Testimony of Kimbirly Moriarty
on behalf of Yale Medicine
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Lieutenant Governor Wyman and Members of the Cabinet: thank you for the opportunity to address the Health Care Cabinet on behalf of Yale Medicine, the faculty practice of the Yale School of Medicine. I am Kim Moriarty and I serve as the Chief Strategy Officer for Yale Medicine. My colleagues and I wish to offer a few observations about the role that academic physician practices play in improving the quality of care to residents of Connecticut; we also wish to explain the factors that make academic physician practices inherently more expensive than other practices. We hope that these observations will be useful as the Cabinet continues to consider strategies for health care cost containment, including spending targets for providers.

Yale Medicine exists to support the teaching and research missions of the Yale School of Medicine. (Yale Medicine is a part of the School, and is a separate entity from Yale New Haven Hospital, although the Hospital (and its parent system) is our principal teaching site and we depend on each other closely in the delivery of care.) We are a practice of 1,400 physicians, all of whom hold faculty titles, and all of whom are involved in the teaching of medical students, medical residents, and physician assistants. Many of them are also involved in research. Our faculty clinicians, like their peers at other academic medical centers, bring high-level expertise, cutting-edge technology, and a multidisciplinary approach to care, all of which redound to the benefit of our patients, most of whom are residents of Connecticut. Yale Medicine is an acknowledged leader in many fields, including autism, diabetes, genetic diagnosis and counseling, geriatrics, personalized medicine (such as use of genomics in diagnosis and treatment of cancer), regenerative medicine, and transplantation, among others.

Since academic physician practices supports the teaching of medical students, medical residents, and clinical fellows in the complete spectrum of human health and disease, including very rare diseases, Yale Medicine has the most highly specialized physician workforce in the state, offering expertise is such areas as cancer, cardiac care, organ transplantation and many others, providing treatments not easily found elsewhere.

Yale is currently conducting over 1,000 active clinical trials and research projects, affording patients access to the newest technologies and therapeutic innovations.

Yale Medicine in conjunction with Yale New Haven Hospital also serves as a major referral center for other providers in Connecticut. In addition to offering the highest quality specialty care that complements the services provided by community physicians and clinics, we maintain on-call staffing, with many of our clinicians in house, on a 24/7/365 basis, ready to care for the sickest patients. This level of coverage eases the burden on other providers and hospitals, especially after hours and during the weekends and holidays – with over 70% of transfers occurring during these times. In addition, patients transferred from other hospitals are particularly high acuity cases – with a case mix index of 2.5, compared to 1.3 for locally admitted patients. Length-of-stay is higher for transferred patients (8 days for transfers vs. 5 days for other patients). The case mix index and length-of-stay is even higher for patients transferred via

SkyHealth. Yale Medicine and Yale New Haven Hospital regularly see patients from hospitals that no longer have obstetrical services, or that do not maintain certain services after hours.

In addition, Yale is exploring the use of telehealth to improve access to care and to reduce its cost. The Child Study Center provides behavioral health care to patients remotely, and is one of three providers that participate in ACCESS Mental Health. Yale New Haven Hospital and Yale Medicine developed the TeleStroke program, which enables caregivers at eight hospitals in the state to engage Yale Medicine stroke specialists who are on-call, in-house at Yale-New Haven Hospital. Yale Medicine also recently began offering follow-up monitoring of transplant patients via videoconference.

Furthermore, we are an economic anchor in our community, providing stable, high-paying jobs. Compensation of our unionized employees is about 36 percent above levels that prevail in the local market.

The very factors that enable Yale Medicine and other academic physician practices to improve quality of care also contribute to a higher cost of delivering care. It is very expensive to staff clinical services on a 24/7/365 basis. In addition, the expectation to support teaching in the full range of human diseases leads to staffing levels that are difficult, in a state as small as Connecticut, with high level of competition from academic medical groups in Massachusetts and New York, to keep 100 percent fully subscribed due to a small patient base. For example, our patient base is arguably too small to sustain a team of pediatric transplant specialists, even though it is appropriate for education and enhances access to care for Connecticut residents. Yale has sought to be creative, agreeing with Connecticut Children's Medical Center in Hartford to share pediatric cardiac physicians to manage all forms of congenital cardiac disease and perform all types of neonatal cardiac surgery for patients throughout the state.

Furthermore, teaching – a central element of our mission – has an unavoidable impact on productivity. Yale Medicine trains more than 1,000 students every year, including residents, fellows in medicine, and physician assistants. Although teaching while seeing patients is the most effective way to train health care providers, it is not the most efficient way to see patients – taking the time to teach inevitably slows the process of caring for patients. A 2015 review paper in the *American Journal of Medicine* by Ellis et al. cites a 5-15 percent reduction in total patient visits (depending upon specialty) per teaching provider. The economic impact of this teaching effort is enormous for Yale Medicine. Applying the results of this study would suggest that Yale Medicine physicians are treating 2 fewer patients/day, which is equivalent to a 10 percent reduction in productivity. That is enormous in a health care delivery environment that is increasingly moving toward forms of capitated payment.

Furthermore, Yale Medicine, like other academic practices, is a leading provider of care to Medicaid patients. We see it as part of our mission to treat all patients, and our faculty and students are in favor of being readily accessible to Medicaid patients. In fact, we see a somewhat disproportionate share of Medicaid patients, who make up 16% of the population of New Haven County but represent 23% of clinical volume in Yale Medicine. As you know, Medicaid reimbursement does not approach covering the cost of care – we estimate that Medicaid currently pays at 31% below Medicare rates and 75% below managed care rates. The subsidy is drawn from revenues from other payors, because unlike other parts of Yale University, Yale Medicine does not have access to the endowment.

This is the policy dilemma that confronts academic physician practices. There is widespread agreement that training new physicians is critically important to health care, and

there is also broad agreement that we enhance quality of life by providing a level of specialty care that complements services offered by other providers. We are economic anchors in our local communities. At the same time, the features that make academic practices distinctive add to our costs, and the payment system recognizes those incremental expenses. Medicare has recognized the resource demands of teaching for hospitals, but not for physicians. Medicaid reimbursement rates do not account for the productivity loss associated with teaching. We have been able to negotiate reimbursement schedules with private payors that allow for the factors that make academic medicine inherently more expensive.

We commend the Cabinet for taking more time to study spending targets and how they would be applied. We urge you to bear in mind that for all these reasons, academic groups like Yale Medicine are inherently different from other kinds of physician practices, both in our cost structure and in our tripartite mission of teaching, research, and excellence in clinical care. We hope the Cabinet will assess any recommendations by the yardstick of whether they would sustain the excellent schools of medicine and academic medical practices that Connecticut is fortunate to have.