**Introduction & Implications of Rutgers Health Privatization**

**Who are Rutgers and RWJBH?**

Rutgers University Biohealth Science (hereafter “**Rutgers**” or “**RBHS**”) consists of 7 schools, 2 of which are the New Jersey Medical School (NJMS) and the Robert Wood Johnson Medical School (RWJMS). Together, the medical schools employ several thousand faculty, staff and others, some of whom provide patient care. Rutgers acquired these institutions from what was once a stand-alone university called University of Medicine and Dentistry New Jersey (**UMDNJ**). That entity also included the University Hospital in Newark, which today is state-owned. University Hospital and New Jersey Medical School were built in the Central Ward of Newark as a result of the Newark Accords. These were agreements reached by among community members, city and state officials, and the federal government that provided jobs, accessible healthcare, and housing to this community. They occurred in the wake Newark rebellion of 1967 that started as a result of people being displaced from proposed construction of the medical school.

**Robert Wood Johnson Barnabas Health** (hereafter “**RWJBH”)** is an 11-hospital health system in New Jersey with many other satellite clinics and related entities. Robert Wood Johnson recently finished merging with the St. Barnabas health system only three years ago. RWJBH has at least 1000 physicians impacted by the proposed alignment. It is also a behemoth, as both the largest health system and employer in New Jersey.

**What is the Master Affiliation between Rutgers and Robert Wood Johnson Barnabas Health?**

RWJBH and Rutgers intend to create single academic health system though “affiliation” and “alignment” without formally merging the two organizations. In August 2017, they announced a “Letter of Intent” to align. On July 24, 2018, they subsequently announced they had reached completed a Master Affiliation Agreement. (“MAA”) The $10 billion-20 year deal envisions selling the faculty practices to RWJBH in exchange for some funds in return. In addition, the two entities agree to have an “exclusive” relationship for the purposes of graduate education (training residents). The “affiliation” or “alignment” can be termed to privatization because work currently performed by public sector Rutgers employees will in the future likely be done by RWJBH (private) employees.

**What is the timeline for this Privatization?**

The Parties have finished a Master Affiliation Agreement. However, many key parts of the deal remain unfinished. These include:

* GME Sponsorship Transition Plan
* Clinical Operating Agreement
* Purchase Services Agreements
* Master Facility Lease Agreement
* Joint Fundraising Agreement

The MAA calls for the Cancer Institute of New Jersey (CINJ) and Robert Wood Johnson Medical School Cardiology Division to be integrated by **January 1, 2019** and all other Robert Wood Johnson divisions to be integrated by the end of 2019. The deadline for New Jersey Medical school, Rutgers School of Dental Medicine, and all other RBHS schools is **July 1, 2020**.

**What Objectives Does the MAA Intend to Achieve?**

The MAA is designed to accomplish 4 objectives:

1. **Assign both operational control and Rutgers clinical service revenues to RWJBH, a private non-profit NJ hospital system.**

To accomplish this, the parties will:

* Align the activities and resources of each organization, including faculty practices, (1000 Rutgers faculty physicians and 1500 RWJ Barnabas Health doctors will be combined.)
* Consolidate the Rutgers faculty practices
* Complete a Clinical Operating Agreement and related Purchase Service Agreements. These Agreements will include a component that specifies the circumstances by which RWJBH will buy services from Rutgers. (Example language: For 2020, Rutgers agrees to provide (#) Full faculty members of ( X clinical specialty) consisting of at least (#) wRVUs to Beth Israel, Monmouth Medical Center, other RWJ Barnabas Hospitals, etc. RWJBH provides (X funds) for such purchase)
* Complete related Facility Lease Agreement, Trademark licensing agreements.

1. **Funnel Back Monies from Clinical Services.**

In exchange for providing RWJ Barnabas Health with residents, space, and clinical services, RWJ Barnabas Health will funnel back certain funds to Rutgers for research, capital development, and for “Major Startup-Packages.”

Specifically, RWJ Barnabas Health will:

* + provide funds for the recruitment of 100 principal-investigators (researchers) over a 10-year period.
  + provide funds for the hiring of chairs/chiefs, institute center/directors
  + renovate infrastructure, technology and provide non-physician support staff (to avoid Stark and anti-kickback laws)
  + create platforms that enable the completion of large scale clinical trials

1. **Combine Graduate Medical Education (GME) Services.**

GME programs are those educational services which train residents and fellows. Both RWJBH and the two Rutgers medical schools receive certain federal funds, referred to as GME funding, for this purpose. The medical schools must figure out how to deploy the residents in area hospitals with appropriate supervision. Recently, Hackensack Meridian formed a relationship with Seton Hall Medical School, whereby the health system would receive their residents. This resulted in the displacement of Rutgers medical school affiliated residents. RBHS will be sole sponsoring institution of all GME programs to optimize size, composition, and number of residency and fellowship program. RWJBH will provide some of its funds to Rutgers for this purpose, plus an “inflation factor.” Rutgers will get a “right of first refusal” meaning that Rutgers gets the first opportunity to place a resident at a RWJBH facility.

1. **Extreme Collaboration for 20 Years**

While not technically a merger, both organizations will be brought close together. Specifically:

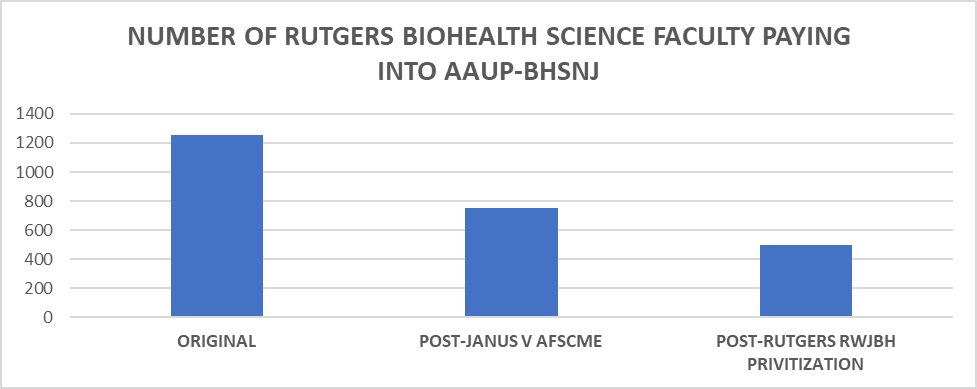
* + There shall be a Joint Committee with an “Integrated Practice CEO” Such Committee will consist of the Chancellor and (3) three other officials from the University, the RWJBH CEO and (3) other officials from RWJBH.
  + Chancellor shall “consult with” RWJBH before the hiring medical school Deans, SAD-CAs, RHG CEO, and others.
  + Rutgers Health Group shall appoint (3) three voting members to is Board from RWJBH.
  + RWJBH will appoint to its Board of Trustees up to (4) four voting members from the University
  + The University will have appointees on individual hospital boards and will keep its representatives on the RWJUH boards.
  + Rutgers must allow (2) appointees from RWJBH to participate and attend to all its Board of Governors Health Affairs Committee meetings.
  + The two organizations will work together in other areas such as fundraising, leasing space, and branding.
  + The Master Affiliation Agreement will last for 20 years with possible auto-renewal.

**How does RWJBH and Rutgers benefit from this arrangement?**

RWJBH receives the prestige of calling itself an “academic health system.” The MAA allows RWJBH to anoint its physicians with faculty tiles like “assistant, associate professor, etc.” Many branding studies suggest that patients may prefer providers which have some academic affiliation. Further, by combining both clinical operations, Rutgers and RWJBH claim that they will be able to provide care for a better value and run large clinical trials for pharmaceutical companies. They will achieve this by generating efficiencies, negotiating better prices with insurance companies, and by building more infrastructure. Many of these claims are though theoretical. Rutgers has a short history providing clinical services, which it assumed only a few years ago. It could be that it simply grew tired of this responsibility. The Rutgers Board of Governors does not have many members who understand the complex nature of healthcare nor UMDNJ’s historical commitments. Quite a good deal of people, regulation, time and energy go into providing good healthcare. When they saw an opportunity to unload this obligation on to another entity, they took it.

**What are the Implications of the Proposed Rutgers University Clinical Services Privatization?**

**Weakening RBHS Unions**



The RWJBH/Rutgers alignment allows for public, unionized Rutgers employees to be moved to Robert WJBH, a private health system where they will not be guaranteed a union. **While there have been assurances that Rutgers employees would not be transferred to RWJBH, there is nothing in the MAA that precludes such transfers.**

According to the Rutgers/RWJBH Health website, “Over time, we expect most new [faculty] who are primarily clinical (i.e. professional practice track) will be RWJBarnabas Health employees.” The combined effect of *Janus v AFSCME[[1]](#footnote-1)* and the RWJBH Alignment will result in 741 less faculty paying into the AAUP-BHSNJ negotiations unit. Rutgers may argue that “this partnership is about growth” and new jobs will be added. According to the press release, “100 new high-caliber investigators by Rutgers over 10 years.” However, this is barely enough to replace research faculty leaving through attrition. As such, it will have little impact on the overall net positions added to the AAUP-BHSNJ bargaining unit.

With such a drastic loss in membership, it may not be able to assist the same amount of faculty it presently. Many large issues like fair compensation, job security, sexual harassment, clinician burnout, and preventing substance abuse will be left by the wayside. At almost 50 years old, it is the only organization that safeguards the rights of the Rutgers medical schools’ faculty. And with the prospect of less members, its voice and influence may be crippled. Already, faculty morale is low and turnover is high. Both RWJMS, Cardiology and Gastroenterology have seen their *entire* departments turnover in the last three years. As faculty are forced to see more and more patients in less time, they get overwhelmed, frustrated, and eventually quit. This is especially true when they have little influence over decision making. The RWJBH/Rutgers alignment will make this problem worse, as faculty with have no say in the clinical operation. Further, since Rutgers’s payments from RWJBH are premised on successfully meeting certain clinical activity and revenue targets, pressure will be created to meet those benchmarks. If clinical positions can be moved to the RWJBH, these doctors will be without union protection, and may be subject to further abuse.

By enabling the creation of non-union faculty, a double-breasted scheme is the result A dean or department chair can simply circumvent the union and its agreement by transferring faculty employment to the private side. Equally, RWJBH does not recognize the AAUP nor any other Rutgers unions, it will be nearly impossible to bargain over clinical issues such as electronic medical records, staffing, clinical schedules, on-call hours/pay, workload, etc. Rutgers and RWJBH may also pre-agree to certain items in the Purchase Service Agreements (PSAs) they are slated to negotiate. This would preclude the unions from bargaining these same issues.

**Eroding the Standing of University Hospital- Newark**

The Newark Agreements of 1968 established a compact between the residents and city of Newark, UNMNJ, the State of New Jersey, and University Hospital. This agreement guaranteed that University hospital would continue to serve the residents of Newark and maintain a comprehensive community health services program. When UMDNJ was dissolved, Rutgers University vowed to continue this commitment. However, the Master of Affiliation Agreement could put this commitment in jeopardy.

At the likely insistence of the State Attorney General, the Parties added language to the Master Affiliation Agreement at the last minute which reads “The Parties acknowledge and agree that nothing in this agreement impacts the status of University Hospital as the principle teaching hospital…” (MAA 7)

However, this language is illusionary. The MAA creates financial incentives whereupon Rutgers is rewarded based on RWJBH financial performance. With the RWJBH health system as the main focus for Rutgers faculty and residents, it is difficult to see how the University can simultaneously maintain its commitment to UH. Further, given that Rutgers will have voting members on RWJBH Boards, it is equally difficult to see how the University officials serving on the UH Board will view it as independent entity with unique needs.

Recently, UH retreated from a plan to move its pediatric ICU completely to Beth Israel, a RWJBH institution.[[2]](#endnote-1) Given this mistake, the Hospital’s poor safety rating, and other issues, the Governor appointed a monitor over the hospital.[[3]](#endnote-2) These problems should be viewed as partially RWJBH’s failure, as it had an agreement to manage UH for the last several years.

The real danger for UH is that RWJBH will remove lucrative clinical services and instead use it as a place to dump patients who can’t pay or for services which don’t have generous reimbursement. RBHS Chancellor Brian Strom said publicly he thinks the RWJ University Hospital in New Brunswick will become the “crown jewel” of the new system.[[4]](#endnote-3) This furthers speculation that there is no strategy for improviing UH’s position or standing in the market. With no way to act independently from Rutgers or RWJBH, it effectively becomes a 12th hospital in the network. And as it is stripped of resources, it will be a target for those who will aim to privatize it.

**Fairness to Rutgers Students and New Jersey Taxpayers**

This deal is likely to be a boondoggle for RWJ Barnabas Health. Through bond initiatives, tuition, and state support New Jersey taxpayers have invested considerably in RBHS facilities. Currently, RBHS generates over $500 million per year in net patient revenue.[[5]](#endnote-4) According to the 2017 Letter of Intent, “it is understood by the Parties that it is anticipated that all clinical revenue and related costs will be assigned to RWJBH.” Further, both parties will enter into this collaboration for “no less than 20 years”. This means that Rutgers is guaranteeing RWJBH at least **$10 billion in patient care revenue** **over this time period**. An amount that will likely increase as healthcare expenses historically rise over time. While RWJBH does agree to provide support for hiring 100 researchers over 10-years, start-up packages, and space renovation, these commitments pale in comparison to the patient care revenue promised. Any public-private partnership should be fair to the taxpayers who have invested in the public institution from the start.

**Rutgers decision to sell its clinical operation is a surprising one. Many universities rely upon clinical revenue as a significant portion of the university budget. At Rutgers, Net patient revenue constitutes 15% of all university revenue. At the University of California, its five health systems represent approximately half of the university’s budget.[[6]](#endnote-5) And at the same time Rutgers is selling-off its assets, it increased tuition 2.3%.[[7]](#endnote-6)**

**Rutgers 2016 Revenue Distribution (Total = $3.6 Billion)**



To replaces this hole in the budget, the MAA provides that Rutgers shall receive mission support payments from RWJBH. $ 100 million up front plus $25 million per year “fixed support payments”. (MAA 30-32) An additional annual “variable support payment” is also possible.

However, with the exception of the initial $100 million, there is big question as to whether these support payments will materialize. According to Chancellor Brian Strom, “if support drops below $25 million per year access to the [Rutgers] brand ends.[[8]](#endnote-7)” A close look at the language of the MAA is not as definitive. It states:

…in the event that such downward adjustment causes Fixed Mission Support to drop below twenty-five million dollars for a give year, one of the following shall occur, at RWJBH’s sole discretion:

(1) the Trademark License shall be suspended, with such suspension to become effective over a timetable consistent with the termination provisions of the Trademark License and to continue as Fixed Mission Support is adjusted downwards; or

(2) an amount equal to the difference between twenty-five million dollars and the downward-adjusted Fixed Mission Support for such year shall be accrued by the University and added to the Fixed Mission Support for the first University Fiscal Year following RWJBH’s mergence from the condition of Financial Exigency.

In plain English, this means that RWJBH gets to determine its own penalty for not paying Rutgers at least $25 million a particular year. It can either suspend use of the Rutgers brand according to yet to be determined timetable or simply add the balance to its tab. To the objective observer this is not a penalty at all, RWJBH determines when and if brand access occurs. Its duty to pay can be perpetually delayed. And with the words “Financial Exigency” not clearly defined, any negative financial situation may qualify. Rutgers’s sole recourse would be to terminate the agreement, a long and costly termination process. (MAA 36-38)

Equally, the Variable Mission Support payments also involve a considerable risk. These payments are based on RWJBH’s “Adjusted Operating Margin.” Since RWJBH is a combined entity of two prior health systems, the combined entity does not have many publicly released financial statements. An application of the MAA’s formula (MAA 31) would indicate that had this affiliation agreement been in place in 2017 Rutgers would have received $50 million as the Variable Mission Support payment.[[9]](#endnote-8) Although, like the Fixed Mission Support, there is no guarantee. “Adjusted Operating Margin” is based on “audited financial statements including the exclusion of investment gains and losses [but] excluding revenues and expenses from non-consolidated joint ventures as well as material non-recurring out-of-period revenues and expenses.” Hence, if RWJBH investments are negatively impacted, let’s say a downturn in RWJBH’s off-shore-accounts, Rutgers could see a reduction in payments. Further, RWJBH could simply categorize revenue as either a “joint-venture” or “non-recurring out-of-period revenue” to diminish the size of the adjusted operating margin, which would in turn reduce Rutgers’s payment.

In addition to giving up rights to clinical revenue, Rutgers also gave up rights to revenue which may flow from any new treatment area developed during the next 20 years. The MAA provides “Neither the University nor RHG nor any other controlled affiliate of the University, directly or indirectly, shall initiate any new Clinical programs in medicine…” (MAA 28) Stem cells may provide the ability to reverse blindness, reverse signs of aging, or create red blood cells to replenish blood during an emergency.[[10]](#endnote-9) Nanotechnology, also a promising area, could mean machines on the micrometer scale being used to diagnose and treat disease. Rutgers has foreclosed the possibility of financially benefiting from any of these discoveries.

**Facilitating Monopoly Medicine**

By promising subsidy and exclusivity, this arrangement would enshrine RWJ Barnabas Health as a state-sanctioned monopoly, enlarging an already huge health system. RBHS Chancellor Brian Strom admits both organizations would have a combined presence in 17 of New Jersey’s 21 counties.[[11]](#endnote-10) Even before the addition of Rutgers, RWJ Barnabas Health has on its own substantial market share. A 2015 report by the Robert Wood Johnson Foundation found that the combined merger of the Robert Wood Johnson and the St. Barnabas Health system would mean that the new organization would have 31.1% of Net Patient Revenue and 32.6% of Inpatient Admissions in the NJ’s Central Region.[[12]](#endnote-11) In addition, it would have 17.7% of Net Patient Revenue and 21.9% of Inpatient Admissions in NJ’s Northern Region. By comparison, University Hospital had 6.8%. As of this writing, reports indicate that Robert Wood Johnson Barnabas is exploring buying St. Peters University Hospital, which if agreed upon would only add to the RWJBH system market share.[[13]](#endnote-12)

By aligning Rutgers’s two faculty practices with RWJBH, additional patients and dollars would flow to it and not to other entities. Thus, it is likely that RWJBH’s share of both the inpatient service market and out-patient market will increase as a result.

This is concerning since many studies show that large health systems fail to improve outcomes and encourage greater utilization of services.[[14]](#endnote-13) Further, a previous Robert Wood Johnson Foundation study found that “increases in hospital market concentration lead to increases in the price of hospital care.” [[15]](#endnote-14)

Finally, there is a real risk of creating a health system that is **too big to fail.** The deal provides that RWJBH will provide certain funds for equipment, research and start up packages to both Rutgers medical schools. RWJBH already has $1.6 billion in debt obligations.[[16]](#endnote-15) If it were to face financial difficulty some in the next 20 years, as already one of New Jersey’s largest entities, RWJBH cannot fail. The resulting job losses, community effects, and cuts to patient care could be a shock to the state. Furthermore, with Rutgers so heavily reliant on RWJBH funds, it too would be in the position of cutting back services, reducing academic programs, and/or curtailing research.[[17]](#endnote-16) It is difficult to prognosticate what healthcare reforms may take shape from one year to next. Amidst the current political turbulence, health insurance companies are uncertain as to whether they will receive quarterly subsidies promised to them from the ACA. The MAA seeks to exacerbate these risks and provides no plan in the event they occur.

**No Transparency and Accountability**

Currently, this 20-year-$10 billion commitment is being negotiated in secret. There has been no input from employee unions, medical faculty, residents, patients, or the community. There are no guarantees that the public will have the right to information or any other mechanism once finalized. Equally, there are no plans for state government oversight. Neither the State Attorney General nor the Department of Health are planning to review these agreements for their potential impact. This is concerning considering it was not quite 10 years ago UMDNJ (now RBHS) faced $ 8.3 million in liability for paying kickbacks.[[18]](#endnote-17) Many reforms were implemented as a result.

The Rutgers unions have proposed a process that it similar to CHAPA (Community Health Access Protection Act), to govern and provide oversight of the aligned entity. To date, that legislation has not been introduced.

**Further, the Joint Committee established by the MAA will not be subject to the Open Meetings Act, nor the Open Records Act. Thus, effectively New Jersey’s largest academic health system will have virtually no public oversight.**

**Increasing Conflicts of Interest**

The MAA raises many questions that implicate conflict of interest rules.

Rutgers Policy 60.5.8 states that faculty are subject to New Jersey Conflict of Interest Law. “Faculty members must not represent, appear for, or negotiate on behalf of any individuals, organizations, or institutions outside the University in connection with any contract, grant application, cause, proceeding, or other matter pending before the University.” It further states, “Faculty members must not act on behalf of the University in any matter involving outside organizations in which they have decision-making authority or a direct or indirect financial interest that might reasonably be expected to impair objectivity or independence of judgment.”

The LOI calls for “multi-year Major Recruitment Packages” to be offered to candidates, who are “mutually acceptable,” to serve as department chairs and institute/center directors. (LOI at pages 12-13). Already, Rutgers and Barnabas have jointly hired chairs of medical school clinical departments pursuant to this understanding. For example, the chair of one NJMS department, is simultaneously the clinical chief at RWJ New Brunswick, St. Barnabas, and University Hospital-Newark. It is unclear how these department leaders can maintain their independence and avoid conflicts when they are receiving large financial incentives from RWJBH and occupying multiple roles. In addition, a public university ceding its hiring authority to a private entity and committing to only hiring “mutually acceptable” candidates raises additional concerns.

The MAA provides for a combined governance structure, complete with a joint-committee and an executive director and places representatives on both organizations’ governing boards. (MAA 9-13). While the MAA makes a commitment that “all individuals shall be subject to applicable law and policies (including conflict of interest policies) of either Party”, it provides no specifics on how to execute this goal. Thus, it is unlikely neither faculty nor other officials will be able to carry out their duties with “independent judgment.”

**Diminishing the Integrity of a RWJMS and NJMS Medical Education**

There is a real risk that the proposed alignment will pose grave threats to the character and manner in which academic medical education is provided by Rutgers’s two medical schools. While the LOI maintains that Rutgers will “lead the academic enterprise,” the flow of funds may compromise this control. The LOI states that “[a]ll RWJBH physicians who meet applicable criteria and Rutgers requirements shall receive appropriate Rutgers faculty appointments.” This raises the possibility that a medical school department chair whose salary or budget relies on RWJBH funding may be conflicted. He or she may not wish to alienate the partner institution by denying an academic appointment or another distinction which is sought. Rutgers’s independent control will in reality be illusory. And with so many more physicians assuming faculty titles, any prestige associated with them may be diluted.

Equally, scholars writing in the *Journal of the American Medical Association* caution that partnerships between academic medical centers and large provider networks may dilute the research mission. “New partners involved in mergers and acquisitions of academic medical centers, such as community hospitals and large specialty practices, may lack the infrastructure, institutional experience, and the knowledge base required to ensure that research occurs in an efficient and compliant manner.”[[19]](#endnote-18) The paper further stated “as a result, mission-driven aspirations potentially conflict with the business reality of delivering high-value, quality care in an economically constrained environment.”[[20]](#endnote-19) Recently, Oklahoma University Medical Center and St. Anthony/SMM Catholic Network called off a proposed merger based on a “[failure to align] health missions that are core to their values.[[21]](#endnote-20) A clash between cultures is a very real problem and should not be trivialized.

The Master Affiliation Agreement also places the focus of research on “cardiac, neurosciences, cancer, internal medicine, surgery, pediatrics.” (MAA 22) However, there has been no faculty input into the decision to emphasize these areas. While creating a larger platform to conduct clinical trials could beneficial, there are no mechanisms to ensure that research that does not have lucrative sponsors is given the same priority. There is no mention of Basic Science research or Biotechnology (e.g. stem cell research), which are some of the most promising areas of future core biomedical advancements.

Finally, one of the highlights of Rutgers’ residency training program is the educational enrichment that comes as a result of a diverse array of rotations. While the deal does not appear to restrict resident rotation serving as front line physicians at University Hospital, one major rotation that enhances the quality of residency training programs appears to be on the chopping block, the Hackensack UMC. The MAA is unlikely to provide training opportunities that are equivalent at RWJ Barnabas Health facilities. In fact, it calls for the reduction of “redundancies.” The educational quality of training programs, as well as the ability to recruit the best and brightest residents may be negatively impacted if these rotations are eliminated.

**Will the Proposed Rutgers University Clinical Services Privatization Contribute to Patient Care with Greater Value and Quality?**

One important principle is that any deal between a state entity and a private provider system should advance the quality and value of care provided to patients. However, the proposed partnership does not meet this test.

According to RBHS Chancellor Brian Strom, the proposed deal would achieve these goals by providing a “networking hub” with a “geographic reach.” This enterprise would be a “cost/value driver,” that is a “large physician/provider organization [with] unmatched control in achieving cost efficiency and value for patients.”[[22]](#endnote-21) With increased size, the combined entity would better be able to absorb risk, achieve economies of scale, and enhance purchasing power.

As the strict fee-for-service model moves to one where payment is made based on quality, a larger patient base is useful. These new models often require the provider to assume the financial risk associated with the patient population by giving that entity a set amount of funding for that population. Larger systems with more resources are thought to be better equipped to provide efficient and innovative care.

As RBHS Chancellor Brian Strom stated, “this is the future of medicine.” Academic medical centers have four options, “form a new system (if they have capital and wherewithal to do so), partner with others in a collaborative network model, merge into a system, or be prepared to shrink in isolation.”[[23]](#endnote-22)

However, studies of shared-savings, risk-based models show mixed results. A study of Accountable Care Organizations[[24]](#endnote-23) from 2012-2016, found that about half remained in the program or shifted to a model with greater risk.[[25]](#endnote-24) The other half either exited the program altogether or shifted to a less risky model. This was because “learning to manage the total cost of care under the rules of the Pioneer model … proved more difficult than anticipated.”[[26]](#endnote-25) While not a part of the Pioneer study, the Barnabas Healthcare Network ACO lost over $340,097 in 2015.[[27]](#endnote-26)

Clearly, neither RWJBH nor Rutgers has figured out how to proceed in an environment with these new risk-based payment models. It makes little sense to partner with an entity when the costs associated with error and experimentation are so unpredictable.

Finally, a look at RWJ Barnabas’s record on safety, quality, and value does not provide a compelling case for partnership. The table “RWJBH Quality and Value” below (page 9) shows that the RWJ Barnabas 11 hospital system needs improvement. It exhibits data pulled from three different tools that measure hospital performance. **The net result is that RWJBH posts a mediocre score for safety, value, and quality with wide variation among its institutions.**

Leap Frog Hospital Safety Grade

The goal of the Leapfrog Hospital Safety Grade is to reduce the approximately 440,000 yearly deaths from hospital errors and injuries by publicly recognizing safety and exposing harm.[[28]](#endnote-27) The Leapfrog Hospital Safety Grade uses national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey, the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and the American Hospital Association’s Annual Survey and Health Information Technology Supplement. Taken together, those performance measures produce a single letter grade representing a hospital’s overall performance in keeping patients safe from preventable harm and medical errors.[[29]](#endnote-28)

Some RWJ Barnabas Hospitals such as RWJ University Hospital-New Brunswick and Newark Beth Israel Medical Center received a grade of C. While other hospitals in the system such Saint Barnabas Medical Center and Clara Maass Medical Center received As.

**Taken together, the entire RWJBH system averages out to a B. For comparison sake, the national average for the 2,639 hospitals graded is somewhere between a B- and a B.[[30]](#endnote-29)**

CMS Hospital Compare Star Rating

The Hospital Compare Star Rating was created by the Centers for Medicare & Medicaid Services (CMS) and tracked data on over 4000 hospitals from 2012 through 2016. It did this in collaboration with organizations representing consumers, hospitals, doctors, employers, accrediting organizations, and other federal agencies.[[31]](#endnote-30) The overall rating includes 57 of the more than 100 measures reported on Hospital Compare, divided into seven measure groups or categories: mortality, safety of care, readmission, patient experience, effectiveness of care, timeliness of care, and efficient use of medical imaging.[[32]](#endnote-31)

**Using a 1-5 scale, RWJBH posted an average of 2.19 for its 11 hospitals. This is below the national average of 2.88 for Safety-Net Hospitals nationwide[[33]](#endnote-32) and below the 3.09 for Non-Safety Net Hospitals nationwide.[[34]](#endnote-33)**

US News and World Report Best Hospitals

Another measure of hospital quality is the *U.S. News and World Report* Annual Survey of Best Hospitals. To help patients decide where to receive care, U.S. News evaluates data on nearly 5,000 hospitals in 16 adult specialties, 9 adult procedures and conditions and 10 pediatric specialties.[[35]](#endnote-34)

**For the 2017-18 survey, U.S. News and World Report ranked the top 24 hospitals in New Jersey. Of the 97 hospitals, 4 RWJBH hospitals were included in this ranking, Robert Wood Johnson University Hospital-New Brunswick, Robert Wood Johnson University Hospital-Somerset, Community Medical Center, and Saint Barnabas Medical Center.[[36]](#endnote-35) RWJBH’s other 7 hospitals *did not* make the cut.**

Rutgers University seeks to build “one of the best academic health centers in the country.”[[37]](#endnote-36) However, partnering with a hospital system with only average quality will not bring Rutgers University to this standard. In fact, many studies also show that as a health system becomes larger in size, the quality diminishes. [[38]](#endnote-37) Rutgers is still becoming acclimated to its absorption of UMNDJ and Barnabas is still recovering from its merger with Robert Wood Johnson Health system. It makes no sense to add to the size of these systems until both entities have shown themselves to be well-managed, efficient and high-quality providers.

**RWJBH 2017 Record on Quality and Value**

|  |  |  |  |
| --- | --- | --- | --- |
| **Hospital Name** | **2017 Leapfrog Grade** | **CMS Star Rating**  **(1-5)** | **2017-18 US News and World Report New Jersey Rankings**  **(1-24 ranked out of 71 NJ Hospitals)** |
| Robert Wood Johnson University Hospital-New Brunswick | C | 2 | 3 |
| Robert Wood Johnson University Hospital-Rahway | C | 2 | Not Ranked |
| Robert Wood Johnson University Hospital-Hamilton | A | 1 | Not Ranked |
| Robert Wood Johnson University Hospital-Somerset | A | 2 | 8 |
| Community Medical Center | B | 2 | 13 |
| Jersey City Medical Center | A | 2 | Not Ranked |
| Saint Barnabas Medical Center | A | 2 | 13 |
| Clara Maass Medical Center | A | 3 | Not Ranked |
| Monmouth Medical Center | A | 4 | Not Ranked |
| Monmouth Medical Center-South | C | 3 | Not Ranked |
| Newark Beth Israel Medical Center | C | 1 | Not Ranked |
| *Leapfrog RWJBH Average* | B | - | - |
| *2017 Leapfrog National Average* | C+ to B- | - | - |
| *CMS Star Rating RWJBH Average* | - | 2.19 | - |
| *CMS Star Rating Safety-Net Hospital National Average* | - | 2.88 | - |
| *CMS Star Rating Non-Safety Net Hospital National Average* | - | 3.09 | - |

1. This is a politically motived Supreme Court decision that prevents the union from requiring all its members to pay into it [↑](#footnote-ref-1)
2. <https://www.nj.com/essex/index.ssf/2018/07/university_hospital_pediatric_unit_closure_1.html> [↑](#endnote-ref-1)
3. <https://www.nj.com/healthfit/index.ssf/2018/08/an_f_in_safety_a_clash_with_union_and_an_ill-timed.html> [↑](#endnote-ref-2)
4. Townhall meeting with Chancellor Brian Strom Thursday, 4:30 p.m. August 3, 2017 Clinical Academic Building – Room 1302 Robert Wood Johnson Medical School. [↑](#endnote-ref-3)
5. 2015-16 Rutgers University Financial Statement, p. 12, <https://oirap.rutgers.edu/PDFs/FinancialStatements16.pdf> [↑](#endnote-ref-4)
6. Bindman, Andrew B. JAMA Forum: Use of Public University Health System Revenues Presents Complex Choices, JAMA, June 8, 2018. <https://newsatjama.jama.com/2018/06/28/jama-forum-use-of-public-university-health-system-revenues-presents-complex-choices/> [↑](#endnote-ref-5)
7. Clark, Adam “Rutgers tuition going up again. Here's how much it will cost next school year” July 19, 2018 <https://www.nj.com/education/2018/07/what_the_latest_rutgers_tuition_hike_means_for_stu.html> [↑](#endnote-ref-6)
8. Presentation to Rutgers Board of Governors, Chancellor Brian Strom, July 24, 2018. [↑](#endnote-ref-7)
9. RWJ Barnabas Health, Inc. Condensed Consolidated Financial Statements and Supplementary Information as of and for the year ended December 31, 2017. [↑](#endnote-ref-8)
10. <https://www.cnn.com/2018/03/08/health/stem-cell-therapy-fda-bn/index.html> [↑](#endnote-ref-9)
11. See *Academic, Provider, and Health System Merger: Opportunities for Population Management, Research,*

    *and Pharma Collaborations*, October 23, 2017, Brian L. Strom, MD, MPH Chancellor Rutgers Biomedical & Health Sciences Executive Vice President for Health Affairs Rutgers, The State University of New Jersey (Slide 43) [↑](#endnote-ref-10)
12. Baumgarten, M.A., J.D. *Recent Changes in Primary Care Delivery and Health Provider Systems in New Jersey* Robert Wood Johnson Foundation, June 2015, <https://www.rwjf.org/en/library/research/2015/06/recent-changes-in-primary-care-delivery-and-health-provider-syst.html> [↑](#endnote-ref-11)
13. <http://www.njbiz.com/article/20180110/NJBIZ01/180119991/saint-peters-rwjbarnabas-informally-exploring-merger> [↑](#endnote-ref-12)
14. Tim Xu, et. Al. *The Potential Hazards of Hospital Consolidation: Implications for Quality, Access, and Price,* JAMA, Volume 314, No. 13 October 6, 2015. [↑](#endnote-ref-13)
15. The Impact of Hospital Consolidation- Update By Martin Gaynor, PhD and Robert Town, Robert Wood Johnson Foundation, June 2012, <https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf7326> [↑](#endnote-ref-14)
16. <https://www.moodys.com/research/Moodys-affirms-A1-on-RWJ-Barnabas-Health-NJ-outlook-stable--PR_904323739> [↑](#endnote-ref-15)
17. Interestingly, the LOI provides that RWJBH may terminate its mission support payments in cases of financial exigency. See page 11, “The layered financial model, which will be defined in the Definitive Agreements, will range from a defined condition of financial exigency for RWJBH that would mitigate future new Mission Support obligations to strong financial performance, whereby incremental support would be shared by Rutgers.” [↑](#endnote-ref-16)
18. Ryan, Joe *UMDNJ to pay $8.3 million to settle kickbacks case*, Star Ledger, September 30, 2009, <http://www.nj.com/news/index.ssf/2009/09/umdnj_to_pay_83_million_to_set.html> [↑](#endnote-ref-17)
19. Paul Hauptman M.D., Richard Bookman, Phd, Stephen Heinig, MA. *Advancing the Research Mission in a Time of Mergers and Acquisitions*, JAMA, Volume 318, No. 14, p 1321, October 10, 2017 [↑](#endnote-ref-18)
20. *Id.* [↑](#endnote-ref-19)
21. Money J, *Merger scuttled between OU Medical Center and St. Anthony parent*, Oklahoman, March 6, 2017. <http://newsok.com/article/5540555> [↑](#endnote-ref-20)
22. See supra footnote 3 (Slide 36) [↑](#endnote-ref-21)
23. See supra footnote 3 (Slide 24) [↑](#endnote-ref-22)
24. Medicare Accountable Care Organizations (ACOs) are designed to provide financial incentives for fee-for-service (FFS) Medicare providers to reduce inefficiencies in care delivery for a population of beneficiaries under their care. ACOs are grounded in the theory that with the opportunity to share in financial rewards (or face penalties), ACOs will reduce fragmentation and duplication in medical care by facilitating improved communication and coordination across providers and between patients and their doctors, thereby improving quality and reducing spending. *Evaluation of CMMI Accountable Care Organization Initiatives*, Pioneer ACO Final Report, December 2, 2016, Prepared by L&M Policy Research, vii <https://innovation.cms.gov/Files/reports/pioneeraco-finalevalrpt.pdf> [↑](#endnote-ref-23)
25. *Id.* at xi. [↑](#endnote-ref-24)
26. *Id.* [↑](#endnote-ref-25)
27. <https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/Medicare-Shared-Savings-Program-Accountable-Care-O/x8va-z7cu> [↑](#endnote-ref-26)
28. <http://www.hospitalsafetygrade.org/what-is-patient-safety/why-the-hospital-safety-grade-works> [↑](#endnote-ref-27)
29. *Id.* [↑](#endnote-ref-28)
30. [http://www.healthleadersmedia.com/marketing/leapfrog-group-releases-2017-hospital-grades#](http://www.healthleadersmedia.com/marketing/leapfrog-group-releases-2017-hospital-grades) [↑](#endnote-ref-29)
31. <https://www.medicare.gov/hospitalcompare/Data/Measure-groups.html> [↑](#endnote-ref-30)
32. *Id.* [↑](#endnote-ref-31)
33. A hospital was identified as a safety net hospital if: 1) the hospital was a public hospital; or 2) the hospital was a private hospital with a Medicaid caseload at least one standard deviation above their respective state’s mean hospital Medicaid caseload. Hospitals’ annual Medicaid caseload and their public or private status were obtained from the AHA Annual Survey (2013) <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-21-2.html#_ftn3> [↑](#endnote-ref-32)
34. <http://www.modernhealthcare.com/article/20160727/NEWS/160729910> [↑](#endnote-ref-33)
35. <https://health.usnews.com/best-hospitals/area/nj/robert-wood-johnson-university-hospital-somerset-6221340> [↑](#endnote-ref-34)
36. <https://health.usnews.com/best-hospitals/area/nj> [↑](#endnote-ref-35)
37. See *supra* footnote 3 (Slide 17) [↑](#endnote-ref-36)
38. The Impact of Hospital Consolidation- *supra* at p 4. <https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf7326> [↑](#endnote-ref-37)