough to send it, talked in general terms about categorizing some of the difficulties. I would be glad to sit down-- I do mention some various things in there, but I did not summarize some of my observations. What I tried to do for the Committee was just to bring some of the problems we have had as small payers -- and, I might add as a patient pay, a person who does not have insurance for one reason or another -- into focus. It seems as though the thrust is trying to force a person into purchasing this insurance. If the industry experiences excessive charges, which happens, they have the luxury of going back to the State Department of Insurance and saying, "Our rates are going to have to go up. We have experienced some difficulties."

We, as self-funded payers, have people working out in the field at Exxon Refinery, etc. That is a pipefitting type of organization.

ASSEMBLYMAN OTLOWSKI: In a supplementary statement, could you suggest ways of coping with those excessive charges, or is that--

MR. REILLY: (interrupting) I can identify why some of them happen. This goes with the horror story. We have found -- and I am not going to point a finger -- that endemic in this system is the idea that a physician, or whomever groups this particular diagnosis, if there is a choice of four diagnoses for appendicitis, for example, it behooves him to select the higher of the DRGs. It only makes sense. Why not get the most bang for the buck? You know? There is an incentive for them to select these higher diagnoses. We find that we don't get the averaging effect. Now, when it was explained to me-- Mr. Leo Brach was eloquent in his comments, but I respectfully disagree with a couple of them. The idea is that I would get an excessive bill of $4,000.00 more to consume the resources. On the other hand, I could get someone who was in the hospital, say, seven days, where the consume resources maybe were $7,000.00 and the DRG still $3,000.00, and that would average it off.

What we found was that hospitals, recognizing this to maximize revenue, will add a secondary diagnosis. In other words, change the one that was going to be charged, the DRG, into an outlyer. Now we get heads they win, and tails they win. We also had what we call a DRG sandwich. One of our participants who is now dead, locally here, was admitted for carcinoma of the lung. I have to trust my memory, I think it was 082, lung carcinoma. That has a rather high trim point. It was when this hospital was just going on a system. It was encoded properly; he was discharged and we paid itemized costs. He was readmitted. In this case, I think they had a trim point of about 45 days. He was in about 20-some odd days. Now, the itemized costs exceeded the DRG. This time his discharge diagnosis was lung abscess, which is an outlyer. As a third condition, he was encoded 082. He had the same lung cancer all along. We received the medical records, and the treatment indicated it was the same basic treatment for everything.

These are just instances; they are dramatic, I grant you. When we first got here with that $8,000.00 memo, it was like Pearl Harbor. Now it is like World War I. We are in trench warfare. You know, we are getting bombarded left and right.

I would like to follow this up with some specific suggestions, but I am just down here mainly to make myself feel good -- no, really, I am here for our participants. I want to thank you for your indulgence.

ASSEMBLYMAN OTLOWSKI: Will you do what I asked you to do?

MR. REILLY: Yes, I will.

ASSEMBLYMAN OTLOWSKI: The other thing you touched on was the fact that some other means have to be found to finance indigent care. That is a tremendous burden on the DRG system. What are some of your offhand observations on that?

MR. REILLY: How to handle indigent care? I guess there are many minds-- There is one thing I would like to stress about it though. I like the idea that in New Jersey, if you are bleeding, they are going to take you in and you are going to get care. They are going to check you out. So, I do not want to go on record as-- I like the New Jersey system in that respect. I recall that down in Maryland there was a guy burned, and he died because he went to three different hospitals. Quite frankly, I am not prepared to give any suggestions along that line. However, as a layman, if you would like me to, I would be glad to give you some.

ASSEMBLYMAN OTLOWSKI: Would you think about that? Also, in a supplementary statement, would you give us-- Some of the great ideas do not come from experts; you know that. As a matter of fact, you may come up with something that would be of interest to us.

MR. REILLY: I thank you very much for your time, and now we are going to go to lunch. The only other thing is, there are about five or six little Band-Aid problems I see with the DRG system that I can identify. I will take those point by point. I just wanted to identify some of the hospital gamesmanship, and I am not putting them down. You hire an accountant and you say, "Hey, make me some money here." On my hand, I have to pay it, and I say, "Well, listen--

ASSEMBLYMAN OTLOWSKI: (interrupting) I'm familiar with your union and some of its operations. I know that you watch the buck, which, of course, is a great tribute to you. As a matter of fact, that is why I am interested to see if you have any ideas on some of the subjects we talked about. Again, I just want to commend your union for how careful they are about running their operation, how watchful they are, and how mindful they are of the dollars they spend.

MR. REILLY: We feel it is the participants' money and we are trying to get the most bang for the health care dollar. That goes for the pensions. I want to thank you very much on behalf of the union and its members for your very kind comment.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Mr. Chairman, there is just one point I would like to make. Unless I am mistaken, several times during your testimony you indicated something about a hospital making a diagnosis or changing a diagnosis, and I do not think this is totally correct. I think the doctor is the only one who can make a diagnosis. So, if anyone is increasing the diagnosis, it is really a doctor.

MR. REILLY: Well, you know, don't you think, Assemblyman Cuprowski, that there may be a little pressure on a physician to select, if he has a cafeteria plan--

ASSEMBLYMAN CUPROWSKI: (interrupting) I don't know.

MR. REILLY: I'm asking too; I don't know.

ASSEMBLYMAN CUPROWSKI: Unless I'm wrong, the doctor makes the diagnosis.

MR. REILLY: We have a problem identifying that one too, since you brought it up. When we offer coverage for our participants, we cover over 365 days in the hospital. We include alcoholism fully because we recognize the devastating problem of alcoholism.

ASSEMBLYMAN CUPROWSKI: I give you credit for that.

MR. REILLY: Well, it is a problem and we are finally getting some recognition in that area. I didn't say that so much as a commercial, but more or less to indicate that we do have a problem with some hospitals giving that as an admitting diagnosis, because we get the admitting diagnosis and if there is a contrary discharge diagnosis,

then we do not have a measurable yardstick. There are instances-- As was rightly pointed out, we have a big problem with psychiatric care. Unfortunately, our Fund at this time is only prepared to pay 30 days for mental illness. Now, if there is a drug dependency or an alcohol problem, then we cover them in full because we recognize they are two devastating factors in our society. But, we need that admitting diagnosis so we can tell them what the coverage is.

These are some of the problems we have had and, as I said, I identify them in my written statement. It is getting close to lunchtime, so I certainly do not want to run over.

ASSEMBLYMAN CUPROWSKI: I appreciate it, thank you.

ASSEMBLYMAN OTLOWSKI: Notwithstanding the hunger of Chris Simon, we are not pushing for lunch that hard. Is there anything else you would like to add, Mr. Reilly?

MR. REILLY: There is so much, and there is so little time. I just want to thank you very much. Oh, I would like to add one thing.

ASSEMBLYMAN OTLOWSKI: Let me just tell you this: The testimony you have submitted, and the supplementary testimony, will be gone over by our staff. If there is anything in here that is good and usable and workable, it will come to our attention for a workup.

MR. REILLY: I want to compliment one thing. A lot of times the State gets a lot of kicks in the tail, you know, when it starts waving around the bureaucracy. I just want to say that the people who directly administer the DRG system -- Bernice Ferguson, Robin Blair, Tony Bruno, who is here -- have always had the utmost courtesy and they always listen very carefully to what your problem is. I don't always agree with their solutions, but I have to compliment the staff down there because it is refreshing. Sometimes you get into a labyrinth and you're rattling around, and you can get some action.

ASSEMBLYMAN OTLOWSKI: As a matter of fact, I wish we could bring that attitude into every facet of government. As you say, even if they don't satisfy you, at least you are treated with courtesy.

MR. REILLY: As I was today. Thank you very much.

ASSEMBLYMAN OTLOWSKI: Thank you very much, Mr. Reilly. You're going to do those two things for us, right? (affirmative response)

We are going to adjourn now for lunch. We will return at a quarter to two; that will give everyone an opportunity to eat. There are some very nice restaurants in the immediate vicinity.

(RECESS)

AFTER RECESS

ASSEMBLYMAN OTLOWSKI: First of all, I would like to apologize. We're late getting started. May we have Mr. Bernard McCarthy now, please? Mr. McCarthy, will you please give us your name, the name of the organization you represent, and tell us whether you represent it in an official capacity?

BERNARD McCARTHY: My name is Bernard McCarthy. I am the Administrator of the Essex County Bricklayers Welfare Fund. I have been in this position for ten years; we have been self-insured for nine years. The Essex County Bricklayers Welfare Fund covers 550 of our members with hospital, medical, and major medical benefits. Of these, 200 are retirees. The active members are currently deferring $1.55 per hour of their wages to fund this program.

What I would like to do, and my testimony is going to be brief--

ASSEMBLYMAN OTLOWSKI: (interrupting) Excuse me, $1.55 per hour is taken out toward this program?

MR. McCARTHY: That's right. That is tax-deferred money, of course. You say "taken out," but it is paid by the employer, and they give it up each year when they vote on what they want to do with their increase.

ASSEMBLYMAN CUPROWSKI: That's $12.00 a day that is paid for health insurance. Is that correct?

MR. McCARTHY: They work seven hours, that's right. What I would like to do, because my testimony is going to be brief, is to actually read each paragraph over and then comment on it as I go along, and we can get through here.

ASSEMBLYMAN OTLOWSKI: How many pages is it?

MR. McCARTHY: It's only two pages, okay?

ASSEMBLYMAN OTLOWSKI: Okay.

MR. McCARTHY: It is common knowledge that all small welfare funds are experiencing hard times because of the ever-increasing high costs of hospital and medical care. I have been paying DRG bills since the beginning of this system and would like to relate my findings.

Since the beginning of the DRG system, I have been watching our hospital bills very closely. The first couple of years there was very little difference between the patient charges and the DRG amount. As time went on it seemed the hospitals were looking for ways to beat the system. Hospital administrators have been attending seminars and openly discussing methods for beating the system. It is a very simple matter, when two diagnoses are similar, to use the one upon discharge that allows the hospital a larger DRG price. As physicians and hospitals are dependent upon one another, the physician has a vested interest in seeing that the hospital remains solvent, whether it is cost efficient or not. The delay of a discharge may take a patient out of a losing DRG billing.

Now, here is where one of our serious problems comes into the picture. Inner-city hospitals, through markup factors, are allowed to charge more because of the indigent care they provide. For example, East Orange General Hospital's intensive care room is $850.00 per day. This is a social problem. The indigent care being given to these patients should not be paid for directly by the people who must utilize that hospital. This seriously affects us because we deal in the inner-city. Many of our people go to these hospitals. Even on an outpatient basis, it is exorbitant.

DRG billings through payer factors allow Blue Cross a discount. The theory behind this is that they must accept everyone. However, in reality, we also must accept anyone who qualifies through

working the necessary amount of hours. Welfare funds should be allowed the same discount. I just can't see why anyone would give Blue Cross a larger discount than us. At one time, we had Blue Cross, and they priced us out of the picture. We cannot afford 120 days, so we certainly cannot afford to supplement Blue Cross through a discount, or to supplement indigent care through a payer factor. This is going to drive us out of business.

Physicians and hospitals are necessary to each other. Physicians have a say in the running of most hospitals, and are also on the staff of most hospitals. I do not object to physicians sitting on appeal boards, but business and labor should also sit on these boards. We find that physicians favor the hospitals and, in some cases, are arrogant in their attitudes. I have been to appeals where it was obvious we were right, and the doctor in charge of the appeal said, "No, you're wrong." I even called the Department of Health to check whether or not a certain fee should be charged as part of a DRG cost, or half of it, with the other half put on the newborn baby. They told me, "You're right; you can't do that." Then you go there and a doctor says, "They can do that; everything is all right," and you lose. It is ridiculous. You don't have anything to say about it. A doctor on one hand is representing the hospital, and he is also representing the hospital on the appeal. He is not representing anyone else.

ASSEMBLYMAN OTLOWSKI: Excuse me, do you use the appeal process of the DRG?

MR. McCARTHY: Yes, we do.

ASSEMBLYMAN OTLOWSKI: You do?

MR. McCARTHY: Yes. Now, I don't see how this DRG system is saving anyone any money. I hear a lot about what happens here and how much money they save. I think that the billing system contributes to the increased costs. There would be more meaningful reductions if we went back to our old system where the anesthesiologists worked directly for the hospital. The radiology work is now going to companies outside of the hospital. I believe that is called unbundling. They give a profit-making section of their work to a contractor outside of the

hospital. They give it to an outside contractor and take it out of their DRG system. To me, we would be better off with the old system where they worked directly for the hospital. I'm talking about the anesthesiologists; I'm talking about the emergency room physicians, who are now giving them out. In every case involving emergency room physicians where the work is given to an outside contract doctor, the prices have doubled. I have seen this happen in the last nine years.

I would like to point something out on the next page of my submitted material because everyone is saying the DRGs are so good. In July, at Riverside Hospital, the same DRG number cost $4,241.00; in September, the same DRG number cost $4,956.00; and, in December, the same DRG number cost $7,014.00. Where are the savings here? This is a six-month period. We're talking about a 60% increase.

ASSEMBLYMAN OTLOWSKI: Mr. McCarthy, you said you felt that the indigent should be taken out of the system and that they should be funded separately, since that is a general social program and the obligation should be met in a different way, rather than under this system. You stand by that statement, right?

MR. McCARTHY: Certainly.

ASSEMBLYMAN OTLOWSKI: Okay.

MR. McCARTHY: At the very least, it should be distributed among all of the hospitals in the State of New Jersey if they are going to continue the same system. How can you dump that care onto one hospital or two hospitals? It's astronomical. That's all I have, Mr. Chairman. I appreciate your time.

ASSEMBLYMAN OTLOWSKI: Thank you very much. May we have Maureen Gilligan, please? (Ms. Gilligan not present) May we then have Mr. Murray Klein, Counsel to the Northern Ocean Hospital, and several other hospitals? Will you please give us your name and your relationship to these hospitals so it will be part of the record?

MURRAY KLEIN: My name is Murray Klein. I am an attorney, and a partner in the firm of Tomar, Gelade, Kamensky, Klein & Lehmann. I have been retained by the hospitals listed as rate counsel to assist them in resolving a matter that has arisen as a result of the new Medicare prospective payment system and the waiver.

ASSEMBLYMAN OTLOWSKI: For the record, do you want to mention the hospitals you are representing?

MR. KLEIN: They are: Northern Ocean Hospital, Riverview Hospital, Memorial Hospital of Burlington County, Zurbrugg Memorial Hospital, Memorial General Hospital, and Community Memorial Hospital.

ASSEMBLYMAN OTLOWSKI: Okay. Do you have a written statement?

MR. KLEIN: I do.

ASSEMBLYMAN OTLOWSKI: May we have it? Will you summarize these nine pages, please?

MR. KLEIN: My clients are hospitals that are in different geographic locations, yet they have a disproportionately high number of Medicare patients whom they treat.

Let me step back for a second before I go on to their immediate concern and give you a brief overview of what the waiver issue is for the State and for these hospitals. The background of the DRG system in New Jersey is, in 1978, legislation was passed to create an all payer system. In addition to that, it also provided for the care of the indigent. In order to do this, it required a waiver from Medicare because the statutes that created the Medicare program on the Federal level specifically state that Medicare will set its own rates of payment, and that they will not pay for anyone else's indigent care.

In order to establish a program that sets equitable payments amongst all insurance companies, Medicare had to agree to allow the State of New Jersey to tell Medicare how much it would pay for its patients in the State. Included in their payment would be a portion for indigent care, so that the cost of indigent care in this State would be spread amongst all payers, including Medicare. That is really the heart of the waiver we have been talking about and the waiver that has been approved.

Coming into 1984, the issue was whether or not we were going to have a waiver. As a result of the DRG program we established in New Jersey, Medicare established its own DRG program. One of the significant things that this Medicare DRG program provided was a data bank of how much it costs to take care of Medicare patients as a sole

category of patients being treated for an illness. With this data available, when New Jersey submitted its application to the Federal government for another waiver, it became quite apparent that the Federal government was recognizing a higher cost of care for Medicare patients than New Jersey was recognizing. For the hospitals I represent, the number totaled approximately $46 million in higher reimbursement for these hospitals, my clients, if the waiver was not approved, because Medicare would pay them more for the treatment of these Medicare patients than the State of New Jersey's DRGs pay for the treatment of these patients.

ASSEMBLYMAN OTLOWSKI: Excuse me, are you saying that your hospitals would have lost $46 million?

MR. KLEIN: That they would otherwise receive.

ASSEMBLYMAN OTLOWSKI: That they would otherwise receive?

MR. KLEIN: That is correct.

ASSEMBLYMAN OTLOWSKI: Is that because of the fact that you have large senior citizen populations in those areas?

MR. KLEIN: There are really four factors; I will briefly go over them.

ASSEMBLYMAN OTLOWSKI: Yes, let's hear the four factors.

ASSEMBLYMAN CUPROWSKI: Over a period of what time?

MR. KLEIN: Over a three-year period.

ASSEMBLYMAN CUPROWSKI: A three-year period, not a one-year period?

MR. KLEIN: No, over a three-year period. The first factor is that the Federal government has a higher inflation factor than that being utilized by the State of New Jersey in reimbursing hospitals. Another is that there is a more generous factor on the prospective payment system for reimbursing resident teaching costs. The third factor is one that is really attributable to the rate-setting system that was established in 1978, and that is, the hospitals in New Jersey are much more efficient than hospitals nationally. As a result of that efficiency, the cost of taking care of patients is less expensive than it would be in almost any other state in the Union.

Finally, and probably most significant, is the impact of sharing in a DRG. There are some 467 DRGs. Some of them are segregated so they clearly address the Medicare patient. They are segregated by age 70 or over. However, there are a number of DRGs in which Medicare patients share that DRG with non-Medicare patients, so if the cost of treating a Medicare patient is $2,000.00 and the cost of treating a non-Medicare patient in the same DRG is $1,000.00, the payment for that patient to the hospital is $1,500.00. Under the DRG system in New Jersey, my clients lose $500.00 of the cost of caring for the Medicare patient; hospitals that have a lower portion of Medicare patients gain $500.00 because the DRG is an average. Since there is no averaging between Medicare and non-Medicare patients in the Federal system, my clients would see a truer cost for the care of a Medicare patient under the prospective system.

As a result of this, my clients went to the Department of Health and to the Governor's office to raise concerns about this. They received assurances from Mr. Stein of the Governor's office that this problem would be addressed. Mr. George Hartnett of the Zurbrugg Memorial Hospital, who will be testifying after me, will be specifically addressing those discussions and the responses of the hospitals, the Governor's office, and the Department of Health.

ASSEMBLYMAN OTLOWSKI: How could this DRG plan be amended or changed so that it wouldn't present this kind of a hardship to your hospitals? What kind of changes would you have to have?

MR. KLEIN: If I may, I was going to sum up with that.

ASSEMBLYMAN OTLOWSKI: Oh, good; all right.

MR. KLEIN: What I am going to talk about is really what happens if there is no waiver. Now we know that we have a waiver, but we also know we have some time to think about alternatives. What we would look for is a system, just as the New Jersey system is now, which would reimburse efficiency. The other is one that recognizes access to care as a factor. Inner-city hospitals with high indigent populations have to maintain their positions in those communities. The hospitals I represent recognize that need and understand the need for industry, government, and consumers to try to address resolutions.

My clients felt it would be important for us to present to you the fact that we are not the only State grappling with the problem of indigent care. There are other states which have adopted legislation in an effort to take care of their indigent problem. Health care is an evolving area; it is not static anymore. New Jersey is clearly out in front, but things are changing all the time. For example, most recently in Arizona, in order to take care of the indigent program in Arizona, the state contracted with another agency to see if they could buy service for indigents at a lower cost than the state had actually been paying to hospitals. It is a pro-competition atmosphere, in which if your hospital wants those admissions, it will provide the service for less than it may have before, so it can have and treat those patients and get that revenue.

In Florida, there is a combination of that, something that is also pro-competition, which means less regulation, a joint partnership of state and industry. What they have done there is, they have assessed hospitals based upon net profit. That assessment is put into a pool with a $20 million matching fund from the general revenues of the State of Florida. That money is then turned around and is used to expand the Medicaid program in that state to pick up 50% matching funds from the Federal government. So, you have less bad debt and indigent. In the definition in New Jersey and nationally now, bad debt and indigent apply to those people who either cannot pay because they have no insurance or have no assets, or who refuse to pay.

ASSEMBLYMAN OTLOWSKI: How much is Florida spending for that program?

MR. KLEIN: Twenty million dollars annually.

ASSEMBLYMAN CUPROWSKI: Is that an equal assessment, or is that calculated? Is there a formula involved?

MR. KLEIN: It is 1% for the first year for each hospital based upon profit; 1-1/2% every year thereafter. That money is poured into the general revenue fund. Additionally, there is the New York Pooling Program, in which Medicare has granted a waiver to the State of New Jersey, but has put a "cap" on their participation.

ASSEMBLYMAN OTLOWSKI: Do you mean to the State of New York?

MR. KLEIN: With you watching me, I won't make any mistakes, you're right. In the State of New York there is a pool, and there is a Medicare "cap." Now, there is a waiver for the State of New York from Medicare, but Medicare said, "We will only pay under a formula we like, for what we think is our appropriate share of indigent." They assess the insurance companies in that State for the differential. So, the industry is participating directly in that. They assess an added fee to the insurance companies to pay for that.

In New York, they have the program that essentially has been set out for you by the New Jersey Hospital Association, which is, "We will look to see what Medicare is going to pay all our hospitals, and we will tell the hospitals what they need to operate. We will then pay them the differential." So, they allow the hospital to take all this Medicare revenue in, but then reduce the amount that other payers might have to pay so that the hospital is maintained as a whole and indigent care is taken care of in the specific hospital.

The facilities I represent found another alternative, and it was one we thought might be the one to lead the way if the waiver was not approved. It takes care of all of the goals I have established and recognizes the needs of not only the indigent population, but also the Medicare population. What we proposed if the Prospective Payment System of the Federal government came into play January 1, 1985, was that for about a three-month period there would just be a continuation of the rates of payment for all payers in New Jersey until this new program might come into play. At the end of the three-month period, all hospitals receiving Medicare revenue would be allowed to keep that revenue. Now, if the revenue was enough to meet their operating needs for their Medicare patients, and if they were even making a profit from that, they would keep that because that would mean they were more efficient in taking care of a Medicare patient than other hospitals. If they couldn't meet that standard of payment, then they would have time to react to the fact that according to the standards they were not that efficient. They would then have to learn to live with what Medicare is willing to pay for Medicare patients.

Because of the sharing example I explained before, when Medicare pays its patients, the DRG rate in New Jersey will be reduced, because to take care of Medicare patients costs more. You are going to pull out that cost from the payment rate for the rest of the DRGs in New Jersey, the other patients in New Jersey, and that is going to drop. The cost of caring for them as to what the insurance companies will be paying for will drop. The differential between what they were paying for before and what they are now going to be asked to be paid for directly for care, we believe, would be enough to make up the uncompensated care factor, the indigent care pool.

That is a very easy solution. It doesn't require that any more money be taken from general revenues, or that we go to the counties. It doesn't require anything except that some quick statistical mathematical numbers be put together and the payers be required to maintain what they had been paying before. The markup factors for those hospitals with higher indigent care ratios would have to go up, but the payment levels would be the same.

Now, unfortunately, the numbers were not ready on this. We expect to have them later today. Our opinion is that it will come very close to breaking even. If it doesn't, you can see that we have explored other alternatives. You could look to the industry to pick up some of the differential. You could look to the State government to pick up some of the differential. You could look to the county government to pick up some of the differential. By the way, in our analysis we found that the county and city governments throughout the country are basically the ones which pick up the people who fall through the cracks. They are not as progressive in New Jersey. They have left that as a problem for the counties. The county that has the poor is supposed to take care of the poor. We know that doesn't work. New Jersey has found a way to spread that. But, there are alternative systems that can be used as adjuncts to what we are proposing.

Finally, at some juncture, and I can tell you that there is a shift-- What we have in New Jersey right now is a very heavy regulatory environment which was absolutely necessary at the time the system was put in. Other states are engaging in pro-competition

environments in which they are saying to insurance companies, "Listen, we are not going to get involved in this. If you want to get a better rate, you just negotiate with the hospital, and the hospital that gives you the best rate is the one you should deal with. We are not going to regulate anyone anymore. You try to get the best deal you can because if your cost is going so high that you are losing subscribers, it is up to you to negotiate a good contract." That is the extreme of the competition end. Somewhere there is a blend. Florida has a blend. They review budgets on an annual basis. What I am suggesting if the waiver is extended for three years, is that over the next three-year period all of these avenues be explored. I can tell you that within a year there will be more and different systems, because health care is one of the big issues of the 1980s and resolutions are going to be hard to find. It is going to require a lot of thought and a lot of hard work. But, there are alternatives. There are more than enough competent professional people in this State to take care of these problems.

ASSEMBLYMAN OTLOWSKI: Are you indicating that the Florida system has great merit?

MR. KLEIN: No, I didn't say that. I said they had an alternative system.

ASSEMBLYMAN OTLOWSKI: Oh. What is your opinion about the Florida system?

MR. KLEIN: My opinion about the Florida system is that it is six months old and has yet to be tried. Let me tell you my opinion of the New Jersey system. My opinion of the New Jersey system is that right now it is probably the best thing going in the country, but that doesn't mean it is the best it could possibly be.

ASSEMBLYMAN OTLOWSKI: What about this thing on Page 8 of your statement, in which you say, "...funds to cover the additional $60 million of uncompensated care, presently paid by Medicare, the shortfall would be made up through an uncompensated care pool"?

MR. KLEIN: That is a possibility. That would mean taxing hospitals, getting some subsidization from the State government, and trying to expand the Medically Needy Program in this State, which, in my opinion, would be a very good idea.

ASSEMBLYMAN OTLOWSKI: You are suggesting four things to help the hospitals you mentioned: the uncompensated care pool, an appropriation from State funds, an assessment on hospitals themselves, and a combination of the above.

MR. KLEIN: Any of them might be acceptable.

ASSEMBLYMAN OTLOWSKI: Any one of these might do it?

MR. KLEIN: Absolutely, and it is possible that you wouldn't need any of them, depending on what the numbers would show.

ASSEMBLYMAN OTLOWSKI: In your opinion, any one of these could do it?

MR. KLEIN: Yes, that is a possibility.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Yes. Mr. Klein, you indicated that the six hospitals you represent would not receive reimbursement to the tune of $46 million over a three-year period.

MR. KLEIN: Three years, that is correct.

ASSEMBLYMAN CUPROWSKI: That is provided the waiver is approved for the next three years, right?

MR. KLEIN: That is correct.

ASSEMBLYMAN CUPROWSKI: Let me ask you this question. Dr. Goldstein, when he testified before this Committee at the last Committee hearing, gave some testimony, as I recall it, that hospitals are not losing money, but they would not make as much money. Using your six hospitals as an example, let me ask you this: Are any of those six hospitals losing money at the present time?

MR. KLEIN: Losing money has to be put into a--

ASSEMBLYMAN CUPROWSKI: (interrupting) At the end of the year, is there a profit or is there a loss? In simple business terms, accounting terms, when you have a profit and loss statement, do they show a profit or a loss?

MR. KLEIN: The answer is, I'm really not sure, but it is not really relevant under the New Jersey system because the New Jersey system does not reimburse based upon profit and loss.

ASSEMBLYMAN CUPROWSKI: I understand that.

MR. KLEIN: It reimburses based upon efficiency. Our hospitals, and I'll give you the prime example-- If an inner-city hospital has a high indigent load, and they are treating DRG 110 at $400.00 a case and are being paid $800.00 a case, they are making a profit on that because they are efficient, and no one cares. What has happened here is that under the Federal system, my hospitals would be making the same type of profit. That is really the issue for these hospitals. They should not be required to lose their profit because they treat the elderly. They are entitled to the same profit that the inner-city hospital which is efficient is entitled to, which is treating the indigent. That is one type of profit. The other is the bottom line, whether they are making money or losing money. If you are going to ask that question of my hospitals, ask it of every hospital in the State of New Jersey.

ASSEMBLYMAN CUPROWSKI: I will. I am just trying to--

MR. KLEIN: (interrupting) The answer is, as I understand it the year 1984 was the best year for every hospital in the State of New Jersey -- every hospital -- because they rebased. They took all the money the hospital spent in 1982 and used that to create the standard. Now, if your concern is whether they make a profit or suffer a loss, and that is the motivation for moving ahead, I assume that they all probably broke even at worst on average, because everyone in the State probably broke even at worst on average.

If the question is, are they being treated equitably compared to hospitals that have high indigent populations, the answer is clearly no. That is exactly the relief we are looking for from the Department of Health at this stage. We have a right, in treating the elderly, to be treated as equitably as every other hospital which is treating indigents.

ASSEMBLYMAN CUPROWSKI: I am just trying to put this into perspective, you know, based on the testimony and comments given by Dr. Goldstein. I think he said very clearly that hospitals would not be losing money, but hospitals would not be making as much money as they did before.

MR. KLEIN: I would say in that context that he is absolutely right. If we had the PPS programs, our hospitals would make more money.

ASSEMBLYMAN CUPROWSKI: They would?

MR. KLEIN: Sure, you're bringing another $128 million into the State. They are going to pick up another $46 million. Every hospital in the State would probably make money in that scenario. I didn't know that that was the issue, though, at least not that I could tell.

ASSEMBLYMAN CUPROWSKI: Well, I don't know if it is an issue. I am just trying to relate the statement he made.

MR. KLEIN: In that context, that is correct, absolutely correct.

ASSEMBLYMAN CUPROWSKI: Thank you.

ASSEMBLYMAN OTLOWSKI: I just want to bring this into focus because you're claiming that you're losing $46 million over a period of three years. The urban hospitals are saying they are losing tremendous sums of money because they are treating the indigent of the urban areas, something, of course, that is not as prevalent in your hospitals. For example, you don't have the problems that Jersey City has, or Newark has, with their hospitals.

Obviously, the hospitals in Jersey City and Newark are losing tremendous sums of money, using your accounting terminology, because of their treatment of the indigent.

MR. KLEIN: I don't think that follows. That does not necessarily follow. First of all, they are being paid. If you treat someone, you are paid a given rate. Now, if the person can't pay for that, the State is paying for it through its uncompensated care factor right now. No one is losing money anymore because they are treating indigents in New Jersey. They are being paid for it now. In 1979, they were losing money for it. Until they came on the DRG system, they were losing money because of that.

ASSEMBLYMAN OTLOWSKI: The problem then is just peculiar to your hospitals?

MR. KLEIN: In terms of the prospective payment system, it is just peculiar to our hospitals. The concern was--

ASSEMBLYMAN OTLOWSKI: (interrupting) Under DRG it is just peculiar to your hospitals?

MR. KLEIN: That is correct, because of the Federal prospective payment program.

ASSEMBLYMAN OTLOWSKI: And, it is peculiar to your hospitals because of the big load of senior citizens you have in proportion to the number of patients that the hospitals treat?

MR. KLEIN: That is absolutely correct. The inner-city hospitals are now being paid for uncompensated care because they have the extension of the waiver.

ASSEMBLYMAN OTLOWSKI: I understand exactly. If the inner-city hospitals didn't have the waiver, they would go right down the tubes because they just couldn't--

MR. KLEIN: (interrupting) That would be a tragedy, and it is totally unnecessary.

ASSEMBLYMAN OTLOWSKI: It would be the collapse of those hospitals; there is no question about that.

MR. KLEIN: I don't think that scenario will ever play again in New Jersey. We have gone too far in that regard.

ASSEMBLYMAN OTLOWSKI: I am going to ask you a question about something I don't understand. Maybe by asking the question I will be able to understand it. If we were to adopt a program similar to Florida's, is it your opinion that Medicare would permit their dollars to be included in the hospital's total profit for the purpose of the tax?

MR. KLEIN: I don't see that they would have any choice the way hospital accounting works and how they define profit. There is a difference between cost shifting, paying for others, and making a profit. Hospitals have made a profit from Medicare before; that would not be something new to Medicare. The fact that it would be taxed would not be uncommon.

ASSEMBLYMAN OTLOWSKI: You don't know if the Florida system would fit into New Jersey, do you?

MR. KLEIN: I don't know of any obstacle to it fitting into New Jersey other than the fact that the legislation in New Jersey is different.

ASSEMBLYMAN OTLOWSKI: Well, we would have to have legislation, of course.

MR. KLEIN: There is nothing I know of that would preclude it.

ASSEMBLYMAN OTLOWSKI: I am going to ask our staff people to make a note to look at the Florida system to find out how it would fit into--

MR. HERSHBERG: (interrupting) We have that.

ASSEMBLYMAN OTLOWSKI: You have that?

MR. HERSHBERG: Yes.

ASSEMBLYMAN OTLOWSKI: We want to talk about that to see how it would fit into the New Jersey system in the event that down the road we don't have the present DRG system, or if we change it to include some of the aspects of the Florida system.

Before you leave, Mr. Klein, when you are talking about hospitals, you are not really talking about profit and loss. Their accounting system is entirely different than that of a business; right or wrong, it is different.

MR. KLEIN: There is only one for-profit hospital in this State. They are all nonprofit.

ASSEMBLYMAN OTLOWSKI: They are all nonprofit hospitals, so we can't talk about profits for these hospitals. They all come under the eleemosynary laws of the State of New Jersey. So, they are not institutions for profit; they are nonprofit institutions. By the same token, if their losses are great, then they close up. There is no magic about that.

Did you say that George Hartnett had something he wanted to add to your testimony?

MR. KLEIN: That is correct.

ASSEMBLYMAN OTLOWSKI: May we have Mr. George Hartnett now?

MR. KLEIN: Thank you, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much, Mr. Klein. Mr. Hartnett, will you please give us your name, the organization you represent, and your official capacity?

GEORGE D. HARTNETT: My name is George Hartnett. I am the President and Chief Executive Officer of the Zurbrugg Memorial Hospital.

ASSEMBLYMAN OTLOWSKI: All right. Now, I suppose you are going to tell us something about the problems of your particular hospital under this system.

MR. HARTNETT: I think that has been elaborated upon by Mr. Klein.

ASSEMBLYMAN OTLOWSKI: He said you were going to add something.

MR. HARTNETT: Yes. I think the issue I might be able to bring to the Committee is the fact that, first, I don't think it is appropriate for us to come in and suggest a formula that is only beneficial to our hospitals. We recognize that, and that responsibility is being met by a meeting we had with the Governor's office approximately three weeks ago. We met with Mr. Stein, who, when presented with the facts that have previously been outlined by Mr. Klein, recognized there would be some inequities, particularly for the institutions which have a higher than average Medicare senior citizen patient volume. As such, he advised the group of six hospitals that he would be willing to take a second look to assure that any inequities in the system would be resolved effectively between those institutions and the Commission, with the oversight of the Governor's office. That was his offer.

We reviewed that in detail, and advised Mr. Stein, Mr. Scibetta from the New Jersey Hospital Association, and Mr. Pierce that we would be very willing to work with them to assure that we would have sufficient moneys to form capital to deal with program needs that the communities we represent are faced with, given the fact that the senior citizen group is growing rather large in those communities.

We received, as of yesterday, a letter from Mr. Stein's office committing to that proposal, reducing that to writing and, in effect, saying they would work with us for that express purpose. At this juncture we, as a group, are preparing a model or a formula that we think might make some sense in giving due consideration--

ASSEMBLYMAN OTLOWSKI: (interrupting) When you prepare that, may we have a copy of it?

MR. HARTNETT: Yes, sir. That is the intent. I believe the prepared testimony I was to read into the record includes the correspondence between the Governor's office--

ASSEMBLYMAN OTLOWSKI: (interrupting) Is it here in the material you submitted to us?

MR. HARTNETT: Yes sir, it is. It outlines, I think in fairly clear detail, what we asked for and what we think is a reasonable solution. I think it is important to point out that we recognize we can't expect our hospitals, or hospitals similar to ours, to receive a one-sided favor as a result of this waiver/nonwaiver issue. We believe it is our responsibility to work with that process and to do it in a correct manner so that all parties, including the indigent question, are answered properly. There is no simple answer; that is why it is a complicated issue that is facing all hospitals, not only in the State of New Jersey, but in the nation.

ASSEMBLYMAN OTLOWSKI: I very seldom work with the devil, but let me play the devil's advocate for a moment. Since hospitals are nonprofit institutions, and since you do not have a problem of solvency, why should you complain about losing $46 million over a three-year period?

MR. HARTNETT: You have to make more money than you expend or you go out of business, whether you are nonprofit or for-profit.

ASSEMBLYMAN OTLOWSKI: Are you saying your hospitals are losing money?

MR. HARTNETT: No, this year my hospital will not lose money. However, it cannot keep up with program needs in the community to form capital, given the expediential growth rate of the senior citizens in our community and the requirements to meet their program needs, if I can only turn a very narrow bottom line relative to those needs. I just can't keep up with the demand. That is my point.

ASSEMBLYMAN OTLOWSKI: With the demand you would have in this very area of providing services for that older group?

MR. HARTNETT: Yes. The service areas we have in our particular hospital are such that we expect about a 30,000 increase by 1988 in people who are 65 or over. That is given in some calculations

on the demographics we try to make our plans on. As a result of that, it requires the formation of capital. When you form capital and go to the money market, you have to demonstrate an ability to repay. Therefore, you have to have a profit.

ASSEMBLYMAN OTLOWSKI: You're saying that this hurts your capital development.

MR. HARTNETT: It hurts the ability to deal with not only operational expenses, but the formation of capital so that you can keep up with those programmatic demands. You cannot go out to the money markets unless you can demonstrate an ability to repay.

ASSEMBLYMAN OTLOWSKI: No, I can understand that, but what I am trying to get into my own mind philosophically, you know-- Hospitals in New Jersey, as testimony has indicated, are all primarily nonprofit hospitals. If they are indeed nonprofit hospitals, if they are fiscally sound, and if the money they are receiving as a result of their operations keeps them in operation, then why should they complain about the fact that in one area there is a loss of $46 million over a three-year period, when they are still operating on the philosophical basis of a nonprofit hospital? How do you justify that?

MR. HARTNETT: The issue at hand is, you either stand still and not meet the quality requirements which are required for any institution to continue-- Do you make the decision consciously to stand still as an institution having very modest, small, tiny bottom lines which prevent you from expanding to meet marketplace needs, when, in fact, people who are not of the not-for-profit business, people who are entrepreneurs and who are not regulated, go about the marketplace expanding into markets that you would normally have a chance to compete in, but you can't because you can't form capital to do that? It seems to me it is unreasonable to expect that the institution should be forced to hold the line close to break even, when those dollars are required to meet the expanding markets that competition can easily enter into, and we cannot as a result of being limited in terms of the generation of that capital. No other business in the world would operate that way. Now, the fact that we are not-for-profit means that any profits that are derived per chance through that operation are

rolled back into the business. They are not distributed to anyone. That is the delineation between for-profit and not-for-profit in simple terms.

So, the concern is how much is reasonable. We believe it is certainly appropriate to have a regulatory process to make sure those are not excessive or unreasonable. No one quarrels with that. The question is, how is that pond of money that might be available to the marketplace distributed? In fact, are people who are 65 and older getting a disproportionate share of what they should receive at the expense of some other class of payer? That is the issue.

ASSEMBLYMAN OTLOWSKI: I hope you understand that I am not singling you out. It is just that in looking for answers-- I'm looking for answers to the total picture here. Assemblyman Cuprowski was talking about the income profits and what not, and we're talking about nonprofit hospitals. What bothers me is, if these hospitals are operating on the basis of where they can meet their obligations, if they can pay their bills and, as a matter of fact, if they are solvent, then how can they complain of losing $46 million? It seems to me the system is designed so that such a nonprofit hospital would lose that kind of money because they don't need it. What about that argument?

MR. KLEIN: It's really a question of quality. It comes down to New Jersey being the forty-eighth state in health care cost and expenditure. At what juncture does a state start providing the quality of care to its elderly that Pennsylvania and New York provide to their elderly? At what juncture do these hospitals put that nurse back on the floor to make sure that the senior citizen has an extra degree of comfort, as opposed to keeping that R.N. off the floor because the DRG rate they are getting does not include the additional cost?

ASSEMBLYMAN OTLOWSKI: You're saying that if you had that money you could provide better service for the seniors. That is what you are saying.

MR. KLEIN: That's right.

MR. HARTNETT: I think it also goes back to the issue of technology, and the extent to which you make a conscious decision -- a

business decision. If you have the opportunity to go into a certain aspect of care for the elderly and you don't have the ability to fund that, then you won't do it.

ASSEMBLYMAN OTLOWSKI: Excuse me. I am mindful of the growth that is taking place in your area; I am mindful of the exodus of older people from the central and northern parts of the State to the southern part of the State. They are doing that for many reasons. If we are talking about technology, and if we are talking about more sophisticated systems, wouldn't we want to go into specialization where everyone in the State would be able to take advantage of those technologies at special places, rather than having them dispersed at great cost throughout the State?

MR. HARTNETT: That depends upon the illness and the kind of technology. That is appropriate in some cases, and I think it ought to be regionalized. That does make a lot of sense. But, you have to look at the kind of technology you're talking about. It's awfully simplistic to suggest that a new piece of equipment comes on the market and can only be used here versus there. I mean, patients have to be moved to that. What are the implications for the patient, as well as just the cost issue? I think those things have to be examined carefully. That is really our suggestion, to examine a more rational way of developing a flexible formula that would give consideration to all of those issues, not just simply make a rather capricious economic argument. That is our suggestion.

ASSEMBLYMAN OTLOWSKI: The sad thing about hospitals is the fact that, under our system, we have to think in terms of economics and we have to think in terms of the health care they are supposed to provide and, damn it, they're intermarried. By the same token, it seems to me that there is nothing wrong with that system. There is nothing wrong with economics being related to the hospitals, not if we are going to preserve our system of a capitalistic welfare State.

In any event, what bothers me, if we are going to continue spending money on new hospitals and for new technology, there won't be enough money to go around if you start spreading it all over the State. That is one of the things which bothers me. Of course, I don't

mean to place that burden on you. I think that is something that some of our health authorities are going to have to give some real thought to.

Yes, Assemblyman Cuprowski.

ASSEMBLYMAN CUPROWSKI: Mr. Chairman, if I may, it is my understanding that all new programs, expansions, and so forth will still require a Certificate of Need. Is that correct?

MR. HARTNETT: If they meet certain dollar limits. Some of those do not always require--

ASSEMBLYMAN CUPROWSKI: (interrupting) I think with the cost of anything today it is probably not too difficult to go over a dollar limit. Most of the capital programs which are planned are normally financed by a tax-free bond through HCFA. Is that correct?

MR. HARTNETT: The tax authority in the State has a bonding authority which is usually used, yes.

ASSEMBLYMAN CUPROWSKI: It seems to me that technology, equipment, programs, and so forth are certainly not unique to any particular hospital. I would imagine that every hospital in the State should be on an equal footing, eligible to compete, if you will, and to offer the services, not necessarily on a competing basis, but to at least have the same interest in the demands for that type of equipment, technology, and programs, and not necessarily restricted to the southern part of New Jersey versus the northern part of New Jersey.

It seems to me that sometimes I hear we are serving the indigent at the expense of the senior citizen. I find that a little difficult to comprehend, especially coming from Jersey City in Hudson County. It seems to me that we have a high proportion of senior citizens and a high proportion of indigent, and basically they are being served; both are being served. I just have a little difficulty understanding -- maybe I am reading the wrong message -- that one is being served at the expense of the other. I do not see that happening in Jersey City and in Hudson County. I see both segments being served. Would you like to comment on that? Maybe I am missing the point.

MR. KLEIN: That was my comment; I will take responsibility for it and will stand by it. The DRG system in New Jersey, from 1980 to 1984, had no data by which to compare what the cost of treating a Medicare patient was compared to anyone else, be they be indigent or otherwise. Anyone can be indigent, as we know; it is not based on age, and it is not based on illness. Anyone can be indigent. So, when you take anyone other than a person who qualifies as a Medicare patient, and you treat that individual, your course of treatment will be different than if you treat a Medicare patient within the same DRG. Since 1975, New Jersey has maintained -- and I can tell you that I worked for the State during that period of time and I adopted this philosophy -- that until someone could show me that the cost of treating a Medicare patient was more than treating a non-Medicare patient, I was going to pay the flat rate. I needed to see something concrete to show me that it costs more. That is what the Federal PPS system has told us, that nationally it costs more.

Now, I am not saying you're not serving your patients in Jersey City who are both elderly and indigent. What I am telling you is that when you treat both the indigent and the Medicare patient in the same way within a given DRG, the probabilities now tell us that that Medicare patient is perhaps not getting the comfort, the attention, or some other factor that he would be getting nationally. It is not an intentional thing; it is not malicious. It is the evolution of the reimbursement process. It is a new factor that we never knew before. It appears now -- and apparently the Governor and the Department of Health recognize this -- that it is not South Jersey versus North Jersey. My parents live in Paterson. They are both Medicare beneficiaries, and they are affected by this too. They go to St. Joe's in Paterson. Everyone is faced with this new factor. It costs more to take care of the Medicare patient. How will New Jersey respond to that? That is all these hospitals wanted to bring to your attention. It just evolved; it just happened. Now, that was one step. When the PPS system becomes our system, what will our reimbursement system look like then? That is another step. They are all just steps along the line.

I was not trying to be accusatory; maybe it was my lawyer's manner. I was really trying to explain what we found, and press that for my clients.

ASSEMBLYMAN CUPROWSKI: I am just trying to understand it a little bit better. I am not an expert in this field, that's for sure.

MR. KLEIN: The cost of treating a Medicare patient is more expensive. That is what the data generated by the New Jersey Department of Health in 1984 tells us, no matter where the the patient lives.

ASSEMBLYMAN CUPROWSKI: I heard a figure. Maybe you would know and could confirm it. Someone said that the Federal government estimates that 75% of health care costs are expended in the last six months of someone's life. Is that correct?

MR. KLEIN: That is a very important issue which has come under the ambit, in the legal profession, of medical ethics and the question is, how long do you carry someone whose life is really terminal? That is another entire issue. Alzheimer's disease is another entire issue. But, they all affect the elderly as one class of patient. The reason the Medicare Trust Fund is losing all this money is not because it was administered badly; it is because health care has improved so much. The number of people who benefit from the health trust has just expanded beyond anyone's initial belief. They couldn't keep up with it. That was the explanation you heard this morning. The senior citizen of today is not the senior citizen we knew 20 years ago. Indeed, in the DRG system it is not the patient who is 70 who absorbs all these resources; it is the patient who is 80 and 85. Our elderly population is expanding. There is a whole new set of data. The health care world is changing, and New Jersey is right in the fore of it. The only issue we wanted to present was this new aspect of it that the Department of Health has provided us with.

We feel now that it is recognized, let's take care of it.

MR. HARTNETT: I think what he is saying is, we are exchanging morbidity for mortality.

ASSEMBLYMAN OTLOWSKI: I just want to make the comment that I am very happy to hear that. (laughter) Don't apologize for being a

lawyer or for your mannerism because, frankly, I think you have made a contribution to this hearing, and a very vital contribution. As you say, we are dealing with a very rapidly changing atmosphere here, and a very rapidly changing climate in dealing, particularly, with the older person who is getting medical treatment. As a matter of fact, as you indicate, because of better diagnostic methods, because of better treatment, because of the whole revolution that is taking place in medical treatment, people are living a whole lot longer. The age factor has increased tremendously, and now that brings all new problems.

So, we are not dealing with something simple here; it is not something simple to bring into perspective. In any event, none of the questions which were asked here were intended to single you out or to try to take that $46 million away from you. You have helped to bring the problem into perspective; some of the things Assemblyman Cuprowski asked here brought some other responses about that helped even more to bring the problem into perspective.

May we go to your other partner in crime, Paul Long? Can we get him?

MR. KLEIN: We have no one else to defend today. They have given up their time in favor of us. We appreciate your listening to us.

ASSEMBLYMAN OTLOWSKI: Isn't Paul Long here with you?

MR. KLEIN: No, Paul couldn't make it today.

ASSEMBLYMAN OTLOWSKI: Oh, but he was part of your team, wasn't he?

MR. KLEIN: That's right.

ASSEMBLYMAN OTLOWSKI: How about Ray Kaden? Is he a part of your team?

MR. KLEIN: He is not here today either. He is back trying to work on the numbers. We wouldn't let him out of the computer room.

ASSEMBLYMAN OTLOWSKI: Let me ask you this. Is there anything else you would like to add? Do you think there is some kind of supplementary thing you ought to present in view of some of the things we have developed here today?

MR. KLEIN: Mr. Hartnett and the other administrators will be working with the Department of Health and the Governor's office in an attempt--

ASSEMBLYMAN OTLOWSKI: (interrupting) And, you are going to give us some of the data when you present it to the Governor's office so we will have the benefit of it?

MR. HARTNETT: I think very simply we are looking for several things that were already enunciated this morning; I don't want to bore you with those. To manage an organization well, you need some degree of predictability. You can't do that well with rules that change, as was mentioned this morning. They ought not to change retroactively; that is a very important point. You could then make rational decisions about the future.

I think you want to develop programs that are unique to the institutions. There are ways to do that which give consideration to the waiting, and to the difficulty of managing patients who are more acutely ill than those in other places. You can help with that in the consideration of the formulas that are developed. That is really the intent behind our taking up the offer of the Governor's office and the Commission. I think the Governor understands this. They recognize that that is a difficult problem and we are all struggling with it.

We want to be part of the solution, but not to just simplify it by saying, "Well folks, you are breaking even or you're close to it." That isn't really a rational answer to a complicated problem. That is our plea.

ASSEMBLYMAN OTLOWSKI: Thank you very much. You have been very helpful. May we hear from James Schuessler? Is he here? (Mr. Schuessler not present) Dr. Robert Ambrose? Doctor, will you please tell us who you are and whom you represent?

ROBERT AMBROSE, M.D.: I am Dr. Robert Ambrose. I am a urologist who has practiced in this State for 19 years, until four years ago when I became Medical Director at Morristown Memorial Hospital.

ASSEMBLYMAN OTLOWSKI: Is that where you are now?

DR. AMBROSE: Currently, I am Senior Vice President for Medical Affairs at Morristown Memorial Hospital. I have come down to

speak on behalf of myself as a physician and as an administrator. I have come to address the issue of quality. That is an allusive term which has been bandied around in rather a cavalier fashion, but which is critically important. It is very difficult to define. As a matter of fact, I asked 10 of my clinical department heads one day to write a definition of quality, and I got 10 different answers, each having its own merit, but each quite different.

Quality is really easy to define if you think of it as matching the intensity of service with the severity of illness. The claim has been made that quality has suffered under the DRG, and I have come to refute that. In my experience, that is definitely not so. I think it is a tribute to the physicians of this State, who have accomplished a great deal more than they apparently realize in adapting to maintaining quality under the constraints of prospective pricing and payment. Quality then really means appropriate utilization of the resources we have, and I would like to address three areas having to do with patient care in which the physicians, by changing their habits, have maintained quality.

They refer to before a patient goes into a hospital, during the hospitalization, and after discharge. Physicians are now saying, "Is this admission necessary?" In other words, people are not being admitted to hospitals as frequently as before, and that is good, because if you don't have to go into a hospital, it is much better to go to another facility. Admission rates are dropping all over the nation, including New Jersey. Alternate facilities are being used. In other words, same-day surgery programs at our hospital-- We do 30% of all of our surgery on the same day without admitting the patient. This is good quality because you do not put them in a facility which they do not need and in which they would occupy a bed that might be needed by someone more acutely or critically ill.

We also have pre-admission testing, so that patients have their vital parameters tested before they come into the hospital in order to uncover something that might delay treatment and have them occupy a bed unnecessarily. So much for before they get in.

Once they are in, you should be aware, at least at my hospital, that we have decreased the average length of stay from ten days to six days in the past four years. That is a 40% reduction in the length of stay. You have to ask yourself, why have we been able to do that? I think one of the reasons is that we haven't been putting people in the hospital who really did not need to be in the hospital, and we have been letting them go home when they are truly able to go home, not squeezing out a few extra days for convenience. It's nice when you can afford it, but we cannot afford that anymore.

We have developed treatment protocols to streamline and monitor the use of valuable hospital resources. We do not give high-powered antibiotics unless the patient meets several criteria. This is good quality because high-powered antibiotics carry some very disastrous side effects. We have protocols for treating certain conditions so as to conserve resources. You are all aware of the new treatment of putting a catheter, within a few hours, into the coronary vessel of someone who has suffered a heart attack, of outlining the clot, dripping in some streptokinase, dissolving the clot using a balloon angioplasty to dilate the vessel, and actually stopping the process of the heart attack. We started doing this and found that we were spending $4,500.00 more than the reimbursement. By looking at that protocol carefully, we reduced the loss to $1,500.00. We saved $3,000.00 by practicing better quality medicine because those patients were being subjected to very dangerous tests and procedures out of curiosity, good curiosity to find out whether we were doing a good job, but something we learned to do without very quickly.

Discharge planning has been elevated to almost the level of a science. We no longer wait until the day before, suddenly realize we have to put this patient somewhere, and have the patient languish in the hospital for a week to ten days while Social Service goes about finding him or her a new place to reside. We have published a discharge finding manual and a video cassette which are sold nationwide to teach other hospitals how to do this. That is good quality.

After the hospitalization is over, we rapidly move people through the acute care unit into a less expensive unit, one which is

less dangerous for them. The longer you are in a hospital, the more likely you are to develop a hospital-borne infection. We have developed step-down facilities; we have relationships with nursing homes; and, we have developed elaborate home health care programs, where people can go home rapidly after using the acute care facility and we will go home with them, with a nurse or a therapist to administer respiratory therapy or start an I.V., so that they can get antibiotics. People with osteomyelitis used to literally sit in a hospital bed for two weeks doing nothing but getting an infusion of an antibiotic. We do that at home now; we don't let them sit in a hospital bed.

We have been able to preserve quality despite reduced reimbursement. We think we are practicing better medicine, not poorer medicine. Doctors would be the first ones to pound my door day and night-- I have not had one doctor come to me and say, "Dr. Ambrose, my patient has done poorly because of this system." Believe me, doctors are not shy. They would come up at the drop of a hat if they had an example, and I would respond to that.

I have two more areas I would like to address. You have been asking for improvements in the system. The biggest fault of this DRG reimbursement system is the fact that it does not respond readily enough to advancing technology. Yes, there is a price with technology. Technology is a blessing on one hand, and a burden on the other. But, it is something we all want, we all need. Look at the patient who comes in to have a cataract removed and now has a lens put in and can see immediately. An elderly person can read immediately, and can avoid falling down the steps, which used to happen quite frequently after they had one of their lenses removed because you couldn't really give them a glass strong enough for the brain to superimpose those two images. This is a wonderful thing, but it cost us $100,000.00 last year because that wasn't on our menu in 1979 when we struck our deal with the State. It is now, but we are being reimbursed as if only half of our patients had lenses in, because that is what happened in 1982. But, this is 1984, and 95% of our patients have lenses in. If we could address that one area, it would help to

make hospitals whole and would help them to deliver first-class care. Make the system more sensitive to the rapidly responding world of technology.

In closing, I must speak to certain statements that have been made about the DRG assignment system because they are seriously in error and I would hate this Committee to leave this room thinking that hospitals can and do manipulate the assignment of DRGs. First of all, you should be aware -- and I am sure you are -- that this carries a civil penalty. This is fraud; it is punishable by a huge fine and a prison sentence. PRO comes in monthly and does random audits to see whether we are assigning DRGs properly. We have a 99% to 100% assignment rate. Why? Because it is done with objective data fed into a computer. The computer assigns the rate.

You have heard comments about taking one DRG in preference to another because one pays more than another. Certainly one pays more than another; that is why there are 467 DRGs. When these several hundred thousand charts were reviewed by Dr. Thompson and Dr. Fedder at Yale, they found that not everyone with pneumonia is as sick as the next patient with pneumonia, which should be obvious. So, they decided that a simple case of pneumonia consumes "X" amount of resources, but a complicated case of pneumonia, or pneumonia in a patient over 70, usually consumes "X" plus resources. They said DRG 210 will pay "X" amount of money, and 211 will pay "Y" amount of money. It is the same condition, but it is totally different in the consumption of resources. You can't manipulate the assignment. The facts are either on the record, or they are not. Was the patient over 70? It pays more. Did the patient suffer a lung abscess and not just have a simple pneumonia? It pays more. That is why some of the speakers who preceded me talked about different payment rates for the same DRG. One might be an inlyer, where there is a lump-sum payment, but the same DRG can result in an outlyer, where charges are paid because the patient was horrendously ill, or had to stay a greater period of time.

Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you, doctor. You have been very, very helpful. You have indicated that your hospital is providing extensive home care programs.

DR. AMBROSE: Yes, sir.

ASSEMBLYMAN OTLOWSKI: Is that generally unique with hospitals?

DR. AMBROSE: We were one of the first in the State. There was a recent survey done in one of the health magazines of about 450 hospitals. They found that about 25% of all hospitals nationwide are getting into non-traditional services -- home health care, urgent care clinics, freestanding surgical units -- a variety of different things. They do this in order to enhance their revenue because the system for inpatients is being cranked down, and if a hospital wants to be viable, it must look to another source for its revenue. You spoke about getting into new businesses and why should the hospitals do this if they are nonprofit? Yes, they are not-for-profit, but they must generate enough revenue to stay in business. Let me give you a perfect example. If a hospital in another town opens a same-day surgical unit and you don't have one, you would suddenly lose 30% to 40% of your surgery. You might then go on to lose your entire surgical offering to the public. That would penalize you severely. It would restrict, contract, and narrow your business to the point where you could no longer be in business to make available to the public other things that they expect, because that hospital would be servicing that town. That is why hospitals are doing that; they are forced to.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: Yes, Mr. Chairman, through you. Doctor, first of all, I want to commend you on what I consider a very excellent presentation.

DR. AMBROSE: Thank you, sir.

ASSEMBLYMAN CUPROWSKI: I think it was very enlightening. May I ask you a question? How many years have you been the Medical Director?

DR. AMBROSE: Three and a half years.

ASSEMBLYMAN CUPROWSKI: Three and a half years. I think you gave statistics that the length of stay dropped from ten days to six days in four years.

DR. AMBROSE: I was talking about my hospital.

ASSEMBLYMAN CUPROWSKI: In a four-year period?

DR. AMBROSE: Since 1979.

ASSEMBLYMAN CUPROWSKI: Obviously it is directly attributed to your leadership.

DR. AMBROSE: I would like to think so. I think it is due to my doctors being aware that there are a lot of ways to skin a cat.

ASSEMBLYMAN CUPROWSKI: That's true. I thought the statistic of 30% of same-day surgery was very interesting. That is a very high percentage.

DR. AMBROSE: It's not as high as I would like it. There are lots of studies to show that as much as 45% of surgery could be done safely without the patient being admitted to a hospital.

ASSEMBLYMAN CUPROWSKI: Okay. I am not criticizing that; I'm just quoting.

DR. AMBROSE: Yes, I realize that.

ASSEMBLYMAN CUPROWSKI: How does that 30% relate to the reduction in length of stay, if you estimate it?

DR. AMBROSE: If they do not come into the hospital, they are not counted as inpatients. You have to be in over one midnight to be an inpatient.

ASSEMBLYMAN CUPROWSKI: So, therefore, the 30% of same-day surgery-- That makes the figures even more startling.

DR. AMBROSE: Yes.

ASSEMBLYMAN CUPROWSKI: It's not a direct reduction in the length of stay in your particular hospital?

DR. AMBROSE: Correct, it is not. It can be figured both ways. You can include them for statistical purposes, or weed them out. In my hospital, that amounts to maybe 3,500 admissions which no longer occur. They don't come in and just lay around in bed before an operation.

I forgot to mention one more thing. We bring a lot of people in the same day as the surgery in the morning and admit them after the operation, thus avoiding them having to come in at two o'clock the previous afternoon to do nothing but just lie around in bed.

ASSEMBLYMAN CUPROWSKI: Very good. Thank you very much.

DR. AMBROSE: Thank you.

ASSEMBLYMAN OTLOWSKI: Doctor, where is your hospital located?

DR. AMBROSE: Morristown, New Jersey.

ASSEMBLYMAN OTLOWSKI: In Morristown. What is your total patient load, you know, inpatient, outpatient, and home patient?

DR. AMBROSE: We have about 25,000 admissions a year; we see about 43,000 outpatients in the emergency room and in the clinics. Our home health care service is only about eight months old, and I can't venture a guess. I would imagine it would be maybe 50 patients.

ASSEMBLYMAN OTLOWSKI: So, there are 43,000 outpatients.

DR. AMBROSE: Yes, sir.

ASSEMBLYMAN OTLOWSKI: And, did you say your home care is developing rapidly?

DR. AMBROSE: Yes, by leaps and bounds.

ASSEMBLYMAN OTLOWSKI: Is anyone looking at it, say, from the New Jersey Hospital Association, to see how it could apply to other hospitals?

DR. AMBROSE: Oh, I think a lot of hospitals are looking at it. We have had a lot of visitors from all over the country really. There are several other large hospitals in New Jersey which are going the route of new ventures.

ASSEMBLYMAN OTLOWSKI: What is your hospital called?

DR. AMBROSE: It is the Morristown Memorial Hospital.

ASSEMBLYMAN OTLOWSKI: The Morristown Memorial in Morristown, New Jersey?

DR. AMBROSE: Correct.

ASSEMBLYMAN OTLOWSKI: The work you are doing is fascinating, particularly in the area you are getting into now, home care. Have you given any testimony to any of the Federal subcommittees of Congress on your treatment of home care patients? Did you testify before any of those committees or subcommittees?

DR. AMBROSE: No, this is the first time I have ever testified anywhere. But, I did go down; I was part of a three-man panel at the George Washington University Health Forum with the Director of the Office of Technology and the president of a surgical products company. I talked about how DRGs are working in New Jersey.

ASSEMBLYMAN OTLOWSKI: If we ask you to come back at another time, would you be willing to do so? We may want to develop some of the things you brought out here further.

DR. AMBROSE: Yes, sir.

ASSEMBLYMAN OTLOWSKI: Doctor, it has been a great pleasure.

DR. AMBROSE: Thank you, sir.

ASSEMBLYMAN OTLOWSKI: You have been very enlightening; thank you very much.

ASSEMBLYMAN CUPROWSKI: Doctor, before you leave, you testified that the DRGs certainly have not reduced quality care in your opinion. Am I correct in understanding that your particular hospital was one of the first hospitals to go onto the DRG system?

DR. AMBROSE: That is correct. We were one of the first group of 26 that went under what they called "a DRG experiment."

ASSEMBLYMAN CUPROWSKI: That's interesting. Thank you very much.

ASSEMBLYMAN OTLOWSKI: Doctor, thank you again.

DR. AMBROSE: You're welcome, sir.

ASSEMBLYMAN OTLOWSKI: Is Dr. Warren Nestler here, please? Doctor, will you please tell us who you are, where you come from, whom you are representing, and all that business?

WARREN NESTLER, M.D.: My name is Dr. Warren Nestler. I am from Overlook Hospital in Summit, New Jersey. I am Vice President/Director of Quality Assurance. Overlook Hospital is 12 miles from Morristown. I appreciate the opportunity to speak to you on the impact of DRG reimbursement on quality care. The preamble to Public Law 1978, Chapter 83, states: "Hospital services of the highest quality of demonstrated need efficiently provided at a reasonable cost are of vital concern to the public health." As a result of the reward penalty, the incentives of the DRG design prospective pricing system, the legislators' concerns -- quality, need, efficiency, and cost -- have become vital concerns for all hospitals. Now, contrary to the gloom and doomers' projection that with implementation of per-case reimbursement the quality of care would go down the drain, in 1984 Overlook Hospital compared with the pre-DRG era, is efficiently providing needed patient care services of a higher quality.

Overlook Hospital is a 550-bed acute care community hospital, and was one of the 26 initial hospitals to implement DRGs. So, we have five years' experience in responding to the DRG system's financial incentives. Using DRG patient management data, through our Quality Assurance Program we have continuously monitored and evaluated our clinical and financial performance. The rationale for incorporating the financial aspects of patient management into the Quality Assurance Program is based on the premise that the quality of care and the cost of care are interrelated and interdependent. Hence, hospital services of the highest quality are necessary, but not unnecessary services, of an appropriate type, efficiently performed with minimum risk of complications, in a manner satisfactory to the patient, and resulting in maximum achievable health benefits.

Now, what has been the impact of DRG reimbursement on selected elements of quality, first, the availability and provision of necessary services, those services required to ameliorate, control, or cure the patient's problems? Those are in-hospital bed services. Patients are admitted only if the hospital is the appropriate site of care, and they remain only for that period of time necessary to provide acute care -- diagnostic services, such as tests, x-rays, and cardiac catheterization, and therapeutic services, such as operations and medications. These are the services that are defined by the clinician for each individual patient.

The patients in the community we serve-- Are we receiving the patients of demonstrated need? The critics' fears and concerns have not become a reality. Services and programs of demonstrated need have not been discontinued. Physician-defined care is available for their patients. For example, critics have anticipated that as a result of pressure from hospital administrators, physicians would discharge their patients prematurely. It has been our experience -- and this has been supported by statewide studies -- that this has not occurred. Patients are discharged when medically necessary, not a day earlier or a day later. However, we can no longer afford to keep patients in the hospital solely for social reasons, such as the family's convenience.

Relative to providing necessary but not unnecessary services, we pay a price for using unnecessary services, such as unnecessary hospital days, over-testing, and over-treatment. For New Jersey hospitals operating under the "You save it, you keep it, but you also risk losing it" payment scheme, unnecessary services result in unnecessary costs. For the taxpayers, over-utilization is a drain on society's pocketbook, but for the patient, unnecessary services subject the patient to the inconvenience, pain, and distress of hospitalization, an operation, a needle puncture, or the unwarranted risk of hospital-acquired infection, a drug reaction, or an operative complication.

The DRG cost-containment incentives are responsible for the elimination of unnecessary services. The decrease in length of stay -- as Dr. Ambrose has described-- We have had similar experiences in other hospitals in the State. I think this reflects the pre-DRG existence of fat days in the system. Now, although measuring similar changes in the over-utilization of ancillary services is difficult, we succeeded in changing physicians' over-testing performance. For instance, the use of two laboratory tests of marginal value has been reduced by 14% and 66%, and the use rate of diagnostic x-rays of doubtful efficacy has declined from 14% to 6%.

The greatest impact, at least in terms of measurable dollars saved, has occurred in the materials management arena -- physicians selection and materials management purchasing of medical/surgical supplies, equipment, and pharmaceuticals, which are both clinically and economically appropriate. Since 1980, product standardization and competitive bidding are a way of life, a collaborative process involving the selection of clinically acceptable types of products by physicians and the pricing skills of materials managers. Examples of cost savings without a diminution of quality are: a change in the manufacturer of operating room gowns and drapes, a $168,000.00 saving in three years; an exclusive contract with the lowest bidder for skin clips -- skin clips are a type of suture -- $20,000.00; permanent pacemaker insertions-- I think pacemakers have gotten a lot of publicity in the last four years. The pulse generator is the most

expensive component of the pacemaker system. The cost of the pulse generator per implant decreased by 8.4% in the first six months of 1984, compared to 1983.

We attribute these cost savings to both the cardiologists exercising technological restraint in selecting the appropriate pulse generator -- this has occurred despite the manufacturer's annual introduction of pulse generators with more bells and whistles and at a higher cost -- and the entrepreneurship of our Director of Cardiology in obtaining the best price.

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me. At this point, I would like to ask a question. In your testimony you're indicating the cost-saving factors that have taken place in hospitals, and you are attributing it in large measure to this system which is operational now. On the other hand, we have heard testimony here today and, as a matter of fact, we have heard previous testimony which bordered on complaints about the high cost of hospital care, the high cost of different technologies and, in some instances, the unnecessary applications of certain technologies. How do you account for that kind of testimony in view of your testimony?

DR. NESTLER: I think the pulse generator example is excellent. We have a very fine group of cardiologists, organized under a Department of Cardiology, with a very good Director of Cardiology. Using the first-year DRG's data -- that's 1980 -- we found we were losing money in that DRG, DRG 116. That was a loser. That information was taken back to the cardiologists. Over the last four years, they have examined all aspects of pacemaker insertion. They looked at the need for the pulse generators. They looked at the budgets for the pulse generators. They looked at all the various types and various prices of pulse generators, and they had many meetings on this. So, they were discussing and reviewing both the costs and the clinical application of this. As I have already presented, it was this year that they began to really say, "Well, we don't need the fanciest pacemaker for our patients." For some patients they do, but they became very selective. By using clinical data, they really determined that in many cases the least expensive pacemaker was just as adequate to take care of the patient.

Now, that is one example of how we have been able to keep the costs down despite advances in technology. You cannot do this in other areas.

ASSEMBLYMAN OTLOWSKI: Doctor, just from your testimony, and from what Dr. Ambrose was talking about, obviously there have been great developments in technology. These developments themselves would immediately present new cost factors. Is that a fact?

DR. NESTLER: Oh, yes. We're caught with many of exactly what Dr. Ambrose was talking about. They are not in the cost base. I think the example he used was lenses. We have the same problem as he does with those. I share his plea that the system be flexible enough to provide an added factor for those DRGs in which there have been significant changes in technology.

ASSEMBLYMAN OTLOWSKI: So, the greater the improvements in technology and the more rapid they are, the more we are going to be faced with these increased costs.

DR. NESTLER: There is a feeling that over the long run, the greatest increase in costs will be due to advances in technology. There are many that think we are never going to catch up with this cost business because of technology.

ASSEMBLYMAN OTLOWSKI: Assemblyman Cuprowski?

ASSEMBLYMAN CUPROWSKI: I think that is a very interesting point, especially with reference to the technology situation. I think when you talk about the medical field, it is common knowledge that medical technology today is moving at the fastest rate imaginable. To not give it any weight or consideration, especially not to put that fact into the reimbursement formula for cost purposes, doesn't seem the proper thing to do. It just doesn't give any recognition to it. I certainly think it is enlightening to know from the experts in the field what their opinion is on that. It is certainly something this Committee should take a good, close, hard look at to try to rectify it, if that is possible.

DR. NESTLER: Are you aware that Congress has an Office of Technology Assessment, in which they have 15 experts whose charge is to do exactly what you are talking about, and to report to the Secretary of HHS on how to adjust the DRGs to reflect this change?

ASSEMBLYMAN CUPROWSKI: Is that right? You're talking about the Federal level now, is that correct?

DR. NESTLER: Yes.

ASSEMBLYMAN CUPROWSKI: But, how does that filter down to New Jersey, if it does?

DR. NESTLER: Well, it doesn't. I was just mentioning that as a point of information. I think the State of New Jersey should design a similar type of system to apply to the hospitals in New Jersey.

ASSEMBLYMAN OTLOWSKI: Doctor, would you repeat that again?

ASSEMBLYMAN CUPROWSKI: That is very interesting.

ASSEMBLYMAN OTLOWSKI: Please repeat that business. New Jersey should do what?

DR. NESTLER: Well, the Office of Technology Assessment is a congressionally-designed office that has a staff of 15 experts from across the country. They have picked some very good men for this. They will review, on a regular basis, the advances in medical technology, and will recommend to the Secretary of HHS how specific DRGs should be modified to reflect the changes in technology.

ASSEMBLYMAN CUPROWSKI: I think that without that mechanism, it almost seems-- It is frightening to think that someday they may decide not to purchase high technology, mainly because they can't take advantage of it in their reimbursement package.

DR. NESTLER: That is one of the fears that many physicians have. We have been very fortunate, particularly with the pacemakers, to be able to adapt to this. We took a loss for several years, and now, because of the change in the cost base, we are able to come out ahead in those DRGs. But, the physicians did address this. Somewhere we may not be able to address it.

ASSEMBLYMAN OTLOWSKI: Doctor, will you please stay in your seat for just a moment? I want to ask Mr. Seamans, who is here from the State Department of Health-- Mr. Seamans, will you please come up here for just a moment? Doctor, stay right where you are.

Mr. Seamans, just so that the record will show it, will you please give us your name and your position with the State Department of Health?

THEODORE C. SEAMANS: My name is Theodore C. Seamans; I am Executive Assistant to the Deputy Commissioner of Health.

ASSEMBLYMAN OTLOWSKI: Now, regarding what the doctor was talking about -- the Federal program on the assessment of technology -- is the State Health Department plugged into that program, do you know?

MR. SEAMANS: We are aware of it and we are watching them. We are seeking to learn from their insight. I have just been told by Barbara Wright from the State Nurses Association that we have a representative from New Jersey with that Office. Is that correct, Ms. Wright?

MS. WRIGHT: Yes. The representative is Rosalinda Toth from Beth Israel Hospital.

MR. SEAMANS: Rosalinda Toth from Beth Israel Hospital is a representative on the committee Dr. Nestler referred to.

ASSEMBLYMAN OTLOWSKI: I would like to make this request of you, Mr. Seamans. If there is something that is being developed there during the sitting of this Committee -- and, this Committee will be going on for some time -- would you please make us aware of it so we can get it into the record and it can be made known to the Committee members and to our staff? Would you do that?

MR. SEAMANS: Yes, sir.

ASSEMBLYMAN OTLOWSKI: Just hold your seat because I am going to send the doctor back to his hospital where he can do some real work. Doctor, we are very, very appreciative of the time you spent here, and of your testimony, which has been very valuable. There is no question about it; it is going to be of help to us.

DR. NESTLER: Thank you.

ASSEMBLYMAN OTLOWSKI: I just want to say this before I call on Mr. Seamans. The next hearing-- Assemblyman Cuprowski, when is the next hearing going to be held, where, and at what time?

ASSEMBLYMAN CUPROWSKI: It will be held next Friday, December 28, at 10:30 a.m., at the Hudson County Courthouse, 595 Newark Avenue, Jersey City. That is basically in the heart of Jersey City. It will be in the Freeholders' Chamber in the County Courthouse.

ASSEMBLYMAN OTLOWSKI: Mr. Seamans, I would like you to wrap this up so that the record will show that one of the Deputy Commissioners of the State Department of Health was here with us throughout the hearing and made himself available to us. Of course, we are very, very appreciative of that. We want you to convey our thanks to the Commissioner. As a matter of fact, we are going to insist that the Commissioner have someone at the Jersey City hearing so we will get the benefit of the Department's answers, if we need them at that time. It would be very, very helpful to us if we had a representative of the State Health Department at that hearing.

MR. SEAMANS: You can be assured that we will be in touch.

ASSEMBLYMAN OTLOWSKI: Thank you very, very much. It was good to see you.

MR. SEAMANS: Thank you, sir.

ASSEMBLYMAN OTLOWSKI: That concludes our hearing for today. Thank you everyone for your attention, your patience, and for the courtesies you have extended to this Committee.

(HEARING CONCLUDED

APPENDIX

New Jersey State Nurses Association

Muriel M. Shore, M.S.N., R.N., President
Barbara W. Wright, M.A., R.N., Executive Director

TESTIMONY

ON

DIAGNOSIS RELATED GROUP (DRG)

SYSTEM OF HOSPITAL RATE SETTING

FOR

THE ASSEMBLY CORRECTIONS, HEALTH AND HUMAN SERVICES COMMITTEE

BY

JEAN R. MARSHALL, B.A., R.N., E.T.

FIRST VICE-PRESIDENT

NEW JERSEY STATE NURSES ASSOCIATION

DECEMBER 20, 1984

Chairman Otlowski, I am Jean Marshall, Vice-President of the New Jersey State Nurses Association, and Enterostomal Therapist at Paul Kimball Medical Center in Lakewood, New Jersey. Appearing with me today is Barbara W. Wright, Executive Director.

On behalf of our 6000 member association, we appreciate the opportunity to present this testimony on New Jersey's hospital payment system - Diagnosis Related Groups.

NJSNA has closely monitored the State's DRG system. As an association, we actively participate as members of the Commissioner of Health's Nursing Advisory Committee. In addition, we comment regularly at public meetings of the Health Care Administration Board and Hospital Rate Setting Commission.

Further, our knowledge has been greatly enhanced through our members who are staff nurses and managers. They are integral players in the system seven days a week, twenty-four hours a day. As the largest nurses's union in the state, many of the contracts we negotiate are impacted by the DRG payment system.

My comments will address the DRG system in general and its impact on nursing in particular.

DIAGNOSIS RELATED GROUPS

NJSNA strongly endorses the continuation of a prospective rate setting system which includes all payers and provides for uncompensated/charity care. We recognize these elements were

hallmarks of S-446 and we support their continuation. Therefore, we supported the Department of Health's waiver application for a three year extension.

We have all witnessed the success of New Jersey's rate setting and reimbursement methodology have had on reducing hospital costs and placing us among the least costly states in the nation. Nevertheless, we know that the ways in which we as health professionals practice may have a greater impact on health care cost containment than addressing hospital costs alone.

For example, variations in health care practices create patient volume and can also increase the complexity of DRGs. Therefore, the addition of surgery in a DRG computation increases its costliness. Exercising the option for hospital versus ambulatory care for a patient increases cost. Many of these costs will be controlled by third party payers through such measures as requiring a second physician's opinion, or introducing a co-payment or deductible for hospital care where there are community alternatives. Since variations in practice do not necessarily yield better patient outcomes, monitoring practice patterns through peer review mechanisms with a cost efficiency dimension becomes a social necessity for professionals.

NURSING AND THE DRG SYSTEM

The system's strengths and weaknesses as they impact on nursing largely focus on nursing as a cost center, salaries, nursing personnel, and the appeal process.

1. Nursing as a cost center

A major goal of the DRG system is to avoid cross-subsidization. Until nursing is established as a separate cost center we believe that it will continue to cross-subsidize other departments through manpower drain, that is by nurses being used for non-nursing or below their skill level.

New Jersey has developed predictive equations for Relative Intensity Measures (RIMS) of Nursing resource use. These measures are the basis for hospital management reports and offer an alternative system to assure that hospital payment is based on nursing resource use, not on days a patient spends in the hospital.

Moreover, it has been well documented that patients with certain diagnoses require greater resources than others. For example, a patient with an acute myocardial infarction requires more intense nursing resources than a patient having a hernia repair. Yet, when rates for nursing are calculated they are based on the patients length of stay, not on resources used.

I offer a few examples. A New Haven hospital has initiated listing nursing charges separately on the patients' bills. Also, nursing charges on the patients' bill will be itemized by Maine hospitals beginning July 1, 1985. (Hospitals, November 1, 1984, p. 25).

We support efforts whereby nursing can demonstrate its potential for revenue generation. These include recognizing nursing's

contributions to bottom line economics by creating incentives and reducing the cost of patients whose treatment is very expensive. Eventually, nursing may begin to surface as a profit-making center.

2. Nursing Personnel

. Adequate Salaries

In a recent review and discussion with the Department of Health, we have learned how problems relating to nursing salaries have occurred. Salaries included in the 1979 certified revenue base year were generally inequitable. Historically very little attempt had been made to offer competitive salaries in the state; therefore, all subsequent salary increases under the cost constrained system have been built on the inadequate base.

We believe that equitable compensation continues to be a serious problem within the system. Some hospitals choose not to address the inequity, even when resources are available, using the excuse that they are not permitted to raise salaries higher than the economic factor paid in the hospital rate.

To assure an efficient health care system, varying types of nursing practitioners must be employed. The shortened hospital stays associated with the implementation of DRGs have compressed the discharge planning and teaching phase of patient care. Staff nurses are on the front line daily.

Nurses regularly assist clients in reducing their hospital stay, adapting to home care, and minimizing readmissions. We believe that

the constraints on nursing salaries are a serious barrier to using nurses with advanced training.

This lack of adequate remuneration discourages nurses from entering the profession. For nurses to practice as full-partners in a system where they are instrumental in offering cost-effective care to the most complex case-mix, a more appropriate economic reward system is imperative. It must be said here that nursing represents a less costly option than many other skilled technologists in hospitals. For example, presence of respiratory therapists to administer oxygen, fragments, duplicates and increases cost. I am not questioning the contribution of these workers, but alert you to a need for judicious use.

. Job Responsibility and Security

The magnitude of nursing shortages is difficult to assess at this time. While the nursing shortage may not be obvious, nurses report increased patient intensity loads with fewer available staff. Nurses do experience the pressure of reducing length of stay and increased technological advances in the Operating Room, and Intensive and Coronary Care Settings. Further, community health nurses are being overwhelmed by patients who require intensive home care such as intravenous chemotherapy and complex treatments not previously provided in the home.

As case-mix changes and volume is controlled, the system will continue to shrink. Job security must be addressed by retraining senior nurses and changing categories through attrition. New Jersey

would want to avoid the pitfalls experienced in Minnesota hospital cutbacks through arbitrary personnel actions.

3. Appeal Process

Hospital rates are based on the institution's historical methods of treatment. When methods of treatment are modified, the rates are not sensitive to such technological changes. Additionally, the appeal process is a cumbersome option, which is both lengthy and costly.

SUMMARY

In summary, the New Jersey State Nurses Association supports the Diagnostic Related Groups methodology for prospective determination of hospital costs. We appeal to the legislature to hold firm in its convictions and to the communities of interest to be supportive through this inevitable and predictable period of development and refinement. We have created an approach which is pace-setting, better, and promises to become more perfect with time and perserverance.

FRANK JOHN PRIMICH, M.D.
5401 BOULEVARD, EAST
WEST NEW YORK, NEW JERSEY 07093

PHONE: (201) 864-3152

November 30, 1984

TESTIMONY BEFORE THE NEW JERSEY ASSEMBLY CORRECTIONS, HEALTH & HUMAN SERVICES COMMITTEE

Public Hearing: To examine effectiveness of New Jersey DRGs, and need for a new waiver.

Gentlemen;

I am perhaps the only one in this chamber to derive satisfaction out of the dilemma that has been created. Five years ago my testimony before some of your colleagues was disregarded. That is forgivable since at that time my credentials offered little more than thirty years as a practicing physician, an inherent distrust of governmental intervention, and a lot of common sense.

Endless hours of study, writing, and lecturing on the subject in the intervening years permits me to return today as probably the foremost authority in the country on the topic of "what is wrong with DRGs". Hopefully, you will be more receptive to my input.

The question most frequently asked is, "What are DRGs, and how will they affect the delivery of healthcare?"

My answer: DRGs were developed as a method of cost-accounting and utilization review, and as such had some validity. The Federal Government sponsored the conversion to a reimbursement mechanism, based upon diagnosis, rather than goods or services rendered. That action was illogical, impersonal, and often inhumane. With cost as the paramount concern, quality of care must necessarily suffer, and eventual rationing becomes inevitable.

Why are DRGs an illogical reimbursement methodology? Proponents claim that greater efficiency would be rewarded. Equal payment for an inferior product hardly supports that argument.

The impersonality of a patient being referred to as DRG #123 should be obvious.

The inhumane aspect applies to the lack of consideration of the myriad social and economic factors that impact to a differing degree upon each individual patient, to say nothing of the medical variations in any given disease process.

We are here today to evaluate the process, as implemented in New Jersey, and to consider its comparison to the Federal Medicare version, which would be inflicted upon us, if the revised waiver is not granted.

This is much more than an either-or situation. You must understand that we are in grave trouble either way!

The intent of N.J. Public Law 1978, Chapter 83 could have been better implemented under the prior SHARE reimbursement system. However, the required waiver to permit the inclusion of Medicare and Medicaid demanded use of DRGs. The Feds wouldn't play, unless we used their ball. Now they are threatening to take their ball and go home!

Commissioner Richard Goldstein and I are in agreement on at least one point. That is that the Federal version is worse than New Jersey's. My contention is that New Jersey DRGs were a calamity, and that Federal alterations of them were catastrophic. Dr. Goldstein, while recognizing the horrendous disruption that loss of the waiver would cause, persists in defending the status quo as the best system available.

Governor Kean, when he campaigned for election, got overwhelming support from physicians, since his election ensured removal of Dr. Joanne Finley. the Brendon Byrne appointee as Commissioner of Health. Dr. Finley's major sin, in our eyes, had been her mandatory imposition of the untried DRG system upon the hospitals of the State.

The elec tion did result in the departure of Dr. Finley, if only to convert her to a still damaging federal advisor. Beyond that, nothing of any consequence has occurred to remedy the damage. Instead, Governor Kean has repeatedly advised that other states follow our misdirected course.

New Jersey bears a large responsibility for the Federal program. It was the unsupported claims of success by New Jersey witnesses which encouraged Washington lawmakers to prematurely push ahead with DRGs. Refuting the concept is your civic duty.

Few people appreciate the fact that hospital administrators who "support DRGs" do so because of the cost-sharing and cost-shifting provisions of Chapter 83. Most will concede, at least off the record, that DRGs are a cumbersome, complicated, and confusing abomination.

The Medical Society of New Jersey (MSNJ) opposes the concept of DRGs. Their policy reflects a series of Resolutions that I have introduced over the years. Each harsher evaluation has been upheld by an increasingly larger majority of the membership.

DRGs were advertised to contain costs and improve quality of care. MSNJ has repeatedly asked for full disclosure of the costs under DRGs, and the comparative costs under the prior SHARE system. Keeping both sets of figures (an additional expense) was mandated in the original "experiment". To date those figures have not been forthcoming. None the less, there are repeated unsubstantiated claims of cost savings. If the overriding purpose of cost containment can not be documented, just imagine what the minimal concerns regarding quality of care permit.

Please listen carefully to my review of this quality of care issue. Beyond the legislative significance, someday your life may depend upon the actions which you take, or do not take, in your policy making role.

Physicians and other healthcare providers have repeatedly raised the unaddressed questions regarding inappropriate denial of hospital admissions, premature discharges and subsequent readmissions, and the early demise of recently discharged patients.

MSNJ has requested the Department of Health to commission an out-of-state evaluation of the quality of care by reputable and knowledgeable organizations such as the American College of Surgeons and the American College of Physicians. There has been no action, conceivably because of the cost involved. None the less, a study was commissioned last year (at considerable cost) wherein 250,000 hospital charts were superficially reviewed regarding the prevalence of readmissions within seven days. The figure was reported as within the normal range of expectation, and pronounced proof positive that there was no validity to concerns voiced by the medical community.

This study did not even address the readmission question adequately, let alone the wide variety of other potential dangers. As if this were not enough foolishness, let me dwell on one ridiculous outgrowth of that misleading "study".

One place where there seemed to be a higher readmission rate was in the catagory of heart failure. You do not need a medical background to appreciate the insanity of what I am about to tell you.

The Professional Review Organization of New Jersey has a contract for more than eight million dollars to monitor hospital and physician conformity to the dictates of the bureaucrats.

One of their high priorities is to check the number and time-span involved in readmission of patients diagnosed as having suffered from Heart Failure. Depending upon the frequency of readmission, the doctor who originally treated is to be admonished, forced to take additional medical courses, and perhaps have his privilege to care for such patients curtailed or revoked.

Assuming that the patient had totally acceptable care during the initial admission, why should the physician be held accountable for the subsequent course, which will be dictated to a far greater degree by the patient's compliance with instructions and medication, external stresses, and the vagaries of nature. This is just one of many ways that the healthcare dollar is being misspent under totally misdirected efforts at cost containment.

It is impossible to solve any problem without an adequate appreciation of all the causative factors involved. But before that, it might be worthwhile to define the problem.

In the abstract, we are told that healthcare costs now account for an "unacceptable" 10½% of the Gross National Product. To whom is this unacceptable? Would you be willing to expend more than that percentage of your gross personal product to retain or to regain your health?

If I, as an Obstetrician, am deemed, no matter by what tenuous evidence, to have been involved in the demise or damage of a newborn infant, an award of over a million dollars would be likely. In the case where my expertise results in a normal healthy baby, who might otherwise have been lost, I am lucky if I collect my usual and customary fee. I practiced for thirty years, including my peak productivity, without a lawsuit. In the past five years I have been harrassed by several, none of which had any merit according to normal standards of malpractice.

The unbelievable escalation of liability insurance premiums has now reached to over $50,000 per year in some areas, with the rest in the process of catching-up. This is purely a cost of doing business, and as such is passed along to the patients to whatever extent possible. The litigious adversarial relationship that current concepts of liability foster has led to extravagant expenditures on so-called "Defensive Medicine". Essentially needless costs are generated for tests and procedures of minimal value, but whose absence might be pivital in a future legal confrontation.

There are many remedial actions that the Legislature and the Judiciary could take, but they have been effectively blocked by the legal profession at both levels. The added costs involved are unique to our profession, and can not be compared to the growing incidence of legal malpractice and product liability. You have it within your power to address this issue. I suggest that you move those appropriate Bills, which have been languishing "in committee" for years.

The costs of compliance with governmental regulations, such as DRGs, have been conservatively estimated at between $45 and $50 per patient day. The Reagan Administration, supposedly dedicated to de-regulation, has sanctioned more regulation of healthcare provision than all past administrations combined. If it is not opportune to de-regulate us, at least spare us further intrusionary regulations.

Minimum wage laws, beyond contributing to unemployment, impact more on hospitals because traditionally low paying jobs are now rewarded, in response to coercive union pressures, at rates higher than the built-in allowances of the ratesetters.

Federal tax policies have encouraged first dollar health insurance coverage by employers and union demands for coverage of every service imaginable, not only for employees and their dependents, but also for retirees, and even their survivors. Nowhere is this more clearly evident than in the unholy triumvirate at Chrysler. Iacocca, Califano, and Frazier, in different capacities, were instrumental in creating the problems for which they now advocate destruction of our traditional fee-for-service system. So much for appreciation among the industrial welfare recipients!

Though I am speaking on behalf of the medical profession, it is not my purpose to picture them as blameless. Most regulations are enacted with the implication that we are a money-hungry bunch of thieves, from whom the public must be protected. Among my colleagues, I number some who are money-hungry, as well as some who are thieves. As a profession, we are less inclined in that direction than most any other group. It took too much effort to get where we are, and we have too much to lose. Those who were so inclined could have found far greater remuneration with much less effort in almost any other field of endeavor. A deprived childhood and a gun are perhaps the minimum requirements in present day society.

Let me not overlook what is probably the biggest single factor in rising healthcare costs; namely progress. Technological advances are responsible for three major catagories of cost escalation.

Expensive diagnostic and therapeutic equipment involves not only high initial capital expense, but continuing costs of software and the highly trained personnel required for proper utilization.

You should all be aware of the prohibitive costs of sophisticated life-support systems, which are increasingly being utilized at the marginal ends of the life-span.

Last, but not least, is longevity, the only factor for which the medical profession is willing to plead guilty. Apparently, we have done our job too well. Thanks to the progress that has been made, people are living longer. In so doing, they have fallen heir to a growing variety of chronic disorders which require available remedies.

It has been estimated that 30% of healthcare costs are expended during the last year of life. Now all we need is for some genious in Washington to determine the life expectancy of each individual. With that information, we could exterminate them one year prior to their Expected Date of Demise, thereby saving hundreds of billions of dollars.

Assuming that only a few of those in attendence would find that proposal feasible, let me see if I can summarize the problem, and suggest at least a partial solution.

Medicare's impending bankruptcy was the trigger mechanism for all the ensuing upheaval. That problem is relatively simple. Politicians overpromised and underfunded. Whether it was shortsightedness or political pragmatism is now an academic point. The first step in the solution is to admit to the true cause of the problem. To continue the false promises, and seek scapegoats for the blame is downright dishonest.

The immediate solution for New Jersey is also simple. Return to the SHARE method of reimbursement. Do it now, before everyone forgets how it worked, and we are again faced with the expense of retraining the bookkeepers. Remember that we were well below the national average under SHARE. Incidentally, it was an essentially prospective rate setting mechanism. I'll admit that I wasn't that fond of SHARE, and that it could stand some improvement. Maybe, next time around, we might apply some sane concepts to correct its shortcomings.

Socialized Medicine, which I refer to as S&M, is appropriate under a socialistic government. Examples abound regarding its inferiority to our traditional system. Our gradualistic drift in that direction has been accelerated by this DRG adventure. This "experiment", which has still to receive any favorable evaluation from anyone with the knowledge needed to make a valid judgment, must be abandoned as an abject failure. Further tinkering will only permit further deterioration of a magnificent healthcare system which represents the dedicated efforts of those who came before us. As we say of our war veterans, let them not have toiled or died in vain.

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TESTIMONY FOR THE STATE OF NEW JERSEY ASSEMBLY COMMITTEE -
CORRECTIONS, HEALTH AND HUMAN SERVICES

DECEMBER 20, 1984

- -

PRESENTED BY:

THOMAS J. ROMEO
CHAIRMAN, LEGISLATIVE COMMITTEE

OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION,
NEW JERSEY CHAPTER

TESTIMONY FOR THE STATE OF NEW JERSEY ASSEMBLY COMMITTEE -
CORRECTIONS, HEALTH AND HUMAN SERVICES

DECEMBER 20, 1984

GOOD MORNING. MY NAME IS THOMAS J. ROMEO, CHAIRMAN OF THE LEGISLATIVE COMMITTEE OF THE HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION (HFMA), NEW JERSEY CHAPTER. HFMA IS A NATIONAL PROFESSIONAL MEMBERSHIP ASSOCIATION FOR ALL LEVELS OF FINANCIAL MANAGEMENT PERSONNEL IN HEALTH CARE AND RELATED ORGANIZATIONS WITH OVER 24,000 MEMBERS AND 74 CHAPTERS. THE NEW JERSEY CHAPTER OF HFMA HAS OVER 600 MEMBERS WITH REPRESENTATIVES FROM HEALTH CARE INSTITUTIONS AS WELL AS MANY LEGAL, ACCOUNTING, CONSULTING FIRMS AND OTHER HEALTH CARE RELATED ORGANIZATIONS.

ON JANUARY 1, 1980, NEW JERSEY BEGAN A MANDATORY SYSTEM OF PAYMENT TO HOSPITALS PER DRG ACROSS ALL PAYORS FOR 26 HOSPITALS, INITIALLY. THE DRG SYSTEM, WHICH IMPLEMENTS NEW JERSEY STATE LAW CHAPTER 83, WAS EXTENDED TO INCLUDE ALL ACUTE CARE HOSPITALS IN THE STATE BY THE END OF 1983.

THE GOALS OF THIS SYSTEM AS WAS ESTABLISHED BY THE NEW JERSEY STATE DEPARTMENT OF HEALTH, WAS TO FURNISH A COORDINATED AND EFFECTIVE SET OF INCENTIVES TO THE PROVIDERS OF CARE IN ORDER TO ACHIEVE IMPROVED ACCESSIBILITY AND QUALITY OF CARE WHILE SIMULTANEOUSLY CONTAINING COSTS. THE CHAPTER 83 LEGISLATION PROVIDES FOR A HOSPITAL RATE SETTING COMMISSION TO PROMOTE THE FINANCIAL SOLVENCY OF EFFECTIVE AND EFFICIENT HOSPITALS.

BY AND LARGE, THE SYSTEM HAS SUCCEEDED IN ACCOMPLISHING ITS ORIGINAL OBJECTIVES. HOWEVER, THERE ARE SOME ASPECTS OF THE SYSTEM THAT HAVE NOT BEEN ADEQUATELY ADDRESSED BY THE DEPARTMENT OF HEALTH AND THE HOSPITAL RATE SETTING COMMISSION WHICH HAVE RESULTED NOT ONLY IN PROBLEMS FOR SPECIFIC HOSPITALS, BUT OFTEN ADDITIONAL COSTS TO THE HEALTH CARE SYSTEM.

THE MOST GLARING FAILURE OF CHAPTER 83 IS ITS LACK OF PROSPECTIVITY. THE INABILITY OF THIS SYSTEM, AS IT IS PRESENTLY STRUCTURED, TO ADEQUATELY COPE WITH THE MYRIAD OF PAYMENT PROBLEMS ON A TIMELY BASIS, HAS RESULTED IN LENGTHY DELAYS IN THE SETTLEMENT OF HOSPITAL SPECIFIC ISSUES FOR PERIODS OF UP TO FOUR YEARS. A HOSPITAL'S RESULTS OF OPERATIONS, CRITICAL TO ALL KEY MANAGEMENT DECISIONS, IS VIRTUALLY UNKNOWN UNTIL LONG AFTER THE PERIOD IS OVER.

IT HAS BECOME MUDDLED IN BUREAUCRATIC RED TAPE WHICH UNDERMINES THE VERY FOUNDATION OF THE CHAPTER 83 SYSTEM AND THE FINANCIAL VIABILITY OF THE INSTITUTIONS IT REGULATES. THE SYSTEM HAS EVOLVED TO THE POINT WHERE IT HAS BECOME SO COMPLICATED THAT IT IS DIFFICULT FOR ALL CONCERNED TO ADEQUATELY EVALUATE THE SIGNIFICANCE OF ANY PROPOSED CHANGES BY THE DEPARTMENT, OR ITEMS REQUESTED ON APPEAL BY THE HOSPITALS IN ORDER TO DETERMINE THE SOCIO-ECONOMIC BENEFITS OF THE ISSUES AT HAND. THE PROCEDURAL AND METHODOLOGICAL REGULATIONS WERE ORIGINALLY DRAFTED BY THE LEGISLATURE OF THE STATE OF NEW JERSEY WITH INPUT FROM INDUSTRY. GREAT CARE WAS GIVEN TO PROTECT THE DUE PROCESS OF RIGHTS OF HOSPITALS, PAYORS AND OTHER INTERESTED PARTIES, WHILE ATTEMPTING TO MAINTAIN A SYSTEM OF EQUITABLE PAYMENT RATES THAT WOULD BE AS PROSPECTIVE AS POSSIBLE. THE ORIGINAL INTENT OF THESE REGULATIONS WAS TO MAXIMIZE THE ABILITY OF THE PAYMENT CARE SYSTEM TO FUNCTION AS A MANAGEMENT TOOL AND A STABLE PREDICTOR OF HOSPITAL REVENUE. EFFORTS WERE MADE TO MINIMIZE THE UNCERTAINTIES INHERENT IN ANY NEW SYSTEM, AND TO DEAL WITH LEGITIMATE EXCEPTIONS AND GENERAL PROBLEMS NOT RELATED TO CASE MIX OUTSIDE THE BASIC SYSTEM.

A SYSTEM OF PROSPECTIVE PAYMENTS, DESIGNED AS A MEANS OF DETERMINING REVENUE FOR A HOSPITAL PRIOR TO THE START OF ITS FISCAL YEAR HAS BEEN ADVOCATED FOR MANY YEARS BY BOTH THE PAYORS AND THE HEALTH CARE INDUSTRY.

THE INTENT WAS TO FREE HOSPITAL RESOURCES FOR PATIENT CARE AND INJECT IN THE INDUSTRY AN ATTITUDE MORE COMMONLY FOUND IN A COMPETITIVE ENVIRONMENT. PRESENTLY, THE CHAPTER 83 SYSTEM HAS FAILED IN THAT RESPECT. IT HAS NOT PROVEN TO BE PROSPECTIVE IN NATURE AND THE UNCERTAINTIES IN SETTLING PRIOR YEAR RATES ARE AS GREAT AS PREVIOUSLY EXISTED UNDER THE COST BASED PER DIEM SYSTEM. SOME OF THE SIGNIFICANT ISSUES THAT HAVE CONTRIBUTED TO THE DELAY IN FINALIZING AN INSTITUTION'S REVENUE BASE ARE THE CONTINUOUS RETROACTIVE CHANGES ENACTED BY THE NEW JERSEY DEPARTMENT OF HEALTH, SUCH AS:

A) CURRENT YEAR FINAL RECONCILIATION METHODOLOGY NOT APPROVED AND ADOPTED;

B) CARVE OUT OF INDIRECT COMPONENT RELATIVE TO IN-HOUSE PATIENTS;

C) APPROPRIATE GUIDELINES TO DETERMINE REASONABLE COLLECTION PROCEDURES FOR UNCOMPENSATED CARE REQUESTS DATING BACK AS FAR AS THREE YEARS;

D) SAME DAY SURGERY METHODOLOGY NOT AGREED UPON;

E) COSTS OF MOBILE INTENSIVE CARE UNITS SCREENED DIFFERENTLY THAN ORIGINALLY AGREED UPON;

F) APPEAL ISSUES GRANTED BY THE NEW JERSEY RATE SETTING COMMISSION SUBJECTED TO REASONABLE LIMITS (DIRECT COMPONENT ONLY);

G) METHODOLOGY FOR DEVELOPMENT OF PAYMENT RATES FOR CLASS III INSTITUTIONS; AND

H) DRG APPEALS RELATIVE TO CLINICAL ISSUES NOT RESOLVED.

IN ADDITION, THE APPEALS PROCESS IS TOO LENGTHY, PAYMENT METHODOLOGIES ARE ESTABLISHED AFTER THE FACT, DATA PROCESSING LIMITATIONS ARE NOT ADEUATELY EVALUATED AND THE FINAL RECONCILIATION PROCESS IS NOT REALLY FINAL.

ANOTHER MAJOR SHORTCOMING OF THE CHAPTER 83 SYSTEM IS ITS FAILURE TO RECOGNIZE THE IMPACT OF MEDICAL TECHNOLOGICAL CHANGE ON HOSPITAL COSTS. THE CURRENT REGULATIONS MAKE IT EXTREMELY DIFFICULT FOR HOSPITALS TO RECEIVE ADEQUATE REIMBURSEMENT FOR CHANGES IN TECHNOLOGY WHICH DO NOT RESULT IN COST SAVINGS. ALTHOUGH IDEALLY, SUCH TECHNOLOGY SHOULD "PAY FOR ITSELF", OFTEN THIS IS NOT THE CASE. MUCH TECHNOLOGY IS SIMPLY THE RESULT OF NEW AND BETTER DIAGNOSTIC AND TREATMENT TECHNIQUES.

ALSO THERE CURRENTLY EXISTS A GROSS LACK OF COORDINATION BETWEEN THE PLANNING (CON) AND RATE SETTING SYSTEMS IN NEW JERSEY. THERE MUST BE A LINKAGE BETWEEN THE PLANNING AND RATE SETTING SYSTEMS SO THAT THE INCONSISTENCIES CEASE TO EXIST. THIS LINKAGE MUST BE FORMALLY ESTABLISHED WITH APPROPRIATE COORDINATION AND MONITORING BETWEEN THE PLANNING AND RATE SETTING SYSTEMS IN ORDER FOR IT TO BE EFFECTIVE.

AS WE SIT HERE ON DECEMBER 20, NEW JERSEY HOSPITALS CANNOT BE CERTAIN OF THE REIMBURSEMENT SYSTEM WHICH WILL BE IN EFFECT ONE MONTH FROM TODAY. THEREFORE, IT IS IMPORTANT TO CONSIDER THE PRECARIOUS POSITION NEW JERSEY HOSPITALS FIND THEMSELVES IN BECAUSE OF THE UNCERTAINTIES SURROUNDING THE CONTINUED PARTICIPATION IN THE MEDICARE PROGRAM.

NEW JERSEY HOSPITALS ARE CURRENTLY PAID BY RATE PAYORS, INCLUDING MEDICARE, BASED ON PROSPECTIVE PAYMENT RATES APPROVED BY THE NEW JERSEY HOSPITAL RATE SETTING COMMISSION. THE LAW, AMONG OTHER THINGS, REQUIRES ALL PAYORS TO SHARE IN THE PAYMENT FOR UNCOMPENSATED CARE AND INDIGENT CARE. THE FEDERAL GOVERNMENT HAS AGREED TO PARTICIPATE IN THE PROVISIONS OF THIS NEW JERSEY STATUTE BY FORMALLY WAIVING (OR EXEMPTING) NEW JERSEY FROM ITS FEDERAL REGULATIONS GOVERNING PAYMENT TO HOSPITALS FOR SERVICES RENDERED TO MEDICARE PATIENTS. THE FEDERAL

GOVERNMENT'S PARTICIPATION IS CRITICAL FOR THE ALL PAYOR CONCEPT TO EXIST SINCE MEDICARE ACCOUNTS FOR APPROXIMA ELY HALF OF NEW JERSEY HOSPITALS' REVENUE.

THE EXISTING FEDERAL WAIVER WILL EXPIRE ON DECEMBER 31, 1984. IF THE STATE OF NEW JERSEY'S CURRENT WAIVER APPLICATION IS APPROVED BY THE FEDERAL GOVERNMENT, AUTHORITY OF THE HOSPTIAL RATE SETTING COMMISSION TO APPROVE PAYMENT RATES FOR MEDICARE PATIENTS WOULD CONTINUE THROUGH 1987. IF NOT, BUT CERTAINLY NO LATER THAN 1987, PAYMENT RATES FOR MEDICARE PATIENTS APPARENTLY WOULD BE ESTABLISHED DIRECTLY BY THE FEDERAL GOVERNMENT OUTSIDE OF THE NEW JERSEY ALL PAYOR SYSTEM.

IT MUST BE UNDERSTOOD THAT UNDER EXISTING FEDERAL REGULATIONS, THE FEDERAL MEDICARE WAIVER, IF GRANTED, MAY BE WITHDRAWN PRIOR TO ITS PLANNED EXPIRATION IN 1987, BY THE FEDERAL GOVERNMENT, PARTICULARLY IF MEDICARE FEELS IT IS PAYING MORE UNDER THE STATE RULES THAN IF THE FEDERAL RULES WERE IN PLACE.

THE CRITICAL ISSUE FOUND BY NEW JERSEY HEALTH CARE PROVIDERS IS WHAT HAPPENS IF AND WHEN THE MEDICARE PROGRAM WITHDRAWS FROM THE EXISTING ALL PAYOR SYSTEM. SERIOUS QUESTIONS EXIST ABOUT THE CONTINUED APPLICABILITY AND/OR VALIDITY OF OF CHAPTER 83 AND REGULATIONS GOVERNING HOSPITAL RATE SETTING AFTER SUCH A WITHDRAWAL BY MEDICARE.

THE STATUTE AS PREVIOUSLY WRITTEN, SPECIFICALLY MANDATES AN ~~Ø~~ "ALL PAYOR" SYSTEM. IF MEDICARE SHOULD WITHDRAW FROM THE SYSTEM IT WOULD BE IMPOSSIBLE TO GUARANTEE THAT ALL PAYMENT RATES SHALL BE EQUITABLE FOR EACH PAYOR.

THE NEXT QUESTION IS, "HOW WILL PUBLIC POLICY ADDRESS THE UNCOMPENSATED CARE ISSUE WITHOUT MEDICARE'S PARTICIPATION"?

IT WAS NOTED BEFORE THAT ALL PAYORS, INCLUDING MEDICARE SHARE IN THE PAYMENT OF UNCOMPENSATED AND INDIGENT CARE. THIS REPRESENTS A COST OF ALMOST 8 PERCENT ON THE AVERAGE PER HOSPITAL. THOUGH THERE ARE GROUPS WHICH FEEL CHAPTER 83 CAN CONTINUE WITHOUT A NEW WAIVER, THERE WOULD BE A TREMENDOUS MALDISTRIBUTION ACROSS VARIOUS PAYORS TO COVER MEDICARE'S SHORTFALL IF AND WHEN THE WAIVER NO LONGER IS IN PLACE. THOUGH MEDICARE S WAIVER WILL EVENTUALLY CEASE, UNCOMPENSATED CARE WILL NOT. THE OTHER PAYORS SHOULD NOT BE "TAXED" FOR MEDICARE'S SHARE OF UNCOMPENSATED CARE AND HOSPITALS CANNOT ALLOW THIS SIGNIFICANT SHORTFALL TO GO UNCOLLECTED. THIS SCENARIO COULD FORCE A LOWER QUALITY OF CARE AND/OR A LESSENED ACCESS TO MODERN HEALTH CARE. WILL HOSPITALS BE FORCED TO REVERT TO THE OLD SYSTEM OF COUNTY APPROPRIATIONS FOR THE INDIGENT?

ALL PARTIES MUST STRATEGICALLY AND CAREFULLY CONSIDER OTHER ALTERNATIVES TO A WAIVER THAT WOULD GUARANTEE THE SOLVENCY OF EFFICIENTLY RUN FACILITIES. THE WAIVER IS HARDLY THE ONLY WAY TO (1) ENSURE EQUITABLE TREATMENT OF PAYORS, (2) RECOGNIZE APPROPRIATE FINANCIAL REQUIREMENTS OF HOSPITALS, (3) MAINTAIN HIGH STANDARDS FOR QUALITY CARE, AND (4) ALLOW CONTINUED FULL ACCESS TO CARE FOR ALL NEW JERSEY CITIZENS. SURPRISINGLY OR UNSURPRISINGLY, THE WAIVER MAY NOT EVEN BE THE BEST WAY TO ENSURE THESE COMPONENTS.

ACCORDINGLY, THE STATE REGULATORY AUTHORITIES INCLUDING THE DEPARTMENT OF HEALTH, HOSPITAL RATE SETTING COMMISSION AND THE OFFICE OF THE ATTORNEY GENERAL, MUST AGGRESSIVELY REVIEW THE EXISTING STATE STATUTES AND REGULATIONS GOVERNING HOSPITAL RATE SETTING AND PUBLICLY PROPOSE APPROPRIATE AND WELL CONCEIVED ALTERNATIVES TO MEDICARE'S EVENTUAL WITHDRAWAL FROM THE EXISTING PAYMENT SYSTEM. THESE STEPS TOWARD OBTAINING SOLUTIONS MUST BE TAKEN <u>NOW</u> WHILE THE EXISTING SYSTEM IS STILL INTACT AND NOT AFTER MEDICARE WITHDRAWS FROM THE SYSTEM.

IN CONCLUSION, WE NEED TO:

- TRULY ESTABLISH A PROSPECTIVE PAYMENT SYSTEM WHICH WILL PROVIDE THE HOSPITALS WITH FINANCIAL STATEMENTS THAT PRESENT THE MOST ACCURATE PICTURE OF THE YEAR'S OPERATION FROM WHICH TO BASE FINANCIAL PLANNING AND SOUND MANAGEMENT DECISIONS;

- RECOGNIZE REASONABLE TECHNOLOGICAL ADVANCES SO THAT NEW JERSEY DOES NOT FALL BEHIND OTHER STATES IN THIS AREA, AS IT HAS IN OTHER AREAS LIKE CAPITAL FACILITIES AND MEDICAL TRAINING PROGRAMS;

- INCORPORATE THE CERTIFICATE OF NEED PROCESS WITH THE RATE SETTING PROCESS;

- RETHINK HOW UNCOMPENSATED CARE SHOULD BE FINANCED OTHER THAN BY PATIENT CHARGES; AND

- CONSIDER NOW OTHER ALTERNATIVES TO THE WAIVER RATHER THAN REACT TO A FEDERAL WITHDRAWAL.

"The world is divided into those who want to become someone and those who want to accomplish something. There is less competition in the second category."

Jean Monnett 1888-1979

NEW JERSEY STATE AFL-CIO
106 West State Street
Trenton, New Jersey 08608
(609) 989-8730

TESTIMONY
of
LEO A. BRACH
HEALTH PLANS ADVISOR
NEW JERSEY STATE AFL-CIO
before the
ASSEMBLY CORRECTIONS, HEALTH
AND HUMAN SERVICES COMMITTEE
at a
HEARING RELATED
to the
"NEW JERSEY D.R.G. SYSTEM &
NEED OF WAIVER"
on
THURSDAY, DECEMBER 20, 1984
PERTH AMBOY CITY HALL
PERTH AMBOY, N.J.

Mr. Chairman and Members of the Committee.

My name is Leo A. Brach, I am the Health Plans Advisor for the New Jersey State AFL-CIO, and collaterally serve as a public member on the New Jersey Health Care Administration Board and the New Jersey Board of Pharmacy.

Prior to my association with the N.J. State AFL-CIO, as Health Plans Advisor in 1974, I served as administrator of the Operating Engineers Local 825, Health Pension and Welfare Funds for a period of eight years.

This experience shows my obligated interest in Health Care Costs covering a span of 17 years. During this period, I participated in probably one hundred conferences, seminars and meetings dealing with the escalating problem of Health Care Costs.

I am sorry to admit, that the many words spoken on behalf of the control of Health Care Costs, were not resolved into formative deeds - until the advent of DRG (Dragnostic Related Groups) system.

Unfortunately, this system which involves a method of reimbursement for hospital care only, was at the very beginning criticized unfairly.

This criticism came about because of a misunderstanding of what the DRG was truly about. For some reason or other the critics were led to believe the DRG was a panacea for controlling <u>all</u> health care costs, including doctor, dental, prescription and other health related costs.

I hope, as a long time proponent of DRG - that this system will lead to the control and decrease of <u>all</u> health care costs.

I would like to tell you, as simply as possible why I was impressed with DRG. To me, as a professional accountant, it was

obvious that DRG, was similar to the Unit Cost Accounting system used universally by industry everywhere - without it they could not function profitably.

The Unit Cost Systems, enables an identification of all elements of cost directly attributable to a particular product. This type of system provides for the evaluation of costs, and the determination of the necessity of such costs to the production and eventual sale of the product.

The DRG system is designed to accomplish the objectivity of the "Unit Cost System" through the identification and allocation of costs directly related to the diagnosis.

The evolution of the DRG system was necessary because previous hospital accounting was similar to that of a motel - where costs relating to space, and maintenance of that space was the prime objective.

We realize that if DRG - is to meet and parallel the objectives obtained by industry through the "Unit Cost System" of accounting - that it must undergo considerable refinement.

The "costs" that were originally used in the establishment DRG - were not truly "actual" costs for each hospital. They represented an average experience of many hospitals. These averages cover varying modalities in the treatment of a specific illness - which did not give rise to a determination as to whether certain phases of those varying modalities and costs were absolutely necessary in such treatment.

This system must provide for screening the elements charged to a particular diagnosis in order to permit evaluations as to necessity - and the elimination of all "frills."

Once a "no frills" cost is established - adjustments may be undertaken for economic indexes, - incentives - and apportionment of reasonable non related costs.

If the "unit cost system" works so successfully for industry - there is no reason why it should not work in the Health Care field.

Unfortunately too many people are not aware of the fact, that if the DRG system was not instituted in this state, that a great number of our hospitals would of necessity close - because of financial difficulties. Undoubtedly this would have caused a Health Care crisis in this state.

Fortunately, because of the ability of the state to secure a "waiver" which provided for economic adjustments in its application of its DRG system - the impending crisis was forestalled. The continuation of that "waiver" is necessary to the preservation of our state's health care system.

The DRG system further enhanced the "rate setting" provisions in New Jersey. The "rate setting" legislation equalized the burden of sharing the cost of indigent care on the part of all payers. Prior to this some payers enjoyed a "break" because prior legislation excluded them from the responsibility of sharing the cost of indigent care.

The "rate setting" system along with DRG - accomplished an equitable system for all payers. Previously hospitals would bill according to the particular allowances permitted by a plan.

This caused different payers to pay different rates for identical situations.

There is no question that if a more refined DRG system, paralleling the advantages of "unit cost accounting" system, was extended to all health care providers, that it would eliminate many costly abuses - such as:

1) Unrelated and unproductive tests, X-rays, drugs, etc. - all imposed on a patient purely to enhance income and profit.

2) Imposing procedures - not deemed medically necessary to the diagnosis or illness, simply because they are covered by some reimbursement plan.

The New Jersey State AFL-CIO, whose members are the largest medical consumers in this state, is dedicated to "quality health care at affordable costs" - strongly urges the continuation of the "waiver," the DRG and rate setting systems.

Respectfully submitted

Leo A. Brach
Health Plans Advisor

State of New Jersey Assembly Corrections
Health and Human Services Committee
Honorable George J. Otlowski, Chairman

Mr. Chairman and Committee Members:

By way of introduction, I am James D. Reilly, Administrator of Steamfitters Welfare Fund, Local Union #475. I have served in this capacity for five years and am employed to administer health and welfare claim payments directly to qualified health care providers and, in some cases, reimburse participants for health care costs consumed.

Steamfitters Welfare Fund is a jointly-administered, multi-employer Trust Fund, as defined under Employee Retirement Income Security Act of 1974 ("ERISA"). The Trustees of the Fund are mandated by applicable law to provide health and welfare benefits in a prudent manner, consistent with sound fiscal planning and are also compelled to actively pursue suspected errors, discrepancies and/or irregularities, which might adversely impact the Fund's resources and, consequently, the covered participants of the Plan and their dependents.

Health care and hospital claims are reviewed, processed and disbursed in-house. Any claim by a hospital or other health care provider, which under common acceptable guidelines would be deemed excessive, would have an adverse impact on the Fund's capacity to provide the maximum benefit available for contributions made in the participant's behalf.

Should the practice of excessive claims become widespread without challenge, it may result in:

- a direct diminution of benefits and/or;
- an increase in required contributions and/or;
- a tightening of eligibility requirements, thus excluding a portion of participants from eligibility and/or;
- reduction, curtailment or cessation of health and welfare coverage for retired Fund participants, since no monies are contributed to cover increased costs and;
- subject the Trustees of such a Fund to a charge of fiscal imprudence under applicable law.

To act in a fiduciarily sound and responsible manner, in husbanding the Fund resources, the basis of payment for hospital benefits is on a reasonable, usual and customary standard, and an active pursuit policy in challenging questionable billings is perceived as mandated by existing law governing jointly-administered Trust Funds. In addition, Trust Fund language obliges payments of valid claims in behalf of eligible participants on the following basis:

> "The Trustees shall have the sole perogative to determine the reasonableness of any fee charged by a doctor, hospital or other provider of medical services, and such determination shall be consistently applied in all similar situations."

Attached please find a letter dated July 2, 1982 from the former State Commissioner of Health, Shirley A. Mayer to

Carolyne K. Davis, Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services which eloquently describes the plight of self pay and small self funded multi-employer funds, such as ours, in regards to the case mix reimbursement system currently in place.

The letter describes the financial hardship placed on persons or entities which do not have the case volume to "balance a hospital bill in which the DRG rate exceeds the itemized charges with another self-pay patient bill in which the opposite is true."

The letter further describes the problems encountered by self pay patients and self funded payers and concludes "that this problem is best resolved by allowing hospitals to bill itemized charges to self pay patients, patients covered by small, local self-funded employer/employee health carriers and Health Maintenance Organizations."

We respectfully submit that this has not been the case.

As self funded payers, as defined under "ERISA," we have been paying itemized charges in cases where implementation of the DRG system provided for charges in some billings, which range from 100% to 500% of consumed resources.

Our participants have been billed for the difference, with the Fund office advising them of their right of appeal under the DRG system.

Under the DRG appeal process an appellant is entitled to a hearing and the hospital ostensibly is advised by the State

to suspend billing until the appeal process is exhausted.

One such participant with a pending appeal has been served a summons on Tuesday, 12/18/84, by an attorney representing the collection arm of Jersey Shore Medical Center, Neptune.

The DRG rate per case for his wife was $8516.73; the consumed resources or itemized charge was $4257.00. Thus the DRG, as assigned, was approximately 200% of the itemized charges.

The participant had excercised his right of appeal but is still being harrassed and humiliated.

Some problems inherent in the system as a whole include:

Inequitable Charges - Hospital services are typically charged on a prospective reimbursement basis.

When the program was initiated on an experimental basis, it was explained through brochures, publications, etc. that this system of flat rate per procedure would be a boon to the Health Care field akin to what the discovery of fire was to cave comfort.

As it stands now, we are paying more for the wood but the cave has ice on the floors.

The idea itself seemed reasonable. Three hundred eighty three separate diagnosis were encoded and the hospital would be paid a flat rate, no matter what the length of stay, provided it was in acceptable length of Stay Trim points, e.g. DRG 193 appendicitis (without peritonitis). Without Major Secondary

Diagnosis - Trim points - Low 3, High 12. In this case, a stay of under three days or over 12 is billed as an outlier or itemized charges.

Theoretically, should a stay fall within the prescribed Trim points, one flat rate would be charged; the hospital would benefit if the length of stay was below the point where itemized costs equaled the DRG and would lose if this point was exceeded. Thus the incentive would be for the hospital to discharge as soon as practicable to maximize resources the following year when rates would be set, recognition would be given to this increased revenue and the DRG rates would be lower, benefiting both hospital payer and patient through lower premium charges.

In practice we find that hospitals knowing these rules and having access to rates appeal processes have been systematically manipulating diagnosis to ensure that

a) Invariably, the highest revenue producing diagnosis is selected.

b) In many cases, when itemized costs exceed rate per case, a secondary diagnosis is added to change billing to an outlier.

c) Discharged patient records are reviewed for appropriateness of diagnosis by hospitals through the means of an in-house Utilization Review Committee which, in many cases, is not much more than either a rubber

stamp or presents a subtle intimidation to the discharging physician to select the highest revenue producing DRG.

d) Many hospitals refuse to divulge an admitting diagnosis when verifying eligibility for coverage with our Fund office. Thus there is no yardstick to compare and identify gamesmanship.

Administrative Costs of the System - Little mentioned when the subject of DRG is discussed, is that administrative costs have soared since its inception.

A five million dollar grant from the Carter administration inaugurated and encouraged this experiment.

I have not seen to date an analysis of implementation costs but they must include:

Consultant costs such as Peat Marwick Mitchell Company.

Salaries of DRG grouping and encodement.

Vast reams of material collection to feed these computors, which means staff must be assembled and paid for this purpose.

Expanded role of the State in evaluating and collating this data and a massive bureaucratic entity has been created which feeds on itself.

Expanded accounting and auditing departments in these hospitals.

These expenditures are massive and unfortunately do not add

one aspirin to better patient care. Indeed, the tendency is to insulate administration from patients, and blur the intended purpose of providing adequate health care at reasonable cost by reducing the patient to a statistic such as Number 283.

Advantages to insurers such as Blue Cross, Prudential, etc, include:

Reduction of hospital procedures and service to a number enables usage of a data processor in administering claims rather than a higher salaried claims adjuster. Many more claims can be processed by punching in a DRG number rather than reviewing each charge on its merits.

Quasi public entities such as Blue Cross and health care insurers, such as Prudential, Travelers, Equitable, et. al., pay excessive claims with the knowledge that even if they don't receive the benefits of the alleged "averaging affect," they have the luxury of presenting to the State the evidence of their increased costs and receiving a rate adjustment.

It would seem that the system is tilted toward those insurers with large patient populations. If a self pay or self funded payer does enroll with these carriers, they are then bombarded with rate increases to pay for the system's inefficiencies.

Horror Stories

Excessive charges often are attention grabbers and we have had our share.

When the DRG system was in it's relative infancy, one of our participants' daughters was admitted to Beth Israel Hospital, Newark (10/2/81).

Diagnosis - Nephrotic Syndrome

Length of Stay - 2 days; 10/28/81 - 10/30/81

Controlled Charges (itemized) - $ 630.20

DRG 237 Charges - 8214.93

A difference of: $7584.73

Briefly, the Fund paid on what appeared to be the correct DRG incodement of 236 since no surgery was performed or 4038.36. The hospital billed the participant for the difference.

In the appeal process the coding of 237 was upheld but since the patient had also initiated an appeal on the basis of excessive charges the bill was changed to an outlier or itemized charges.

Some examples of excessive charges:

ADM DATE	DRG#	DX	HOSPITAL	LOS	TRIM POINTS	DRG PR.	ITEMIZED
7/22/82	174	GI Hemorrhage	Hunter Med	5	3-18	3418.45	1930.90
1/10/82	151	Vascular Disease	Newark Beth	21	2-50	5315.98	3443.90
1/22/82	186	Stomach Ulcer	St. Eliz.	9	8-38	5015.31	1499.75

Some other more recent examples:

2/12/84	260	Lesion Exc.	Hackensack	2	2-14	3495.56	1447.97
4/3/84	143	Chest pain	JFK	2	2-13	2291.51	861.35
8/15/84	138	Arrythmia	Mon Med	3	2-18	3237.24	1619.65
9/17/84	373	Episiotomy	Tom's River Comm Mem	3	3-6	1679.30	853.00

ADM DATE	DRG#	DX	HOSPITAL	LOS	TRIM POINTS	DRG PR.	ITEMIZED
9/17/84	391	Newborn	Tom's River Comm Mem	3	3-6	989.94	382.00
4/17/84	324	Ureteral calculus	Muhlenburg	1	1-8	1149.12	277.08
4/16/84	139	Arrythemia	Hunterton	2	2-13	2267.04	929.35
12/7/83	138	Myocardial Infarction	Jersey Shore	2	2-18	3490.92	1832.00
9/15/83	391	Newborn	Kacketstown	5	3-6	956.23	381.75

The Fund has also experienced DRG "Sandwiches."

A Fund participant was admitted to Riverview Hospital and treated for carcinoma of the lung - DRG# 082. The Fund paid itemized charges of $2107.90. A subsequent admission for the same complaint was encoded as DRG# 079 (Lung Abscess). Since the itemized costs exceeded the DRG rate per case, we were billed as an outlier.

An admission on 3/11/83 to Bayshore Community Hospital again for the same complaint was encoded DRG# 082 (Carcinoma).

Other problem areas:

Unbundling - Many institutions have formed profit making entities, billing separately for these services (Lab, ER, etc.) and leaving capital/labor intensive services such as house keeping, plant, nursing service thus effectively removing off-setting income from the DRG rate and increasing the charges.

Indigent Care - A very real problem particularly for inner city hospitals. The DRG system of Soaking the Sick for these charges seems to us the very core of this system's problems.

The solution to this socio-economic issue (unpopular as it is in some quarters) would be more appropriately addressed by a

governmental authority and the costs spread through the population at large.

Continuance of this present system would force many firms and funds to eliminate coverage for their retirees where a large portion of the costs lie and for whom there are no contributions, and shift the burden to the system, exascerbating the problem geometrically.

System Complexities - Components of the DRG rate per case are Byzantine and when read, seems as if Joseph Heller was the author.

I've enclosed a copy of the upside and downside volume shifts as extracted from the Procedural and Methodological Regulations to illustrate this point.

Spend it now mentality - Under this system, it behooves a hospital to exhaust resources in some areas so that if the funds aren't spent, the following rate per case would indicate a disincentive or lower rate the following year.

Cost Containment Objectives - One idea put forth was that less than efficient hospitals or under utilized hospitals would either consolidate or fold, thus the remaining hospitals would provide adequate health care at a reasonable cost and full patient populations.

Many newspaper articles have suggested that this consolidation process is in effect. However, there are many hospitals throughout the state which are overbedded and they fill these empty beds or departments by opening a unit of the latest illness in vogue.

Mark-up Factor - After the direct costs are calculated, indirect cost or mark-up factors are a multiplier. Attached is an illustrative example where in the space of 1½ years, the mark-up on the specified procedure as well as the DRG rate went up approximately 175%.

Payer Factor - after all the alchemy is completed in assigning a rate per case, the resultant figure is multiplied by this payer, which varies from hospital to hospital.

This is a particularly onerous "tax" in that self pays and self funded groups are forced to subsidize the supposedly "not for profit" Blue Cross organization. In some cases we are then required to pay 106% of the bill be it itemized or DRG.

In conclusion, I would like to thank the committee for the opportunity to explain some of the difficulties we've either perceived or encountered with this system as noble as it's declaration of

> "It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided, and properly utilized at a reasonable cost of vital concern to the public health."

We find it in effect, wanting.

Respectfully submitted
20 December 1984 by

James D. Reilly
Administrator

JDR/ep

cc: All committee members

RECEIVED AUG 0 7 1984

July 2, 1982

Carolyne K. Davis, Ph.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Room 309G, Hubert Humphrey Bldg.
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Doctor Davis:

I wanted to tell you how much I appreciated the time you spent with Mr. Joseph Morris and myself on May 27. We hope that you found useful the update he provided on the impact and successes of the case-mix reimbursement system, which is being conducted as a demonstration project under a waiver negotiated with the Health Care Financing Administration.

As discussed with you at our meeting, the issue of billing self-pay patients on the basis of itemized charges, rather than using the price per case, is one that we feel is very important. The equitability and public acceptability of the case-mix rate setting demonstration is closely linked to the way in which we ultimately resolve this issue. When the regulations governing the implementation of this system were first promulgated in 1979, a policy decision was made that all payors should be billed the price per case which had been established for each Diagnosis Related Group. The decision effected large third-party payors and self-pay patients. Self-pay patients included those patients with no insurance coverage whatsoever, and patients covered by small local self-funded employer/employee health carriers. This decision was made after extensive discussions with staff from HCFA's Office of Research and Demonstration, and was based on the following ideas:

First, it was felt that an equitable reimbursement system required that relatively uniform rates be issued to all payors, in addition to those rates being used for the calculations at final reconciliation. Second, it was felt that hospitals would be more effectively encouraged to constrain their cost increases if they were required to bill each payor the price per case at the time of the inpatient stay. It was felt that if the price per case were only used at final reconciliation, and if during the year hospitals were allowed to bill itemized charges, hospitals would not experience the direct impact of the cost constraints and incentives or disincentives built into the reimbursement system. These arguments made a great deal of sense when applied to such third-party payors as Medicare, Medicaid, Blue Cross, Prudential and the other large commercial carriers. Not only were these payors responsible for the bulk of hospital payments, but the volume of claims they processed effectively protected them from the payment fluctuations associated with price per case billing.

Since these payors process such large claims volumes, the impact on their pay-out of cases in which DRG rates exceed actual charges is balanced by the payment for cases in which charges exceed the actual DRG payment rate. The result of this averaging effect is to limit dramatic shifts in each payor's overall liability.

However, when self-pay patients are billed the price per case, they are more likely to experience financial hardship. In short, the effects of averaging which benefit third-party payors do not impact on the payment liability of these self-pay patients. A self-pay patient (or small self-funded local carriers) can seldom balance a hospital bill in which the DRG rate exceeds itemized charges with another self-pay patient bill in which the opposite is true. In turn, a number of administrative and public relations problems then confront the Department of Health. In fact, a part of the utilization review process which has been implemented in New Jersey is geared to handle appeals from self-pay patients who have serious difficulty with paying a rate higher than the actual charges for a hospital stay.

It is our feeling that self-pay patients should be billed differently from other payors. Self-pay patients are in a qualitatively different position from most subscribers to the major third-party payors. Individual self-pay patients are liable for all or most of their hospital bills, and must share in the cost of medical care in a way that those with health insurance do not. They already face the health care market with incentives to keep down their admissions, lengths of hospital stay, and use of ancillary services. Such caution in the use of health care services may not, however, ensure that these patients will become outliers, subject only to itemized charges. For instance, a self-pay patient may be more likely to request an earlier discharge from the hospital. This early discharge may set the patient's overall length of stay above the trim point, but below the average for that diagnostic group. By requiring self-pay patients to pay a price per case for a hospital stay, we are placing a burden on them which is not faced by individual subscribers to most insurance plans. We are limiting their ability to benefit from the lowering of charges in New Jersey hospitals which is the result of institutions aligning their charges with actual costs. The same arguments can be made on behalf of small local self-funded carriers which work with very limited resources, and which are more vulnerable in the health care market.

Our feeling is that this problem is best resolved by allowing hospitals to bill itemized charges to self-pay patients, patients covered by small local self-funded employer/employee health carriers and Health Maintenance Organizations. At final reconciliation, these charges will be reconciled to the appropriate price per case. Given the unique status of self-pay patients, and their relatively minor impact on hospital revenues, we feel that such an exception would not undermine the hospital cost constraint efforts, would not compromise the Medicare/Medicaid waivers, and there would be substantial benefits in terms of consumer satisfaction and equity. We would be more than happy to discuss this issue in detail, since we sincerely feel that a proper resolution is crucial. Again, many thanks for your openness and consideration.

Sincerely,

Shirley A. Mayer, M.D., M.P.H.
State Commissioner of Health

SAM/JIM/LE/ams

UNITED HOSPITAL MEDICAL CENTER

APPENDECTOMY

982	Price/Case	X	Mark Up	=	Charge without payor factor
6/1	$1,121.19		1.709		$1,916.11
1983					
1/1	$1,179.91		1.992		$2,350.38
3/1	"		2.232		$2,633.56
5/1	"		2.339		$2,759.81
1984					
1/1	$1,351.37		2.467		$3,333.83

Above charges multiplied by Payor Factors of: 1983 1984

	1983	1984
	1.143	1.066
Blue Cross Payor Factors:	1.010	0.991

HYSTERECTOMY

1982	Price/Case	X	Mark Up	=	Charge without payor factor
6/1	$1,715.04		1.709		$2,931.00
1983					
1/1	$1,804.86		1.992		$3,595.28
3/1	"		2.232		$4,028.45
5/1	"		2.339		$4,221.57
1984	$2,060.16		2.467		$5,082.41

The payor factors cited above also apply for this diagnosis

Upside and Downside
Volume Shifts

A. Volume is measured by the volume/intensity proxy described in the previous section.

B. For volume changes of between 0% and 10% between the base and rate years, in either direction, then

1. The hospital will receive the full variable cost proportion of any marginal revenues it receives in the rate year, plus an increasing percentage of the fixed portion of marginal revenue, if volume is increasing.

2. The hospital will receive a decreasing fraction of the fixed portion of any rate year revenue that has been lost due to a volume downturn.

C. For volume/intensity changes equal to or greater than 10% in the period between the base year and a given rate year, then

1. If volume is increasing, the hospital may keep all of the marginal revenue it gains.

2. If volume is decreasing, the hospital may not recover any of the revenue it loses.

D. The earned marginal revenue of the hospital is the adjusted marginal revenue and is a function of the variable and fixed costs of treating more patients or a more acute case-mix.

The earned marginal revenue of a hospital, if it has undergone an overall percent change in volume/intensity between 0 and 10% will equal:

1. 100% of the supply-type revenue related to the increased volume. (This is revenue related to supplies; contracted services; other expenses; depreciation; lease costs; and physician salaries, fees, and fringes.)

2. A variable percentage of the employee compensation revenue. The percentage of the compensation portion of marginal revenue which the hospital retains is calculated in accordance with section E below. (Revenue related to non-physician salaries and fringes).

E. For volume/intensity increases between 0% and 10%, the following calculation is used to determine how much of marginal revenue may be kept by the hospital as earned marginal revenue:

Earned
Marginal Revenue = 100% of the Supply Revenue + A variable % of Compensation Revenue
= (Supply %) X (Total Incremental Revenue) +

(Variable % of Compensation) X (Compensation %) X (Total Incremental Revenue)

This relationship can be expressed by the following equation;

$$y = (m)(x) + (b)(f)(x)$$

where

y = marginal revenue due the institution (earned marginal revenue)
m = average variable cost percentage for the hospital's Direct Inpatient cost centers (supply costs as a percentage of total direct inpatient care costs.
x = total marginal inpatient revenue received by the hospital in the rate year (a function of volume/intensity changes)
b = $\frac{(\text{total \% change in volume/intensity between base and rate years})^2}{(10)^2}$

f = average fixed cost percentage for the hospital's Direct Inpatient cost centers

Example: If the rate year is 1982, and the base year is 1979, if the total volume change as measured by the volume/intensity and admissions measures is 6% between the base and rate years, and

m = 40%
f = 60%,
x = $1,000
b = $\frac{(6.0)^2}{(10)^2} = \frac{36}{100} = .36$

then:

$y = (.40)(1000) + (.36)(.60)(1000)$
$y = 400 + 216 = \$616$

This is the earned marginal revenue that the hospital may keep. The term b determines what portion of the fixed (compensation) cost percentage of marginal revenue will, in fact, be considerable variable. As the size of the volume increase gets larger, more and more of the fixed cost proportion is considered variable. The logic of this formula is that, as volume changes over the period between base and rate years, the possible hospital response must shift from more efficient use of personnel to the hiring of more personnel.

If volume shifts by more than 10% in this period, then all costs are considered variable, and the hospital is due all the marginal revenue.

F. If volume/intensity decreases between 0% and 10% between the base and in the rate year, the following calculation is used to determine how much of the resulting lost revenue may be recovered by the hospital:

Recoverable Inpatient Revenue = (Compensation % of the Lost Revenue)

X

(Total direct inpatient care revenue lost by the hospital in the rate year, due to a decrease in admissions or case-mix intensity

(That percentage of the compensation part of lost revenue which the hospital should be allowed to keep).

OR

$e = (h)(i)(1 - g)$

WHERE:

e = Recoverable inpatient revenue

h = Compensation portion of lost revenue

i = Total Lost Revenue

$g = \frac{(\text{total \% Change in the Volume/Intensity Measure Between Base and Rate Year})^2}{(10)^2}$

1-g = Recoverable percentage of the compensation portion of ~~lost~~ revenue

Thus: If a hospital loses $1000 in total direct inpatient revenue in the rate year, 60% of the lost revenue represents compensation revenue, and the total decline in volume intensity between base and rate years was 6.0%.

$h = .60$

$i = \$1000$

$g = \frac{(6.0)^2}{(10)^2} = \frac{36}{100} = .36$

$1-g = 1 - .36 = .64$

$e = (h)(i)(1-g)$

$e = (.60)(\$1000)(.64)$

$e = \$384$

The hospital is allowed to keep $384.

If the total volume decrease is greater than 10%, the hospital loses all of the $1000.

EXHIBIT I

Background Information

The Steamfitters Welfare Fund, Local Union No. 475 is a Multi-employer Trust Fund that was established on 10 October, 1950, and which provides Hospital, Surgical, Medical and other similar benefits for employees and dependents working in the Building and Construction Industry. The Plan is financed by Employer Contributions in accordance with the terms of a collective bargaining agreement between Steamfitters Local Union No. 475 of Warren, New Jersey and The Mechanical Contractors Association of New Jersey.

Employee Information

The Fund covers retirees, employees and dependents of workers engaged in the Building and Construction Industry (essentially commercial and industrial heating, air conditioning and pipefitting work) in Essex County, Union County and portions of Hunterdon, Mercer, Middlesex, Morris, Somerset and Warren Counties.

The Plan, except for Accidental Death and Dismemberment Benefits, became self-funded on April 1, 1983. All benefit payments, with the exception of the Accidental Death Benefits and Prescription Drug Benefits are paid directly by the Fund. Prescription Drug Benefits are administered through PCS and their participating pharmacies. The Accidental Death and Dismemberment Benefit is currently underwritten by Federal Life Insurance Company. (A Chubb Group).

Prior to April 1, 1983, the Plan of Benefits was underwritten by the Union Labor Life Insurance Company using a "Mini Premium Type Contract," with a pooling of Accidental Death and Dismemberment and Major Medical claims.

The contract with Union Labor Life was renewable on January 1, 1983. The renewal proposal submitted by Union Labor Life for the contract year 1983 was found to be unacceptable, and the Trustees, based on the recommendation of its professional advisors, decided to self-fund the Health Insurance Benefits effective April 1, 1983.

Tax Ruling Status

The Fund is exempt from Federal taxes under Section 501 (c) 9 of the Internal Revenue Code. The exemption has been in existence since March 17, 1953. The plan is established and maintained in accordance with the terms of a Trust Agreement. The benefits and eligibility requirements are fully described in a benefit booklet, which has been distributed to all eligible participants and other interested parties. The plan is in compliance with all Federal Rules and Regulations and complies with all ERISA requirements.

ADMINISTRATION

The Fund Office maintains a staff of five full-time employees, who are under the direct supervision of the Plan Administrator, Mr. James D. Reilly. For the last 30 years, this Office has processed all Hospital, Surgical and Medical Claims (including Dental and Major Medical) using a Draft Book System. The Death and Accidental Death Claims are first processed by the Fund Office; however, the actual payment is made by the Insurance Carrier, except for those self-insured death benefits paid to eligible retired participants.

The Fund Office also has in place a complete Data Processing System, All claim payments are processed using this system. The Fund Office generates a complete payment register daily, monthly, quarterly and annually.

A separate Claim Benefit Account is established with the Somerset Trust Co. of Somerville, New Jersey. All benefit checks are processed by the computer system through this account and are subject to audit controls and compliance tests, as mandated by applicable law and customary accounting standards.

In addition to processing all benefit payments, the Fund Office also has the responsibility of processing all Employer Contributions made to the Fund. In conjunction with the foregoing, they also maintain all eligibility records and are responsible for the determination and certification of eligibility for benefits.

The Trustees have retained the services of a firm of Certified Public Accountants, to monitor and provide periodic audits of the Fund Office Operations.

Submitted by Bernard McCarthy

JANUARY 1, 1984 DIAGNOSIS # 087 - PRICE PER CASE AT

RIVERSIDE HOSPITAL $ 4,570.29

JULY - $ 4,241.00

SEPT. - $ 4,956.00

DEC. - $ 7,014.00

GOOD AFTERNOON. MY NAME IS MURRAY KLEIN, AND I AM A PARTNER IN THE TRENTON LAW FIRM OF TOMAR, GELADE, KAMENSKY, KLEIN & LEHMANN. OUR FIRM SPECIALIZES IN HEALTH CARE ISSUES. I AM BEFORE YOU TODAY AS A REPRESENTATIVE OF SEVERAL HOSPITALS, SPECIFICALLY THOSE THAT SERVE A HIGH PROPORTION OF MEDICARE PATIENTS. THEY ARE: POINT PLEASANT HOSPITAL LOCATED IN POINT PLEASANT, MEMORIAL HOSPITAL OF BURLINGTON COUNTY LOCATED IN MOUNT HOLLY, ZURBRUGG MEMORIAL HOSPITAL LOCATED IN WILLINGBORO, AND COMMUNITY MEMORIAL HOSPITAL LOCATED IN TOMS RIVER. I WILL ADDRESS THE CONCERNS OF THESE HOSPITALS AS THEY APPROACH THE YEAR 1985 REGARDING TWO SCENARIOS: THE WAIVER IS APPROVED AND THESE HOSPITALS WILL LOSE $31 MILLION DOLLARS IN MEDICARE REVENUE THEY WOULD OTHERWISE HAVE TO OPERATE THEIR HOSPITALS; THE WAIVER IS DENIED AND THE STATE MUST ONCE AGAIN ADDRESS HOW IT WILL PROVIDE FOR THE VIABILITY OF THOSE HOSPITALS TREATING DISPROPORTIONATE NUMBERS OF INDIGENTS.

ASSUMING THE WAIVER IS GRANTED, THESE HOSPITALS WILL LOSE $31 MILLION DOLLARS THAT THEY WOULD OTHERWISE BY PAID BY MEDICARE FOR THE TREATMENT OF THEIR PATIENTS. THERE ARE MANY REASONS FOR THIS, SEVERAL OF WHICH ARE:

1. NEW JERSEY'S COST CONTAINMENT EFFORTS SINCE 1975 HAVE REQUIRED THAT HOSPITALS OPERATE MORE EFFICIENTLY, AND AVAILABLE DATA STRONGLY SUGGESTS THAT NEW JERSEY HOSPITALS ARE THE MOST EFFICIENT IN THE COUNTRY.

2. THE FEDERAL GOVERNMENT INCLUDES AN AUTOMATIC AND MORE GENEROUS FACTOR TO REIMBURSE HOSPITALS FOR RESIDENT AND INTERN TEACHING PROGRAMS.

3. THE INFLATION FACTOR UTILIZED BY THE FEDERAL REIMBURSEMENT SYSTEM IS HIGHER THAN THAT ALLOWED FOR BY NEW JERSEY.

4. THE IMPACT OF "SHARING" OF DRGS REIMBURSES HOSPITALS WITH HIGH MEDICARE VOLUMES LESS THAN WHAT THE FEDERAL GOVERNMENT DATA BASE HAS IDENTIFIED AS THE COST FOR MEDICARE PATIENTS IN THOSE DRGS. FOR EXAMPLE, ASSUME IN DRG NUMBER 1 THERE IS A HIGH PERCENTAGE OF NON-MEDICARE PATIENTS. THEIR COST OF CARE IS $1,000. HOWEVER, THE TRUE COST FOR A MEDICARE PATIENT IS $1,500. THE HOSPITAL, AS A RESULT OF THE AVERAGING PROCESS, IS PAID $1,250 PER CASE. THEREFORE, THE HOSPITAL TREATING MEDICARE PATIENTS IN THAT DRG LOSE $250.00 OF ITS COST FOR EACH MEDICARE PATIENT TREATED. IT WAS NOT UNTIL THE FEDERAL DATA BECAME AVAILABLE THAT THIS INEQUITY BECAME APPARENT.

IT IS THE INEQUITIES GENERATED BY THESE DIFFERENCES THAT WE HOPE TO RESOLVE WITH THE COOPERATION OF THE COMMISSIONER OF HEALTH, AND THE GOVERNORS OFFICE.

THE REMAINING QUESTION THEN IS WHAT WILL NEW JERSEY BE FACED WITH ON JANUARY 1, 1985 IF HEALTH AND HUMAN SERVICES DOES NOT EXTEND THE WAIVER. NEW JERSEY WILL HAVE TO ONCE AGAIN GRAPPLE WITH ITS NEED TO ASSURE THE OPERATIONS OF THOSE HOSPITALS TREATING HIGH PROPORTIONS OF INDIGENTS. AND THIS GROUP OF HOSPITALS INTENDS TO SUPPORT THAT ENDEAVOR, AS THEY DID THROUGH THEIR SUPPORT OF THE CHAPTER 83 LEGISLATION.

II. OBJECTIVES

OUR GOAL SHOULD BE TO CREATE A REIMBURSEMENT SYSTEM WHICH ACCOMPLISHES THE FOLLOWING OBJECTIVES:

1. REWARDS THOSE HOSPITALS WHOSE OPERATING COSTS ARE BELOW THE PEER STANDARDS BY ALLOWING THEM TO KEEP THE DIFFERENCE BETWEEN THEIR COSTS AND THE PAYMENT RATES.

2. PROTECTS THOSE HOSPITALS WHO BECAUSE OF THEIR LOCATION MUST BEAR A DISPROPORTIONATE SHARE OF THE STATE'S TOTAL UNCOMPENSATED CARE LOAD.

3. PROVIDES AN APPEAL PROCESS FOR ADDRESSING THE LOCAL NEEDS OF THE STATE'S INSTITUTIONS ON SUCH MATTERS AS TECHNOLOGICAL CHANGES, CERTIFICATE OF NEED AND LICENSURE REQUIREMENTS.

4. PROTECTS INSTITUTIONS WITH LONG-TERM CAPITAL DEBT BY INSURING FULL REIMBURSEMENT ON EXISTING CAPITAL COSTS. LIMITS ON FUTURE GROWTH IN CAPITAL COSTS COULD BE IMPOSED AND WOULD NOT BE INCONSISTENT WITH THIS MADATE SINCE HOSPITALS COULD PLAN AND REACT ACCORDINGLY.

5. ALLOWS SUBSIDIZATION OF OUTPATIENT SERVICES THROUGH REVISIONS IN THE METHOD OF ALLOCATING OVERHEAD COSTS TO THESE SERVICES. SUCH ACTION WOULD ALLOW HOSPITALS TO PRICE OUTPATIENT SERVICES SO THAT THEY WOULD BE COMPETITIVE, THEREBY BENEFITING THE CONSUMER AND INSURING CONTINUANCE OF THESE SERVICES BY THE INSTITUTION.

6. Provides for the equitable reimbursement of medical education costs.

7. Insures that New Jersey hospitals whose costs have been slowly reduced over the past five years under the Chapter 83 System will receive some benefit from this condition and that New Jersey will receive its fair share of federal funds for Medicare services.

III. Proposed Solution

The loss of the Medicare waiver in New Jersey should not result in chaos in the state with regard to reimbursement for hospital services. The following proposed solution will accomplish the objectives as outlined above:

A. Medicare Patients

Hospitals which are able to operate efficiently for Medicare patients should receive adequate reimbursement through the federal P.P.S. rates. The NJHA study prepared by Kaden & Arnone Associates shows that nearly 90% of the New Jersey hospitals have Medicare costs

PER CASE BELOW THE NATIONAL PRICES AND THEREFORE SHOULD RECEIVE SUFFICIENT REIMBURSEMENT USING THE BLENDED P.P.S. RATES IN 1985. BY 1987, THESE HOSPITALS WILL RECEIVE INCENTIVE AMOUNTS AS MORE NATIONAL PARICES ARE BUILT INTO THE P.P.S. RATES. HOSPITALS WITH MEDICARE COSTS EXCEEDING THE P.P.S. RATES HAVE OVER TWO YEARS TO RESPOND TO THIS PROBLEM.

B. NON-MEDICARE PAYORS

REIMBURSEMENT FOR ALL OTHER PAYORS WILL BE BASED ON THE N.J. DRG RATES, HOWEVER, THE BASE YEAR COSTS WILL HAVE THE MEDICARE COSTS REMOVED. THIS WOULD BE ACCOMPLISHED SIMPLY BY USING ONLY THE UB'S FOR NON-MEDICARE PATIENTS TO CREATE THE HOSPITAL AND STANDARD COST BY DRG.

THE EXCLUSION OF MEDICARE COSTS FROM THE BASE WOULD HAVE THE FOLLOWING EFFECTS:

1. Rates in many DRGs will be lower than the current overall rates due to the removal of longer staying (and higher cost) Medicare cases.

2. The percentage of standard included in the rates could be increased by redefining the coefficient of variation for each DRG, since the new distribution of non-Medicare cases only will be more tightly compressed around the mean LOS.

3. Hospitals which treat Medicare patients efficiently will be allowed to retain the incremental funds paid to them under the P.P.S.

4. The inclusion of the uncompensated care no longer covered by Medicare (approximately 1 1/2 - 2% of total costs statewide) would be offset by lower DRG rates which now would exclude medicare costs. The overall rates paid by Blue Cross Commercial Insurers, etc., even with the additional amounts of uncompensated care, would actually be lower than the current rates they pay. (A study is currently underway to prove this assertion).

Note: Should the savings to all other payors generated through the removal of Medicare costs from the cost base <u>not</u> result in sufficient

FUNDS TO COVER THE ADDITIONAL $60 MILLION OF UNCOMPENSATED CARE, PRESENTLY PAID BY MEDICARE, THE SHORTFALL WOULD BE MADE UP THROUGH EITHER

A. AN UNCOMPENSATED CARE POOL

B. AN APPROPRIATION FROM STATE FUNDS

C. AN ASSESSMENT ON HOSPITALS THEMSELVES

D. A COMBINATION OF THE ABOVE

IV. CONCLUSION

THE CURRENT CHAPTER 83 SYSTEM CAN SURVIVE WITHOUT MEDICARE PATIENTS BEING COVERED UNDER IT. THE PRIMARY GOALS OF REWARDING EFFICIENCY AND PROTECTING UNCOMPENSATED CARE CAN BE ACHIEVED. IT IS INAPPROPRIATE, HOWEVER, TO TRADE ONE FOR THE OTHER, FOR IN DOING SO THE HOSPITALS IN THIS STATE ARE EITHER NOT RECEIVING THEIR FAIR SHARE OF FEDERAL MEDICAL FUNDS OR ARE BEING FORCED TO USE THESE FUNDS TO SUBSIDIZE OTHER PAYORS.

IN SUMMARY, THESE MEDICARE INTENSE HOSPITALS RECOGNIZE THAT SHOULD JANUARY 1, 1985 ARRIVE WITHOUT A FEDERAL WAIVER, THEY WILL ONCE AGAIN BE CALLED UPON TO FORMULATE AND SUPPORT ALTERNATIVE SYSTEMS TO CARE FOR THIS STATE'S INDIGENTS. WE WILL BE CONTINUOUSLY REVIEWING ALTERNATIVE SYSTEMS FOR SO LONG AS THE STATE'S WAIVER APPLICATION REMAINS IN DOUBT.

TESTIMONY BEFORE THE

ASSEMBLY CORRECTIONS HEALTH & HUMAN SERVICES COMMITTEE

DECEMBER 20, 1984

GEORGE D. HARTNETT, PRESIDENT
ZURBRUGG MEMORIAL HOSPITAL
RIVERSIDE, NEW JERSEY 08075

Mr. Chairman, and members of the committee, thank you for the opportunity to speak to you on behalf of hospitals that will suffer a most serious financial inequity under a waiver from the Federal Prospective Pricing System -- and without a fair, appropriate financing mechanism to administer medicare funds available to New Jersey under such a system.

Zurbrugg Memorial Hospital comprises two divisions; Riverside Community Hospital in Riverside, and Rancocas Community Health Facility in Willingboro. Both divisions provide 491 beds for the service community.

Zurbrugg is the primary service provider for Burlington County, while at the same time drawing almost 10% of its patients from outside Burlington County. Current projections show that the population of Zurbrugg's market area will increase by 10 to 15% between 1980 and 1988. That segment of the population which is 65 and over is expected to increase 50% during this same 8 year period. It is clear that health policy will have to address the

problems associated with an aging population - and do so with all expedience.

The financing of medicare within this state is, without doubt, a problem that directly affects our aging and disabled population. Any solution must be unselfishly implemented so as to benefit those recipients of medicare in the most complete manner possible, and to leave our successors in health care administration a rational, and competent legacy on which to build future systems.

Under the Federal Prospective Pricing System, the state of New Jersey predicts that our hospital would enjoy at least an $7,300,000 increase in medicare revenues over a three year period. There is no question that such an increase in medicare revenues would enhance our presently competitive market position while concurrently ensuring that medicare services and programs for the aged and disabled would first, be more sufficient for consumers, and, second, be on par with services offered by the majority of

states that are already operating with the Federal system. Conversly, under a waiver, and as funds to cover medicare expenses are continually reduced, we experience constraints in our ability to form and access capital both in our hospital and in the capital markets. Constrictions in the amount of medicare funds available to this hospital effectively deaden efforts to expand or even improve services that are currently available. Simply stated, we cannot be innovative without cash. Furthermore, existing systems imply increasing efficiencies as hospitals are forced to provide services with a shrinking pool of funds. In reality, hospitals in New Jersey are already at such a high level of comparitive efficiency, that marginal efficiencies decrease drastically under a waiver system, and, in fact, cost more in quality and quantity of services than they are worth. We believe that it is the state's obligation to ensure maximization of total medicare dollars available to New Jersey. To pursue any alternative mechanism or system that admittedly lessens the amount of money available for service provision and

cost coverage, is tantamount to depriving medicare recipients of quality health care and health services. This is an issue of premier importance as we anticipate the changing demographics of an aging population.

A second issue which this state must confront and answer definitively concerns the equity associated with distribution of medicare dollars within the state, under any system. Should the waiver be denied, current formulas which are used for allocation of medicare monies must be adjusted to reflect fair and rational distribution criteria for the additional dollars that will flow into the state. Concurrently, this state must effect a mechanism that will deal with financing uncompensated care which is not addressed by the federal prospective pricing system.

If the waiver is allowed, this state must prepare itself to ration, more effectively, its own limited medicare coffers. It will be imperative to ensure that hospitals with high medicare use will not be forced to share disproportionately in the allocation of funds. Ideally, no one class of patients, for

example, the indigent or the elderly, should be penalized at the expense of the other. We recognize that it is the duty of participants in any system to offer constructive criticisms in order to ensure the survival and viability of such dynamic efforts. We further recognize our responsibility to contribute tangibly to that system. In that spirit, several concerned provider institutions met with Mr. Gary Stein, Director, Governor's office of Policy and Planning, and Mr. Charlie Pierce, Deputy Commissioner of Health on November 26, 1984 to discuss the equity and uncompensated care problems associated with medicare reimbursement both with and without a waiver.

At that time we were apprised by Mr Pierce that the Department of Health was quite sure that the State would be granted a waiver from the Federal system, and as such, had no existing alternative plan which would address the issues of equity and uncompensated care in this State. Upon recognition of this situation, Mr. Stein gave assurances on the part of the Governor's office, that no one class of patients would suffer more than another class because of

a waiver system. He further assured the group that no hospital would suffer as a result of inequities associated with the waiver. But most importantly, Mr. Stein invited institutions to participate with the State and the Department of Health in the preparation and institution of a financing mechanism that is rational, understandable, and equitable in its method of allocating medicare dollars. We were pleased to accept Mr. Stein's offer in a letter dated November 27 1984, and enjoined Mr. Louis Scibetta, President of the New Jersey Hospital Association to assume his appropriate responsibility in working with such a task force. To date, Chief Executive Officers, and Chief Financial Officers from several hospitals have met frequently to develop an alternative financing mechanism which addresses both the inequities of existing systems, and the question of uncompensated care coverage in the event the waiver is denied. In a subsequent meeting with Mr. Stein on November 30, 1984, and through a letter from the Governor's office on December 10, 1984, Mr. Stein has reiterated his desire to work

with the Department of Health and provider institutions in close partnership so that an appropriate financing mechanism may be developed.

We are proud to be involved, not as dissident selfish provicers that seek personal gain from the system, but as concerned, dedicated institutions which are committed to proactive measures for refining our present system of health provision in order to enhance the value of future services, and to continually upgrade the quality of care that is passed to the consumer.

Thank You very much.

December 11, 1984

Mr. Louis Scibetta
New Jersey Hospital Association
746-760 Alexander Road
CN-1
Princeton, New Jersey 08540-0706

Dear Lou:

As you are aware, we have been in contact with the Governor's office through Mr. Gary Stein and the Department of Health regarding critical financial issues associated with the institution of the "waiver" in New Jersey.

You are also aware that Mr. Stein has invited us to work with the State in the development of a financing mechanism for an all payor system that is rational, easily understood, and fair to all hospitals who are regulated by it. We feel that it is imperative to proceed in a cooperative effort to develop such a model with Mr. Stein and the Department of Health. One of our objectives in doing so, is to assure maximization of medicare monies that are paid into the State of New Jersey. Such an effort will be beneficial to all parties regardless of whether the "waiver" is obtained for the ensuing period. Our commitment to work in partnership with the State transcends, and is not dependent on the Status of the "waiver" in New Jersey.

We presume that the NJHA would feel it imperative to participate in activities that involve the chance to formulate and influence health policy on a direct level.

We thank you for your kind remarks to the legislative on behalf of hospitals which face a particularly heavy burden in the event that the "waiver" is obtained. We invite both you and the NJHA to join with us in actively assuring that hospitals most seriously affected by financial inequity, will retain their economic viability and identity. This will help to assure that present programs will continue to provide needed services to the elderly and indigent populations.

We look forward to your involvement in this regard and await your reply.

Sincerely,

ZURBRUGG MEMORIAL HOSPITAL

George Hartnett

George D. Hartnett
For the Attached Hospital Executives

Samuel H. Michael

Samuel H. Michael
For the Attached Hospital Chairmen

GDH:mm

cc: Mr. Gary Stein
Charlie Pierce

1. Northern Ocean Hospital System
   Richard J. Leone - President
   Roy B. Basso - Chairman, Board of Trustees

2. Zurbrugg Memorial Hospital
   George D. Hartnett - President
   Samuel Michael - Chairman, Board of Directors

3. Riverview Medical Center
   John K. Pawlowski - President
   Joseph P. Grause - Secretary to Board of Gov rnors

4. Nexus Healthcare Corporation
   Dave Hunter - President
   Paul Long - Senior Vice President
   William C. Haines - Member, Board of Trustees

5. Community Memorial Hospital Toms River
   James P. Schuessler - President and Chief Executive Officer
   James C. Casey - Vice President, Administration

November 27, 1984

Mr. Gary S. Stein
Director - Governor's Office
of Policy & Planning
State Health
Trenton, NJ 08625

Dear Mr. Stein:

On behalf of the Hospitals represented at yesterday's meeting, November 26, 1984, we thank you for your courtesy in hearing our concerns regarding the "Waiver."

As we noted yesterday, the essence of the issue is the overall financial loss of Federal Medicare Funds to New Jersey hospitals and the unreasonable and unfair burden placed upon institutions which, by circumstances beyond their direct control, accommodate a high percentage of Medicare patients. While many items were discussed at the meeting, we would like to repeat several in order to establish a focus whereby the hospitals, the Department of Health, and the Governor's office will work toward a resolution of this "equity issue." It was indeed unfortunate that the Department of Health had not properly advised you of the situation, which ultimately obviated the need for the meeting.

Of primary importance is a need to develop a financing mechanism for an all-payor system which is rational, easily understood and provides hospital Trustees and their respective management a predictable atmosphere in which to govern their hospitals and effectively operate their institutions.

Our collective assumption is that a well-governed and properly managed institution is the key to successfully implementing the regulatory mandates established by the legislature in the development of a New Jersey financing system. As well, it is reasonable for the hospitals and your office to assume that the dollar amounts identified in the Waiver application will probably change, especially in the latter years of implementation. Concurrently, we recognize the problems associated with the Federal deficit and the compelling need to reduce that deficit. We must, however, refrain from using the dollar argument selectively to placate institutions faced with serious financial losses as a result of these inequities, while at the same time using these calculations to seek approval of a Waiver. Waiver aside, we are in accord that the issue centers on how monies would be distributed, and are assuring that the total amount of money within the New Jersey health system is sufficient to provide adequate coverage for all payors including the indigent and elderly.

Given the above, we are willing to accept your offer to work directly with your office, the Department of Health and the Commissioner in concert with the New Jersey Hospital Association (as per Mr. Scibetta's comments) and others to immediately develop a mechanism to eliminate any loss of Medicare monies to our hospitals. This effort must assure both immediate relief (assuming the Waiver's acceptance), and a longer term solution for the indigent question (post Waiver). We will provide the assistance to assure development of a specific model(s) which includes provision for an equitable and quantifiable financing mechanism for Medicare patients and indigent patients. In any case, this model must include a base used as a premise from which calculations for correcting wrongs associated with those identified in the Waiver. This point is essential so all hospitals, regardless of size and political impact, can best serve their patients.

Further, we ask that a specific deadline be established in order to achieve the development of this model(s), and request that a letter from your office be forthcoming to confirm your desire to proceed as outlined above.

We ask the Governor's Office to advise the Commissioner of Health of this commitment, and willingness to work to resolve this issue.

As indicated to you by phone on November 27, the hospitals involved are preparing testimony for the meeting on the 30th. They will outline their concerns regarding the negative impact on their finances as they currently perceive them. We are prepared, as well, to advise the legislative committee of the fact that we have accepted your offer to work closely with the Governor's Office, the Department of Health, and hospitals to resolve the "equity issue."

We appreciate the opportunity to work with the State on this very important matter and are pleased, to date, with the open and cooperative atmosphere articulated by you on the 26th. We hope this is the beginning of many such efforts.

Yours truly,

George Hartnett

George D. Hartnett
For the Attached Hospital Executives

Samuel Michael (SH)

Samuel H. Michael
For the Attached Hospital Chairmen

GDH:ar
cc: Louis P. Scibetta, FACHA
Charlie Pierce

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   Community Memorial Hospital Toms River
   James P. Schuessler - President and Chief Executive Officer
   James C. Casey - Vice President, Administration

STATE OF NEW JERSEY
OFFICE OF THE GOVERNOR
TRENTON
08625

THOMAS H. KEAN
GOVERNOR

GARY S. STEIN
DIRECTOR
OFFICE OF POLICY & PLANNING

December 10, 1984

Mr. George D. Hartnett
Chief Executive Officer
and
Mr. Samuel Michael
Chairman, Board of Trustees
Zurbrugg Memorial Hospital
Hospital Plaza
Riverside, New Jersey 08075

Dear Messrs. Hartnett and Michael:

I am pleased that you and your colleagues are willing to work with my office, the Department of Health and others to develop an equitable response for those hospitals with Medicare patients making up an exceptionally high percentage of their total admissions. As your letter of November 27, 1984 suggests, achieving equity for high Medicare hospitals is directly interrelated to achieving and maintaining equity for hospitals with a high percentage of patients who receive uncompensated care. The two equity issues must be addressed simultaneously.

As soon as the waiver issues are settled, the Department of Health will pull together a task force to work on these problems, starting with the high Medicare hospitals. I would appreciate a copy of the proposal for financing uncompensated care that was mentioned by several of your colleagues at our meeting. My office will be working with the Department of Health staff as they work with you.

Please be assured of my continuing concern and that of Governor Kean for the special problems faced by your hospitals. Successful resolutions will require hard work and the technical competence possessed by your organizations and the Department of Health. I am confident that working together and with the support of the Governor's Office we will be able to achieve the equitable solutions we need.

Sincerely yours,

Gary S. Stein

cc: J. Richard Goldstein, M.D.
Charles F. Pierce, Jr.
Louis P. Scibetta

INDUCTOTHERM INDUSTRIES, INC.
10 INDEL AVENUE RANCOCAS, NEW JERSEY, USA 08073

COMMENTS INTENDED FOR THE PUBLIC HEARING
ON THE DRG PAYMENT PROGRAM
SCHEDULED FOR NOVEMBER 30, 1984
(The schedule did not permit that these views be presented)

We all agree that medical costs are almost out of control and Inductotherm and its relatively small group of employees is struggling with this same problem. In what we consider to be a misguided effort to control medical costs, the State of New Jersey has adopted the DRG hospital payment program whereby the hospital no longer charges according to the services rendered but rather charges according to an arbitrary diagnostic schedule. Apparently, the selection of the program was based on the concept that if the amount the hospital received for a patient was fixed by the diagnosis, then it would be in the hospital's interest to move the patients out as quickly as possible instead of keeping patients in the hospital in order to "keep the beds full."

Will society and the legislature never learn? Whenever the payment for any service is independent of the service rendered, then people will seek out, demand, and obtain the very finest service regardless of cost. Costs will become completely out of control. Only when patients have a direct stake in reducing their medical bills by reducing medical services will costs come down.

Under the DRG plan, hospitals may no longer have an interest in keeping patients in the hospital as long as possible, but hospitals rarely have a lot of say about how long patients stay anyway. This is usually left to the doctors and doctors can have a keen interest in keeping patients in as long as possible. At $35.00 per "walk-by" (hospital visit) a doctor with fifteen patients in a hospital can add $500.00 per day to his income for an hour's work, so he is a lot better off to have patients there longer. Some doctors will take advantage of it.

And what about the patients themselves? Since the cost to the patient is the same regardless of how long he stays he might as well persuade the doctor to keep him there a little longer. With a few well-timed groans and imaginary pains a patient who likes the hospital environment can stay there for many extra days.

(609) 267-9000 TWX (510) 683-9392 TELEX 685-1048

Or what about the conscientious patient? We had a young lady who went in for what was first thought to be a gall bladder attack but later diagnosed as an inflamed pancreas. She was given $1,400.00 worth of service and then discharged, but the charge under the DRG program was $2,665.00. Since the patient was paying 20% of the cost, her out-of-pocket loss was $253.00 (a week's pay) for this overcharge. And can the DRG program be fair when one inflamed pancreas can be treated in one day with a shot of antibiotics and another might take weeks to clear up. Should each patient and each illness be charged the same regardless of the severity of the problem.

And finally, did it ever occur to our legislators that the arrangements made between a private insurance company, the hospitals, and the citizens of New Jersey are just not any of the government's business. When the government dabbles with these arrangements through DRG payment programs or other restrictions it interferes with the free enterprise system, interferes with the rights of the citizens, and in the end raises the net cost to citizens.

I hope the legislators will join together to repeal this ridiculous socialistic legislation.

Henry M. Rowan
President

Atlantic
Industries, Inc.

P.O. Box 216
Nutley, NJ 07110

Tel. 201 235-1800
Cable: / nildye-Passaic

TWX 710-989-1468
TLX 6853089 Achem UW

Bernar l Rabinowitz
Presid nt

December 17, 1984

The Hon. George J. Otlowski
Chairman, Corrections, Health &
Human Services Committee
511 New Brunswick Ave.
Perth Amboy, NJ 08861

Atlantic

Dear George:

I am writing to you in connection with the D.R.G. hearings which you have been scheduling. These hearings are providing a valuable public service in that, I would hope, you will develop the fact (not generally known) that in New Jersey, the D.R.G.'s, as an important component of our total health care system, were and continue to be a great success.

Yes, there were some problems that developed early on in the implementation; yes, we were overly generous to the hospitals at the beginning in an effort to induce them to adopt the D.R.G. prospective payment system. But on balance, the D.R.G. worked because in New Jersey, we were guided by two main considerations:

Access to a medical facility, and
Equity for all of our citizens.

The net result of the D.R.G. system is that our hospitals learned to manage themselves, learned what their real costs were and how to control them. The upshot of this exercise, as you know, is that our inner city hospitals in New Jersey, for the first time in decades, are enjoying a positive cash flow, while the well-run and well-managed hospitals are very comfortable indeed. Some hospitals are struggling, but generally this is traceable directly to the fact that their patient mix or their doctor mix or their location is such that no hospital would be viable, and it is possible that additional changes in the system will continue.

One extraordinary development I must bring to your attention: by virtue of our New Jersey All-Payer D.R.G. System, no person failed to receive treatment in New Jersey because

he was unemployed or because his insurance had run out during the recession of 1982 when hospitals in other states were closing their doors to these unfortunate citizens.

With the proposed cutbacks in Medicaid, it can well be anticipated that the unemployed and poor people will be forced to accept second and even tertiary levels of medicine in other states, but one would hope not in New Jersey.

All of the foregoing, however, is a prelude to my major thesis: any consideration of D.R.G. must, in order to deal with the complexity of the issues raised, also deal with the totality of the New Jersey health care system. You must consider our strong Health Planning element; you must consider our strong Certificate of Need Program; you must consider our strong Hospital Rate Setting Commission; you must consider our strong Health Care Finance Agency. It is only when all of these elements of the New Jersey system are combined with the D.R.G. that one can understand why it has been so successful in New Jersey.

To study D.R.G. without reference to the remainder is to make the same error, in my view, that the Feds are presently making with their imposed D.R.G. program for Medicare patients. What will happen in other states is perfectly obvious: hospitals will simply transfer to other payers whatever the Feds take away in Medicare reimbursement, almost insuring that we will have medical triage for our citizens.

I hope your committee will be able to relate your D.R.G. investigation to the entire gamut of the New Jersey Health Care system.

With warmest personal regards and with every good wish for the New Year, I remain,

Sincerely,

Bernard Rabinowitz
President

BR:er

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

100 BERGEN STREET / NEWARK, NEW JERSEY 07103

December 17, 1984

Mr. David Price
State House Annex
CN-042, Room #311
Trenton, New Jersey 08625

Dear Mr. Price:

Enclosed please find a written testimony actively supporting the need for New Jersey to obtain a PPS waiver from the Federal government.

The comments presented herein, represents the position of the University of Medicine and Dentistry of New Jersey.

If I can be of any further assistance, please do not hesitate to contact me at (201) 456-6620.

Sincerely,

Kim D. Osterhoudt

Kim D. Osterhoudt
Assistant Director
Financial Planning Department

KDO:m

C

PUBLIC HEARING

Testimony for the Continuation of the New Jersey DRG Waiver

November 30, 1984, 10:30 a.m.

Assembly Chamber
Trenton, New Jersey

The testimony refers to the continuation of the Medicare Waiver and the comments on it herein are from the University of Medicine and Dentistry of New Jersey.

While there are aspects of the chapter 83-DRG system that have had a negative financial impact on University Hospital, the University pledges its support for a new waiver from the Federal Government for New Jersey and the continuance of New Jersey's Chapter 83 DRG system for all payors.

Public law 1978-Chapter 83 dictates that all payors share the cost of uncompensated care in New Jersey. The existing Federal Waiver in New Jersey will expire on December 31, 1984. If the federal PPS system is implemented, the major issue of concern for University Hospital will be reimbursement for uncompensated care, since this issue is not addressed by the Federal PPS system.

The need to focus more attention on this issue for University Hospital is apparent and essential. Although other hospitals do serve the poor in Newark, the real importance of University Hospital to the population of the city is reflected in its uncompensated care statistics. Over 75 percent of total annual indigent patient days in the City of Newark are provided by University Hospital. The care of these indigent patients represents one third of the total annual in-patient care provided by University Hospital. Presently, while University Hospital treats more indigent patients than any other New Jersey hospital, its reimbursement for uncompensated care is arbitrarily capped at 7 percent. At the same time, other New Jersey hospitals receive full reimbursement (in excess of 7 percent) while they treat fewer indigent patients than University Hospital. If uncompensated care ceases to be reimbursed through the New Jersey DRG system, the result will be a tendency towards increased dumping of indigent patients at University Hospital.

If University Hospital is to meet its goals and mission to continue providing quality care to an indigent patient population, continued reimbursement and funding for such care is essential. Hence, the University supports the New Jersey State Department of Health's request for a new waiver from the US Department of Health and Human Services in order to preserve New Jersey's all payor system and reimbursement for uncompensated care. Loss of the New Jersey waiver will create a severe financial dilemma for University Hospital.