Positions on Health Care Policy & Advocacy Issues

2005

NJCTH

NEW JERSEY COUNCIL
OF TEACHING HOSPITALS

Mission

> To Educate

...New Jerseyans about the role, status and future of academic medicine in the state;

> To Advocate

...for the community of teaching hospitals by providing research-based policy analysis and direction for progress in health care policy for New Jersey;

> To Initiate

...research studies that can inform these efforts and sponsor forums that bring together New Jersey's medical and policy professionals around issues of common concern;

> To Aggregate

...the policy resources of teaching hospitals throughout the state to provide a credible foundation for positive change; and

> To Articulate

...a pragmatic vision of a superior health care system for all New Jerseyans.

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NEW JERSEY COUNCIL
OF TEACHING HOSPITALS

From the Desk of J. Richard Goldstein, M.D.

President, New Jersey Council of Teaching Hospitals

The New Jersey Council of Teaching Hospitals believe the state's academic health centers have a heightened responsibility to provide leadership with regard to the measurement and delivery of quality care and patient safety and the dissemination of evidence-based medicine—especially in relationship to New Jersey's diverse population. The future belongs to providers and institutions that substantiate their specialized care is superior through the use of uniform metrics. Important member-wide initiatives focus on quality and patient safety improvement programs to enhance care for all patients.

In response to NJCTH's Board of Trustees challenge to play a thought leadership role on key strategic issues affecting the well-being of the entire health care system, the Council will concentrate its intellectual and advocacy efforts on "Transforming Medical Education," "Reducing the Uninsured" and "Accelerating the Digital Transformation of Health Care." To do so, NJCTH presents its position on issues affecting:

- Graduate Medical Education (GME)
- The Uninsured and Charity Care
- Conversion of Horizon Blue Cross from a non-profit to a for-profit entity
- Diversity
- Quality and Patient Safety
- Digital Transformation of Health Care

To continue to advance patient care through medical education and clinical innovation, NJCTH is dedicated to ensuring that the interests of both our members and the communities they serve are properly represented.

Working on behalf of a healthier New Jersey,

J. Richard Goldstein, M.D.
President, New Jersey Council of Teaching Hospitals

Graduate Medical Education (GME)

New Jersey's teaching hospitals are the "classrooms" for more than 2,700 residents and provide the necessary clinical experience to prepare physicians to practice medicine. Between both hospital-based and community health center practical experience, New Jersey's teaching hospitals are better preparing medical and surgical residents for the future through Graduate Medical Education (GME) programs.

>GME Funding

Both federal and state budgets fund hospitals for the cost of training physicians through GME, but both allocations have significantly declined over the last ten years.

Issue 1:
GME is underfunded by $200 million.

Position:
Improve (restore) funding of GME by $200 million over five years.

Statement:
The total cost of GME training to New Jersey hospitals is $572 million. Federal and state funding has been reduced over the years and now only covers $372 million of costs. This leaves a $200 million shortfall that exists between the actual cost to hospitals and the amount they receive from government payers.

Issue 2:
Medicaid is not paying their fair share of GME.

Position:
The first phase of the five year plan to increase GME funding should be to increase Medicaid funding for GME by $36 million ($18 million from the state and $18 million from federal funds). Additionally, $53 million is being paid to Medicaid HMOs for GME—funds that should flow directly to teaching hospitals.

Statement:
Medicaid's proportionate fair share of the total $572 million GME cost is $56 million. Currently they are reimbursing hospitals only $20 million, leaving a $36 million shortfall. Since GME payments are federally matched, an increase of only $18 million would be needed to correct the inequity. Additionally, according to Medicare payment guidelines, GME funds should flow directly to teaching hospitals.

Issue 3:
Efforts to cutback federal Medicare funding for GME are likely.

Position:
Since GME funding is already at a deficit position, no further reductions to GME Federal funding should occur.

Statement:
The federal budget deficit will likely cause legislators to recommend further cuts to health care providers in the upcoming fiscal year. Similar reductions have occurred in the past.

Issue 4:
The Department of Health and Senior Services (DHSS) is planning to change the method of calculating the GME component of Charity Care reimbursement.

Position:
Maintain the current calculation of the GME component of the Charity Care rates.

Statement:
The cost of GME has been a recognized element since the inception of Charity Care and the current calculation has been in effect for the last seven years. The Greenwald Charity Care bill did not intend to change the definition of GME, yet the DHSS has unilaterally–without input from legislators or the hospital industry–decided to change the calculation of the GME component of Charity Care. The proposal would cut reimbursement to teaching hospitals by $105 million and would disproportionately impact major teaching safety net hospitals. Seven safety net hospitals would receive $84 million in cuts or over 80 percent of the reduction.

>Centers for Medicare & Medicaid Services Funded Residency Slots

In accordance with the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) is currently evaluating the Medicare resident caps which impact GME and IME payments. This evaluation addresses the inequity that some hospitals, which provide training for residents, are in excess of their Medicare residency caps, while others train fewer residents than their resident caps, yet receive full payment. MMA will result in a reduction of residency caps for certain hospitals, and authorizes a "redistribution" of these residency slots to other hospitals.

Issue 1:
New Jersey teaching hospitals currently train more than 100 residents above the CMS cap for which they do not receive Medicare GME reimbursement. An allocation of redistributed residency slots will not only fund positions currently not covered by Medicare, but will also help New Jersey teaching hospitals meet proposed resident duty hour restrictions (as identified under Resident Duty Hours) and address the long term threat of an impending physician shortage.

Position:
Advocate for additional residency slots from the "unfilled pool."

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Graduate Medical Education (continued)

Statement:
CMS will be redistributing approved but unfilled slots nationally, with teaching hospitals in rural states receiving priority. With the advent of new Resident Duty Hour rules, New Jersey teaching hospitals will be challenged to meet patient care demands with work hours diminished among its residency caregivers. Additional residency slots from CMS's redistribution will help the state's teaching hospitals meet patient care demands more cost effectively than through the use of physician extenders. An increase in the allocation of residency slots to New Jersey's teaching hospitals will also help the state prepare for the growing health care demands of an evolving population.

Issue 2:
While CMS's redistribution of residency slots seeks to more efficiently utilize the current allocation of residency caps, it fails to meet the future patient demands of an evolving population and does not address the need to train more physicians in light of growing concern of a physician shortage.

Position:
Expand the number of CMS approved residency slots nationwide by 15 to 20 percent over the next five years.

Statement:
It is yet to be determined whether New Jersey teaching hospitals will be the recipients of CMS's redistribution. While additional residents from this redistribution will help New Jersey in the short term, it does not address the need for an expanded pool of residents for New Jersey teaching hospitals to meet its patient care demands and for the state to address the future medical needs of its population.

>Resident Duty Hours

Even in light of the year-old ACGME Residency Duty standards, academic medical centers are still challenged to evaluate and determine the advantages of continuity of care against the effect reduced resident hours have on medical errors. Recent studies published in the *New England Journal of Medicine* indicate that eliminating residents extended work shifts significantly decreases attentional failures and serious medical errors in the intensive care unit. The Council will investigate issues related to resident duty hour restrictions, including: the value of stress management seminars for residents; patient safety concerns related to transitions in care; shift-work sleep disorders; systemic approaches to analyzing residents errors and how to prevent them; the use of virtual and robotic learning tools for residents; competency-based versus volume-based evaluations; and the conflict between procedural volumes requirements mandated by accreditation entities and duty hour limitations.

Issue 1:
Legislating additional resident duty restrictions based on two limited studies within ICUs does not effectively evaluate the entire graduate medical education landscape.

Position:
Promote ACGME as the preeminent entity in overseeing and determining changes in resident duty hours by allowing them to oversee comprehensive studies to address all related issues and propose solutions.

Statement:
Allowing ACGME to study the effectiveness of the current regulations, and perform additional analyses on all the issues (as identified by the Council in the introduction of this Resident Duty Hour section) should be the next step in finding system-wide solutions.

Issue 2:
The new ACGME resident duty hour standards have had a substantial impact on New Jersey teaching hospitals' staffing and their operational effectiveness.

Position:
Determine the operational and financial impact of the current ACGME work rules on replacing residents with physician extenders, the more frequent transfers of care, and the resultant impact on patient safety.

Statement:
In order to adhere to the new regulations, hospitals have hired additional physician assistants and nurse practitioners, extended the work hours of regular staff, or left these shifts unfilled. Reducing the number of hours per shift increases the need to "hand-off" care responsibilities more frequently. These "critical junctures" in care and communication create potential safety lapses. Another solution in addressing the decrease in resident duty hours is to increase the number of residents in GME programs most impacted by the new rules. However, some hospitals are already paying for residents over their caps and New Jersey would need to receive a greater allocation of CMS funded residency slots to remain solvent.

>Residency Rotation Validation

CMS and ACGME require stringent record keeping to validate resident educational rotations, yet there is no specific system that has been developed to accomplish this nationwide.

Issue 1:
Lack of a standardized system of record keeping for residency educational rotations and preceptor evaluations, as required by CMS and ACGME, has led to poor compliance and denials of payment for some resident positions.

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Graduate Medical Education (continued)

Position:
Share best practices on monitoring actual resident work hours.

Statement:
By sharing "best practices," a uniform electronic tracking system can be developed and used by all New Jersey teaching hospitals to improve GME funding.

Issue 2:
Medicare audits of residency programs.

Position:
Investigate and resolve unfair GME Audits by CMS/Riverbend (i.e., outsourced audit vendor).

Statement:
Medicare, through fiscal intermediaries, such as Riverbend and other for-profit vendors, audits residency programs for compliance with Medicare rules. Requirements for resident rotation validation (hours and educational achievements), compliance monitoring, record keeping, and reporting, as well as other standards, impact a hospital's Medicare reimbursement for IME and GME. Audit criteria has been vague, with intermediaries taking different approaches, some of which have disallowed reimbursement for the residency program. By identifying all audit and record keeping standards, New Jersey's teaching hospitals can fulfill all requirements and better prepare for an audit.

>Transformation of Medical Education

To meet the needs of a rapidly evolving health care system, New Jersey's academic medical centers must do more than the direct training of health professionals. The state's teaching hospitals must demonstrate leadership in the design and development of educational approaches for health professionals throughout the continuum of education.

Issue 1:
Clinical rotation optimization for sites, instructors, and funding

Position:
The design and development of medical education is more than curricular reform—consideration must be given to how the clinical settings in which students are trained reinforces the attributes desired of health professionals in the 21st century.

Statement:
NJCTH's Academic Affairs Council identified the following issues for further study:

- Outpatient clinical site identification
- Movement of residents into outpatient sites (including ensuring reimbursement)
- The recruitment of voluntary medical staff, incentives, and the unique challenges of community hospitals
- Identification of various specialty instructors and the related reimbursement issues
- Closer relationship development with Federally Qualified Health Centers (FQHCs)
- Medicare rules for payment of voluntary preceptors

Issue 2:
Experts believe the curriculum, methods of teaching, lack of integration of disciplines, poor use of evidence-based education, minimal rotations in outpatient and community settings are undermining the health care system.

Position:
The development of a "Best Practices Resource Bank" will allow New Jersey teaching hospitals to examine and moderate new medical education methodologies and structures.

Statement:
Medical education methodologies and structures have been scrutinized by national thought leaders in the Institute of Medicine's report *Academic Medical Centers, Leading the Health Care Transformation in the 21st Century.*

NJCTH's Academic Affairs Council identified the following issues for further study to achieve higher quality in medical education and to improve patient care outcomes and patient safety.

- Sharing of competency tools and identification of "champions" to share best practices
- Innovations in graduate medical education (GME)
- Team modeling development
- Evaluation of rotations
- Chronic Care model integration

>Nursing Shortage

For several years New Jersey has addressed and begun to stem the current nursing shortage through effective recruitment efforts that have enlarged the pool of student nurses, boosted enrollment, and increased the number of nursing graduates. However, these efforts are being hindered by a shortage of nursing faculty.

Issue:
A lack of nursing instructors and teaching positions is inhibiting enrollment in nursing schools and the state's ability to train and increase the supply of professional nurses.

Position:
Funding for both nursing faculty slots and competitive faculty salaries need to be improved.

Statement:
The inability to produce more nurse graduates through New Jersey's nursing schools is no longer due to a lack of interest in the profession, but a lack of instructor positions to meet the demands of growing enrollments for all levels of nursing degrees. Additionally, nursing faculty salaries are currently less than staff salaries in hospitals. Without salary increases for instructors, schools will be at a disadvantage to fill faculty slots.

The Uninsured and Charity Care

The growing number of uninsured people threatens access to timely and appropriate care for more than 1.2 million New Jersey residents who lack health insurance while another 1.4 million are underinsured. Teaching hospitals are a critical component of the state's safety net for the uninsured. From wellness programs, to preventative and primary care medicine, to health education initiatives and emergency care, teaching hospitals provide services that are essential lifelines for the uninsured. Medicaid provides a vital safety net in New Jersey and is a lifeline to health care for children, people with disabilities, mental health, chronic illness, and low-income elderly people. Medicaid and FamilyCare provide health coverage to more than 1.4 million adults and children in New Jersey.

NJCTH has vigorously studied the uninsured for a year, and Council representatives have been meeting weekly with the Vitale/Morgan Task Force. Many of the recommendations and solutions presented with in this section are expected to be introduced in several comprehensive bills, intended to improve access to public and private health insurance in order to effect a reduction in the number of the uninsured and improve access to needed services by the uninsured population in the next 12 to 24 months.

>Charity Care

The new Charity Care formula provided a $202 million increase and recognized the financial duress New Jersey's teaching hospitals face in providing care to many of the uninsured in the state. While the improved reimbursement reversed a decade long trend of reduced funding even in the face of a growing volume of Charity Care patients, New Jersey's Charity Care formula still only covers 75 percent of the cost of caring for Charity Care patients in the state.

Issue:
In light of the projected New Jersey state budget deficit for the coming year, efforts to reduce Charity Care funding are likely.

Position:
In recognition of the New Jersey state budget crisis, the current funding should not be increased. However, in recognition of below cost reimbursement to hospitals, the current financing should not be decreased. The current $583 million level of funding for Charity Care should be maintained and a permanent funding source identified.

Statement:
While funding for Charity Care increased in 2004, it is still below the actual cost of providing services, reimbursing at 75 cents on a "Medicaid" dollar. To maintain the 75 percent level, increased funding would be necessary, but unrealistic due to the State's budget crisis. Thus, it is critical that the State, the Council, the Legislature, and providers target the longer-term solution—"Insure the Uninsured."

>Medicaid

New Jersey's Medicaid program languishes under numerous obstacles and political barriers, including antiquated and costly county-run administrative structures; extremely low income eligibility levels of 42 percent of FPL; no state-wide data warehousing and data sharing capabilities, which would allow system efficiencies across county lines; and costly benefit packages that limit the states ability to expand to more beneficiaries. Additionally, New Jersey health care providers (i.e., physicians, hospitals, nursing homes, home care agencies, etc.) have long suffered under inadequate Medicaid reimbursement. Medicaid physician fees are 56 percent of the national average, which is the lowest in the nation (Zuckerman, 2004). Low reimbursement may threaten Medicaid beneficiaries' access to care (especially to doctor's offices that choose not to accept new Medicaid patients) and further strain safety net providers.

Issue 1:
Medicaid is structured to selectively inhibit rather than promote its services.

Position:
Medicaid can be significantly expanded by refining eligibility requirements and eliminating expensive, counter-productive "red tape" that impedes qualified citizens from enrolling and maintaining enrollment in appropriate state programs (Medicaid, FamilyCare, Food Stamps, LIHEAP, WFNJ/TANF, WFNJ/GA, etc.).

Statement:
Possible solutions to improving Medicaid include:

- Simplify, shorten, and merge all application forms, as well as provide clearer instructions.
- Coordinate and automate eligibility, enrollment, and renewal with other programs such as, Food Stamps, School Lunch Program, TANF, and Head Start.
- Increase income eligibility for low-income parents.

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The Uninsured and Charity Care (continued)

- Create a buy-in program that allows families to buy-in to NJ FamilyCare.
- Eliminate the enrollees' need to submit documents to verify income.
- Establish stringent performance criteria with financial penalties for vendors who perform application and renewal processing functions.
- Establish on-line enrollment and renewal processes, and expand on-line and hard copy application languages.
- Restructure the current county-administered system into a state-administered program.
- Reduce or eliminate the six month waiting period.
- Adopt rolling renewal processes through outstation sites and primary care physician offices.
- Computerize and revamp the Premium Support Program to encourage small employer participation.
- Improve physician relations to strengthen the Medicaid Managed Care Provider Network with the goal to ensure that patients have access to care in the most appropriate environment.
- Establish performance criteria for Medicaid Managed Care companies, including the reduction of emergency visits for non-emergent conditions.
- Require Medicaid Managed Care companies to submit data to the state allowing aggregation and analysis for better management.
- Reestablish an aggressive outreach and promotional campaign.
- Establish a single IT eligibility and management information system/database that can be shared by counties, providers, Federally Qualified Health Centers (FQHC), and state health agencies.

Issue 2:
Medicaid rates are currently based on 1988 data. This information does not account for the thousands of medical changes that have occurred over the last 17 years.

Position:
As safety net hospitals and providers of a large proportion of care for the uninsured and underserved, teaching hospitals must not be adversely affected by the rebasing. The rebased rates must recognize the appropriate reimbursement levels for teaching hospitals.

Statement:
Medicaid has indicated that they intend to rebase their rates to a more current year, most likely 2003. The rebasing will update cost, medical, technology, and treatment pattern information to more current levels, which should better recognize the more complex patients treated at teaching hospitals. DHSS has indicated that they intend to keep statewide Medicaid funding at a budget neutral level, which means that some hospitals will receive increased funding while others will receive less.

Issue 2:
The nation's lowest fee-for-service Medicaid rates limit physician participation in New Jersey. A lack of access to participating physicians drives patients, who have no other choice, to seek care in emergency departments, increasing charity care requests.

Position:
Expand Medicaid primary care and specialty physician networks by encouraging more physicians to participate in Medicaid by increasing fee schedules.

Statement:
New Jersey's Medicaid fee-for-service payments to physicians are well under cost and are the lowest in the nation. Medicaid Managed Care fees are higher but still low compared to other states.

Council initiatives will focus on:

- Demonstrating the unproductive costs being incurred by New Jersey due to the lack of physician access.
- Modeling cost savings against increased physician fee schedules.
- Creating an advocacy coalition to press this issue.
- Seeking tax relief for underpayments and uncompensated care based on reasonable market-based rates, in addition to securing fee schedule increases.

>The Uninsured

More than 1.2 million New Jersey residents lack health insurance and everyone feels their pain. An astounding 500 to 600 deaths in New Jersey are attributed to a lack of health insurance, as women with breast cancer and men with late stage colon cancer are twice as likely to die due to being uninsured. With more than 100,000 children enrolled in NJ FamilyCare, 226,000 remain uninsured. Learning to read, write, and do arithmetic is even harder for children who lack basic health insurance, since they are more likely to suffer illness. Six out of 10 people who lack health insurance are in working families, accounting for 719,000 of New Jersey's uninsured since they have no health coverage through their place of employment and cannot afford health coverage on their own.

Issue 1:
262,000 New Jersey children are uninsured.

Position:
Aggressively enroll eligible children in FamilyCare/ Universal Child Care Plan, which will theoretically pick up 96 percent of the state's 226,000 uninsured children.

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The Uninsured and Charity Care (continued)

Statement:
Possible solutions to reduce the number of uninsured children include:

- Market the program to generate enrollment interest through schools and physicians.
- Enroll babies at birth.
- Enroll children during school registration.
- Ensure that completion of the school lunch program application automatically enrolls children in FamilyCare.
- Expand coverage to parents.
- If available, use savings from Medicaid simplification reforms to fund this additional coverage.

Issue 2:
Over 400,000 of New Jersey's uninsured work for small employers.

Position:
Reforms providing access to affordable, quality care are desperately needed by uninsured workers (and their families) of small businesses.

Statement:
Revive the Premium Support Program (PSP) by simplifying the administrative and wrap around protocols.

- Invest in an electronic enrollment, case management, and payor reimbursement system.
- Establish a network of PSP representatives to inform and partner with small business owners and overcome historical barriers to participation.

Promote the uptake of the new federal IRA-like Health Savings Accounts (HSAs), which could reduce the uninsured among certain populations.

- While untested in the marketplace, many experts predict that the uptake could be large, especially by uninsured young adults and self-employed individuals, providing that the plan is actually available to these parties in New Jersey and is cost effective. (ERISA businesses are not an issue as they are already exempt from the state's insurance plan requirements).

Issue 3:
Twenty percent of New Jersey's large companies do not provide health benefits, leaving more than 200,000 employees uninsured.

Position:
Initiate measures to encourage large employers to insure their work force.

Statement:
Ensure employers providing health insurance are provided an equal playing field in which to compete. The state should investigate methods to establish a "Play or Pay" business environment.

For example: NJCTH members have agreed to offer contracting preference to employers with 500+ employees that demonstrate they provide health benefits for their workforce.

- NJCTH will work with member purchasing agents to establish a contracting preference system.

State purchasing processes should also show contracting preference to employers that have an insured workforce.

Issue 4:
More than 175,000 young adults (ages 18 to 26) lack health insurance.

Position:
Encourage younger New Jerseyans to seek and maintain health coverage.

Statement:

- Support Senator Vitale's bill to increase family health benefit plans to include children up to age 26.
- Support changing community ratings for age, demographics (e.g., age cohort 18 to 26).
- Ensure HSAs are available in New Jersey.

>Long Range Goals for the Uninsured and Underserved (three to five years)

- Establish Play or Pay for large employers.
- Improve Medicaid provider rates.
- Improve Medicaid eligibility up to 200 percent FPL.
- Include single adults for Medicaid eligibility.

>Mental Health Services

Acting Governor Richard Codey established the Governor's Task Force on Mental Health in November 2004 to "evaluate the state's mental health system, and develop recommendations to assure the availability of, and access to, treatment, housing, rehabilitation, and supportive services for New Jersey's mentally ill."

Issue:
Behavioral health patients accounted for $100 million in Charity Care funding in 2004.

Position:
This population requires adequate domicile programs and access to ambulatory behavioral interventions, or the current cycle of emergency department and inpatient admissions will continue.

Statement:
Design, fund and implement a comprehensive plan to improve the behavioral health infrastructure and delivery of services, and advocate for sizable increases in Medicaid behavioral health fee schedules. Advocate for a dedicated alcohol tax as a funding source, due to its affinity with behavioral health.

Horizon Blue Cross Blue Shield

As New Jersey's largest health insurance provider, Horizon Blue Cross Blue Shield maintains a market share exceeding 40 percent in numerous markets and product offerings, such as Medicaid Managed Care. Given their sheer size, decisions made by Horizon Blue Cross Blue Shield can have serious effects on the state's health care delivery system and the cost effectiveness of insurance products in the future.

>Horizon Blue Cross Blue Shield Conversion

Horizon Blue Cross Blue Shield is considering a conversion to for-profit status. State officials and legislative leaders have resumed informal talks with Horizon that would allow the not-for-profit company to convert to a for-profit, domestic stock company.

Issue 1:

Due to the state's current budget deficit and a windfall of revenues that would be generated from an Horizon Blue Cross Blue Shield for-profit conversion, the likelihood of the conversion happening is high.

Position:

Given the likelihood of a Horizon Blue Cross Blue Shield conversion to for-profit status, New Jersey must not use this revenue as a short-term, one year budget fix and invest in the "health" of New Jersey in the future.

Issue 2:

Horizon Blue Cross Blue Shield's existence as a not-for-profit health care entity has afforded the organization tax-exempt status since its inception.

Position:

Revenues generated by a conversion should be prudently allocated to create a stable funding source that should be used to finance GME and Charity Care in order to make up current shortfalls in government funding.

Statement:

A fund established by the revenues generated by the conversion of Horizon Blue Cross Blue Shield to for-profit status is consistent with trusts that have been setup by health systems who have purchased other providers (e.g., St. Barnabas Health Care System's purchase of Newark Beth Israel Medical Center created the Healthcare Foundation of New Jersey) and required by legislation enacted in 2001 that allows Horizon to convert pending regulatory approvals.

Issue 3:

Conversion of Horizon Blue Cross Blue Shield to a for-profit entity presents unfair market advantages.

Position:

The Legislature must address Horizon Blue Cross Blue Shield's domineering market share, which could disadvantage providers–non-profit hospitals and physicians–when negotiating rates. Limiting market share by region and product offering will reduce the potential of monopolistic practices and promote competition.

Statement:

As a public company, Horizon Blue Cross Blue Shield would be able to acquire other companies. Horizon is the only not-for-profit health care insurer in New Jersey and has more than three million subscribers.

>Horizon Blue Cross Blue Shield Imposing Their Own Fee Schedule on Out-of-Network Hospitals

As part of a contractual arrangement with participating providers, managed care organizations (MCO's) negotiate fee schedules in return for the provider accepting the MCO's patient. Non-contracting providers do not have a financial arrangement or a requirement to accept the MCO's subscribers and, therefore, are permitted to bill the individual patient (not the MCO) at the hospital's listed charges.

Issue:

Horizon Blue Cross Blue Shield has reduced their subscriber benefits for non-emergency services rendered at non-contracting hospitals.

Position:

Horizon Blue Cross Blue Shield's new practice of imposing their own fee schedule on out-of-network hospitals is essentially an unfair business practice. This practice must be redressed by Horizon Blue Cross Blue Shield or legislation is required to prevent Horizon Blue Cross Blue Shield and other health insurance carriers from implementing non-negotiated fee schedules.

Statement:

Previously Horizon Blue Cross Blue Shield paid billed charges, but they will now pay less based on a fee schedule they have developed.

Diversity

New Jersey has the most diverse population in the United States and foreshadows the demographic landscape of the nation in 2020. For example, more than 82 different languages are spoken in the state, representing a variety of cultures and backgrounds.

>Health Care Training to Meet the Needs of Evolving Demographics

To address the demands of both present and future patients, the current care model requires examination.

Issue 1:

From cancer, heart disease, and HIV/AIDS to diabetes and mental health, minority populations tend to receive more fragmented health care than caucasians, resulting in higher mortality and morbidity rates.

Position:

Both medical students and residents need appropriate training to better understand the care needs of minorities and women. The first step in this process is to examine outcomes for the most prevalent disease conditions by ethnicity and gender amongst members.

Statement:

New Jersey's outcome statistics demonstrate the need to improve care processes and providers' cultural competency to improve health status and outcomes across all ethnic populations.

Issue 2:

According to the Institute of Medicine (IOM), cultural differences and a lack of access to health care, combined with high rates of poverty and unemployment, cause disparities in health status and outcomes among minority groups.

Position:

NJCTH's Quality and Patient Safety Collaborative will identify services and systems to ensure equity and quality in care is given to minority patients.

Statement:

Council members are committed to reducing health disparities in care and have placed this initiative at the highest priority.

>Workforce Planning and Recruitment

Research indicates that minority health professionals are more likely to serve minority and medically underserved populations, yet there is a significant under-representation of minorities in health professions. Increasing the number of minorities in our health professions is a key component to eliminating health disparities, according to the IOM.

Issue 1:

Enrollment of racial and ethnic minorities in nursing, medicine and dentistry has stagnated despite the nation's expanding diversity.

Position:

NJCTH advocates increasing the number of minorities in health professions to minimize the health disparities experienced by minority populations.

Statement:

Experience shows partnerships with high schools and associations like the Boys Scouts of America's Learning for Life program that create apprenticeships and generate interest in health professions will increase enrollment by minority students.

Issue 2:

The lack of minority health professionals is compounding the nation's racial and ethnic health disparities.

Position:

Increased diversity will improve the health status for all of New Jersey citizens, who will benefit from a health care workforce that is culturally sensitive and focused on patient care.

Statement:

The Institute of Medicine and other research organizations have documented that increasing the number of minority health care providers improves the health care outcomes and experiences of minority populations.

>Improving Quality Care Delivery to Diverse Patient Populations

New Jersey's unique demographic composition replicates the future demographic trends of the United States and is challenged to provide health care to varying cultural backgrounds.

Issue 1:

New Jersey teaching hospitals lack appropriate research tools and information to prepare curriculums and services that will best serve the state's diverse patient populations.

Position:

Members will establish a plan to implement a member-wide data sharing initiative.

Statement:

A statewide data repository will advance medical and scientific knowledge and enhance professional preparedness to care for New Jersey residents.

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Diversity (continued)

Issue 2:
Diversity in New Jersey's health care workforce will strengthen the cultural competence of the state's entire health care system, and language is a vital component.

Position:
Expand pool of interpreters within New Jersey's health care settings.

Statement:
Two out of ten Americans speak a language at home other than English, and more than 82 different languages are spoken in New Jersey. Errors that occur in health care among minority patients due to misunderstanding or mistranslation can be reduced through expanded pools of interpreters trained to handle health care situations. Clearer communication between patients and caregivers will result in more efficient diagnoses, care, and follow-up, resulting in decreased health disparities among minority patients.

>Hiring and Contracting Minority-Owned Corporations

Historically, minority firms have been disadvantaged in contracting with our institutions, based on a lack of knowledge regarding opportunities, as well as hospital policies and procedures.

Issue:
Reducing "Unequal Treatment" in health care includes not only care processes, but business practices. Improving minority financial status will have a positive impact on minority health status.

Position:
The NJCTH Board of Trustees has agreed to implement minority contracting practices across all institutions.

Statement:
Identifying qualified firms is the first challenge. The Council will work with UMDNJ, which has done an excellent job in this area, to create an initial list of qualified vendors, as well as host a joint conference for purchasing directors to promulgate this best practice process.

Quality and Patient Safety

While patient safety and quality care have always been a primary concern of health care providers, the age of consumerism in health care impacts it significantly.

>Quality and Patient Safety Improvement Efforts

Academic medical centers should be the trend setters in the delivery of evidence based medicine. NJCTH members must not only provide "cutting edge" medicine, they must also deliver value by providing safe care with optimal outcomes.

Issue 1:
Rising consumerism as well as government, accreditation, and commercial entities (Leapfrog, AHRQ, JCAHO, etc.), who are evaluating outcomes, are bringing quality and patient safety to the forefront of health care.

Position:
NJCTH will establish a collaborative initiative among members commencing in 2005. The following initiatives are actively being considered:

- *Diversity– New Jersey has the most diverse population in the United States and foreshadows the demographic landscape of the nation in 2020. To address the patient demands of both the present and the future, the current care model requires examination. The first step in this process is to examine outcomes for the most prevalent disease conditions by ethnicity and gender.*

  Next, the team will identify services and systems to ensure equity and quality in care given to minority patients.

- *Busy ED Patient Safety Issues– Busy, overcrowded EDs pose significant patient safety issues, especially by patients awaiting admission. Studying how to improve patient safety within the ED environment, as well as improve through-put, will provide value to the state's citizens.*

Additional Activities:
Quality and patient safety efforts include:

- Establish a profiling system to compare member outcomes and costs.
- Proactively identify future conditions and indicators that will be measured by government, accreditation, and commercial entities (Leapfrog, AHRQ, JCAHO).
- Continue to support cross-site knowledge of CMS indicators to enhance membership scores on the New Jersey Hospitals Performance Report and the CMS Voluntary Initiative.
- Collaborate with Senator Corzine to establish a demonstration project that addresses patient safety issues associated with medical education.
- Prepare for "pay for performance" demonstration projects.

> Health Care Professional Responsibility Reporting Act

New Jersey's legislators are responding to recent "Nurse Cullen" events by introducing legislation that require hospitals to share information on former employees.

Issue 1:
Current language in the Health Care Professional Responsibility Reporting Act does not address the potential of litigation resulting from background checks on employment candidates.

Position:
Employers must be able to ensure that they have the opportunity to perform reference background checks on potential hires without fear of litigation.

Statement:
NJCTH's immunity language should be adopted to ensure protection of hospitals from liability when seeking appropriate employment history from previous employers.

Issue 2:
The federal government currently does not provide an immunity shield for interstate background checks.

Position:
Reference check immunity for hospitals must also be provided on a federal level to address background checks on nurses who cross state lines or relocate for employment.

Statement:
While adoption of immunity language on a state level would protect hospitals from litigation for background checks conducted at intra-state institutions, it is the role of the federal government to regulate interstate activities.

(continued, next page)

Quality and Patient Safety (continued)

>Nurse Staff Ratios

Hiring an adequate number of health care professionals to ensure optimal care is every institution's objective. Establishing a proper staffing mix while balancing costs is the ultimate intent of staffing.

Issue:
Current nurse staffing legislation has not addressed the additional costs to the state and hospitals to fulfill the obligations outlined in the measure nor the issue of supply.

Position:
The Council has recommended to both the legislature and governor that an evaluation of nursing supply and demand, the cost of compliance for both the state and New Jersey's hospitals, and an analysis of patient diversions due to low staffing should be conducted before further action is taken. Additionally, vacant faculty positions at New Jersey's nursing schools must be filled in order to train more nurses and increase the profession's supply.

Statement:
California adopted similar well-intended nurse to patient ratio legislation, but has recently repealed components of the bill. In light of the added cost of implementation, a huge uncompensated care bill, and the difficulty in complying with legislated ratios due to the shortage of nurses, several financially strapped hospitals have either closed or are facing closure. Society has yet to balance the conflicting goals of improving patient care and safety against constraining reimbursements.

>Tort Reform

Medical schools and teaching hospitals across the nation are dealing with rapidly increasing medical liability insurance premiums. Coupled with other budgetary pressures, these fiscal burdens could eventually compromise academic medical centers' educational, research, and patient care missions.

Issue 1:
The malpractice crisis has deeply affected physicians, especially subspecialists in high-risk practices, such as neurosurgery, obstetrics and gynecology, and orthopedics. Malpractice insurance premiums for some of these specialties exceed $100,000 a year.

Position:
Tort Reform must address "cause" for both practitioners and hospitals. The negative effect of liability litigation is swaying physicians to either leave the profession or relocate. The prospect of entering a profession negatively impacted by litigation is also compounding the impending physician shortage, since a career in medicine is becoming more of a liability.

Statement:
Tort Reform is expected to move forward given President Bush's re-election.

Issue 2:
Defensive medicine practices increase the aggregate cost of health care.

Position:
For teaching hospitals and health care providers to aggressively pursue reducing costs within their environments, the underlying issue of excessive malpractice litigation must be addressed.

Statement:
Duplicative or unneeded tests are costing payors up to 20 percent more due to defensive medicine practices.

Digital Transformation of Health Care

The Digital Transformation of Health Care will improve efficiencies and reduce costs associated with providing care. Digital standards will allow health care providers to communicate more securely and effectively, and through standardized medical records health care providers will implement evidenced-based medicine more effectively, resulting in higher quality, safe, and cost-effective care.

>State-wide e-Health Initiative

The lack of IT integration has made the state marginally effective in addressing population health needs, integrating and coordinating the state-wide health system, and optimally managing state health related expenses.

Issue:
New Jersey, like many other states, has not prioritized information technology capabilities and related budget and people resources to excel in this rapidly changing environment.

Position:
NJCTH will introduce a bill in 2005 to make New Jersey a model for health care Information Technology.

Statement:
Legislation should implement the following:

- Establishment of e-Personal Medical Records (PMRs) for public program beneficiaries in the short term and for all New Jersey residents within five years.
- An interoperable health care IT system that enables information sharing, data warehousing, identification of best outcomes, clinical research, and disease management across all providers within ten years.
- Agreed upon standards that require all teaching hospitals to have a 24/7 IT emergency disaster recovery site for clinical data and mission critical systems.
- Establishment of a single IT eligibility and management information system/data base, which can be shared by counties, providers, federally qualified health centers, and state health analysts, will significantly reduce the back office costs associated with health care for Charity Care and Medicaid patients and allow these payments to more directly impact and improve the health of these patients.
- For several years, New Jersey has hesitated to implement a standardized IT system due to concerns over HIPAA, but lessens learned from other states' initiatives indicate that HIPAA is not an impediment to implementation.

>NJCTH Data Warehouse Project

A recent article in the *Harvard Business Review* argues that the only competition between providers that makes sense should be over producing the best outcomes. The author argues that a few centers of excellence promote higher quality and lower costs.

Issue:
While the state has published "cardiac report cards" for nearly ten years and has just begun to publish other quality reports, standardized quality indicators and repositories across disease groups are still lacking.

Position:
To know who delivers the best outcomes requires a data warehouse containing all of the pertinent clinical information in New Jersey. This aggregated data will help institutions to examine and implement best practices across institutions, raising the quality of health care delivery for all of New Jersey.

NJCTH Member Initiatives:
Establish NJCTH members as leaders in the use of Information Technology, enhance the effectiveness of care through evidence-based medicine, reduce costs, and integrate patient safety practices in all settings by initiating a membership-wide Data Warehouse Project within 24 months.

- New Jersey's unique demographic composition replicates the future demographic trends of the United States. A multi-function data repository, which is frequently updated with relational data–including clinical, administrative, process, and financial data–will allow New Jersey's teaching hospitals to prepare appropriate curriculums and services that will best serve the state as a group and individually.
- Additionally, this robust database will allow members to excel in clinical research, quality improvements, and breakthrough innovations.
- A Data Warehouse is an imperative component for members to prepare for "pay for performance."

MEMBERS:

Atlantic Health System

Cooper University Hospital

Meridian Health

Somerset Medical Center

St. Joseph's Regional Medical Center

Robert Wood Johnson University Hospital

Robert Wood Johnson University Hospital at Hamilton

University of Medicine and Dentistry of New Jersey

UMDNJ-University Hospital

Warren Hospital

NJCTH

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