

New Jersey Commission on Rationalizing Health Care Resources



Final Report

January 24, 2008



Jon S. Corzine
Governor

New Jersey Commission on Rationalizing Health Care Resources

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A Letter from the Chairman

January 24, 2008

The Honorable Jon S. Corzine
Governor of the State of New Jersey
Trenton, New Jersey

Dear Governor Corzine:

On October 12, 2006 you had established through Executive Order 39 the **New Jersey Commission on Rationalizing Health Care Resources**. The Commission worked throughout 2007 to respond to your order. In my capacity as Chair of the Commission, I am pleased to submit to you herewith its Final Report. In this perhaps longer-than-usual transmittal letter, I shall first present a very brief synopsis of the substance of the report. In my capacity as a long-time student of health systems here and abroad, I shall then append some personal observations on the inconsistent expectations Americans have of their health system. These inconsistencies – a form of cognitive dissonance – stand as barriers to a rational health care system and will, before long, price more and more hard-working Americans in the lower middle-income classes out of the health care enjoyed by the solid middle- and upper-income classes in New Jersey and elsewhere in the nation.

The Content of the Report in Brief

As the Commission understood its mandate, you had asked it to explore (1) why so many hospitals in this State are struggling financially, (2) which among hospitals approaching the State for financial assistance warrant that assistance and (3) what steps might be taken to rationalize the functioning of New Jersey's hospital system and other components of the health care delivery system that interact with the hospital system.

The Commission responds to your request with this report, composed of 16 chapters and 8 appendices. These 16 chapters fall into five distinct parts, as follows:

- I. Introduction
- II. An Overview of New Jersey's Health Care System

- III. Factors Affecting the Economics and Performance of New Jersey Hospitals
- IV. Prioritizing Financial Assistance to Financially Distressed Hospitals
- V. A Vision for a 21st Century New Jersey Health Care System

Probably of the most immediate interest to your office will be Part IV of the report, “Prioritizing Financial Assistance to Financially Distressed Hospitals.” The chapters in this section present the Commission’s criteria and analytic algorithm for categorizing hospitals into four distinct groups, to wit:

- 1. Financially distressed hospitals whose continued operation is essential in the sense that their closure would deprive New Jersey residents of access to essential health services;
- 2. Financially distressed hospitals whose continued operation is not essential in the sense that their services could be replaced with other capacity in the relevant market area;
- 3. Essential hospitals that are not currently financially distressed but worth monitoring on a continued basis for financial viability;
- 4. Non-essential hospitals that are not currently financially distressed.

The general idea underlying our proposed algorithm is that the limited budget your office has to assist distressed hospitals should be reserved for financially distressed hospitals classified as “essential.” The criteria we have used to make this classification are not thought to represent the final word on the issue, because there are sundry other less quantifiable dimensions to the problem that you would wish to take into account when making decisions on financial assistance. We have suggested some of these other dimensions in the report. You undoubtedly will wish to consider still others.

A final point to emphasize on this classification is that it is a living thing, by which is meant that hospitals will move among categories as more current data become available or as hospitals in the original set drop out through closure. That being so, the Commission has chosen not to classify in this report hospitals by name, but instead to furnish your office with software that can at a moment’s notice provide you with the latest classification on the basis of the latest available data.

Sprinkled throughout the other sections of the report are numerous recommendations on changes believed by the Commission to be capable of

enhancing the proper functioning of the State's health system. These recommendations include a call for greater transparency on the cost and quality of hospital care, in a form that facilitates comparisons with performance benchmarks and facilitates more explicit accountability by the hospital sector for the resources entrusted to it. These other sections of the report also include suggestions for more effective governance of hospitals, steps to be taken to avoid hospital closures and, should they occur, an orderly process of closing hospitals.

In its final chapter, the report sketches out a long-run vision for the health-care information infrastructure that will be the *sine qua non* of cost-effective, high quality, 21st Century health care. Several nations in Europe and Asia are now leading the U.S. in this effort. There is no reason, however, why New Jersey could not become a leader in this regard, in the United States and the rest of the world, should the State puts its mind and resources to the task.

On the Prospect for a Rational Health System

As a long-time student of health systems in the United States and in other parts of the world, I cannot resist the temptation to add to the Commission's formal report to you some purely personal impressions that may or may not be shared by other members of the Commission¹.

Specifically, it is my sense that certain deeply ingrained traits in American culture stand in the way of a rational health system. Therefore, it is not likely that any Commission could provide you with a blueprint for a truly rational health system, nor could our Commission, notwithstanding its ambitious title.

A "rational" health system would be one in which the following elemental functions of a health system work harmoniously toward an agreed-upon set of social goals. These elementary functions are:

1. The financing of the health system, which always and inevitably originates in private households in the form of taxes, premiums or user fees, and which flows through various channels to the providers of health care;
2. The manner in which the financial risks that individuals face as a result of illness are pooled by some insurance mechanism to provide individuals with financial protection and unfettered access to health care when needed;

¹ These observations reflect in part work on a paper entitled "The Potential Role of Private Markets and Private Health Insurance in China's Health Reform" (November, 2007), co-authored with Tsung-Mei Cheng.

3. The production and delivery of health care by its so-called “providers”;
4. The purchasing of cost-effective, high-quality care from the providers of health care, either by individual patients or in conjunction with private or public insurers;
5. The payment of the providers of health care for their services (fee-for-service, fee per case, fee per diem or fee per patient per year); and
6. The regulation of the whole system by government.

Every nation’s health system must perform these six functions. The performance of the entire system depends not only on how well each of these functions is performed, but also on how well they are attuned to one another in the pursuit of a widely shared social goal.

Distributive Social Ethics: To illustrate, if a nation aspires to an egalitarian health system in which the clinical and financial health-care experience of individuals is independent of their socio-economic status, then the individual’s contribution toward financing health care should be based strictly on ability to pay, rather than be levied per capita or on the basis of the individual’s health status, as is the case with commercial, “actuarially fair” insurance premiums. Similarly, the providers of health care should be paid on the basis of a uniform payment schedule that does not vary by the socio-economic class of patients.

Although no nation’s health system is perfectly “rational” in this sense, those of Canada, Germany or Taiwan come fairly close to this attribute. Whatever one may say about these systems, their various functions tend to be aligned to work toward a well-articulated, ethical goal on which there is broad political consensus, namely, a roughly egalitarian distribution of health care based on what they call the ethical principle of “social solidarity.”²

By contrast, the United States has always lacked a broad political consensus on the distributive ethic that should govern its health care system. Like Canadians, Europeans and many Asians, many Americans do believe that health care is a *social good* that should be available to all socio-economic classes on roughly equal terms and should be financed on the basis of the individual’s ability to pay. But just as many other Americans believe that health care is essentially a *private consumer good* – like

² To be sure, some 10% of Germany’s population has private health insurance, rather than the statutory coverage, but their health care proper is not noticeably different from that received by the rest of the population.

clothes, food and shelter – whose procurement and financing is primarily the individual's responsibility, and they routinely (and quite incorrectly) deride the former school of thought as “socialists.” From that gulf of ethical premises emerge many of the confusing economic signals that have always bedeviled American health care, and are likely to do so in the future. There is no reason to believe that New Jersey will be different in this regard.

Through the payment system for the providers of health care, for example, Americans tell these providers that the value of their work is lower when applied to uninsured patients or to patients insured by Medicaid than it is when applied to patients who are commercially insured.³ A “rational” health system responsive to this powerful economic signal would be openly two-tiered, with bare-bones facilities devoted strictly to Medicaid patients and the uninsured (perhaps with some public grants for treating the latter), and much more luxurious, better equipped and better staffed facilities for commercially insured patients whose insurers are willing to pay higher fees. As it happens, however, the same citizenry, which signals its preference for a class-based health system through the payment mechanism, soothes its conscience by holding physicians and hospitals to strictly egalitarian standards when it comes to the treatment of patients of all socio-economic classes. Woe to the hospital that would give inferior care to Medicaid patients, relative to the care given to commercially-insured patients. In this acute cognitive dissonance lie the roots of many of the financial problems besetting so many American hospitals. As the Commission's report indicates, these problems are particularly acute in New Jersey.

“Markets vs. Regulation”: Another cognitive dissonance regarding health care in this country springs from the tenuous, age-old debate over “regulation versus market.”

By international standards Americans tend to be unusually disdainful of their governments at all levels, as can be inferred from the editorial pages of many of the nation's daily papers. Running against government is a time-hallowed tactic on the election circuit. For example, claiming that a health-reform proposal expands government's role in health care usually is the proposal's kiss of death. It seems an article of faith that private commercial markets are inherently more efficient than government can ever be.

³ The fees New Jersey Medicaid pays physicians, for example, are only a fraction (less than 50%) of those paid to physicians by Medicare which, in turn, are lower than those typically paid by commercial insurers. In fact, relative to Medicare fees and the national average of Medicaid fees paid by the states, New Jersey ranks at the bottom of the nation. Until your Administration recently added \$5 million (\$20 million once annualized and matched with federal dollars) for Medicaid payments to pediatricians, for example, New Jersey Medicaid paid pediatricians only about \$30 for a pediatric office visit, while commercial insurers paid between \$90 and \$120. Many physicians comprehend the implied economic signaling and refuse to accept Medicaid patients altogether, devoting their time instead to patients whose treatments are deemed by society to have a higher value.

At the same time, however, the same Americans seem troubled and unwilling to accept for health care – and now even for mortgages – the harsh verdicts of the “free market,” among which are:

1. That a market allocates resources not to individuals most in need of them, but to those who have the most money to bid high prices for them;
2. That individuals or institutions, including hospitals, unable to fend for themselves in the competitive market’s free-for-all – among them hospitals in low-income neighborhoods – should be allowed to wither away; and
3. That in the free-for-all of the market place, not only the quick-witted and better-informed, but also the morally more flexible participants, often will take advantage of less quick-witted and less well-informed market participants who are naïve enough to trust even the morally flexible.

These mutually inconsistent positions – an instinctive distrust of government and faith in the superiority of private markets but an unwillingness to accept the harsh verdicts of the market – have led nationwide into a bewildering system of “half-hearted competition and half-hearted regulation” for health care, to use a phrase coined by Brandeis economist Stuart Altman.

This approach encourages in health care an economic free-for-all in a highly imperfect market which increasingly turns patients into blind-folded shoppers thrust into a health-care shopping mall that is only haphazardly controlled by ad-hoc, often mutually inconsistent regulations that further distort the health-care market. Unevenly applied Certificate of Need (CN) laws, for example, are an illustration of this free-for-all, as is the rampant and non-transparent price discrimination in American health care that rewards neither efficiency nor superior outcomes, and that all too frequently allows uninsured Americans of the lower middle-income classes to be charged the highest prices for health care. Financially troubled hospitals that concentrate on poor, low- or non-paying patients are yet another manifestation of this approach.

In this connection, it may be noted that the Commissioners noted, but should not have been surprised, that in oral briefings before the Commission some representatives of the hospital industry hearkened back with evident nostalgia to the “good old days” when the State’s hospitals were subject to rate regulation (as hospitals still are in Maryland), without the completely chaotic and often pernicious

price discrimination now rampant in New Jersey's hospital sector. Nor, however, was it surprising that none these representatives formally propose that New Jersey return to that system. On this issue ambivalence reigns.

Rationing Health Care: A third major confusion in the minds of Americans arises over the issue of “rationing” health care.

Boasting that theirs is the best health system in the world, bar none, Americans have long tended to deride most other nations' health systems for “rationing” health care, a phenomenon believed to be absent from the American health system. In fact, nothing could be further from the truth.

A health system can be thought of as a giant enterprise that can purchase from nature-added “quality-adjusted life years” (QALYs) for patients. The QALY is a widely used concept in health services research, which allows one to collapse both longer longevity and a better quality of living into one metric.⁴ Some QALYs can be cheaply had through good primary and secondary care, including immunizations. Other QALYs can be purchased only at enormous costs – e.g., the added life days or weeks or months that can be wrestled from nature in the intensive care unit or with highly expensive, new biological products that purchase only a few months of extra life. Relatively cheap tests or MRI scans deemed to add only relatively little information to a diagnosis also turn out to be very expensive per added QALY actually purchased with them.

Most nations implicitly or quite explicitly put an upper limit on the price per QALY they will pay out of collective insurance pools – be they private or public insurance. Thus, they either deny payment for such care or make people wait for it in a queue. Americans find that approach abhorrent as can be inferred from their frequent disparaging remarks on the Canadian health system in which queues and rationing do have a place. Indeed, there does not seem to exist even a truly astronomical price per QALY so high that Americans would not pay it, especially when the patient is well-insured. Sometimes this refusal to say “No” is carried to the point of throwing hundreds of thousands of dollars at what expert clinicians would regard as hopeless cases.

This refusal to ever say “No” for insured patients has helped drive the cost of American health care to extraordinary levels by international standards. For example, the U.S. now spends roughly twice as much per capita on health care as does neighboring Canada (on purchasing power parity basis). The ever-growing cost

⁴ One year in a specific, less-than-perfect health status might be counted as the equivalent of 0.8 of a year in perfect health.

of American health care, in turn, has driven up insurance premiums in step and, thus, has driven more and more hitherto insured Americans into the ranks of the uninsured, whose numbers are rising inexorably and will do so with ever greater speed in the decade ahead. It is well known that, once in these ranks, many of the uninsured will forego timely, relatively lower cost primary and secondary care until they fall critically ill and then look to their neighboring hospital for expensive tertiary care, frequently on an uncompensated basis. Not only does this approach saddle American hospitals with the cost of such uncompensated care, but according to the Institute of Medicine of the U.S. National Academy Sciences, it causes an estimated 18,000 Americans to die prematurely each year, not even to speak of needless suffering borne by uninsured patients with unattended but curable afflictions.

Cognitive Dissonance on Health Insurance: Confusion also reigns among Americans in their approach to health insurance.

On the one hand, many Americans decry as outright un-American the idea of mandating the individual to procure adequate health insurance coverage for at least catastrophically expensive health care. Those same presumably “rugged” individuals, however, would bristle at the idea that, say, a private, investor-owned hospital should have the right to withhold from them, for want of ability to pay, costly life-saving medical interventions, should these individuals be seriously injured or become critically ill. Such interventions are presumed to be an American right as well, and the people’s representatives have passed laws to make it so. These unfunded mandates on hospitals effectively ask hospitals to provide uninsured individuals with the catastrophic health insurance they are free not to procure, at the expense of insured patients and, in the case of investor-owned hospitals, of shareholders as well.

Just as inconsistently, some states that grant the individual the right to go without health insurance coverage see nothing wrong with imposing on private, commercial health insurers the strictures of “community rating,” which prohibits insurers to adjust the premiums to an individual’s health status, and the “guaranteed issue,” which mandates insurers to sell an insurance policy to anyone willing to pay that community-rated premium. New Jersey enacted such mandates in 1993 in its *New Jersey Individual Health Coverage Program (IHCP)*. Any high school senior should be able to figure out that this dubious constellation of rights and mandates subjects health insurers to “adverse risk selection” on the part of the insured, which means that individuals are free to go without health insurance when they are healthy, but have the right to throw themselves on the mercy of a collective insurance pool when they fall seriously ill.

Sooner or later this dubious mixture of freedom and mandates tends to lead to what is known among economists as the “death spiral” of health insurance, in which insurance pools become ever more heavily populated by relatively sicker individuals

with commensurately higher, community-rated premiums. In response, more and more relatively healthy individuals – especially lower-income individuals – exit these insurance pools and prefer to remain uninsured, which in turn drives the community-rated premiums for the remaining pool up even further. Thus, it is not surprising that, after their 2004 study of New Jersey's IHCP, Alan C. Monheit *et al.* conclude that

the IHCP's current situation points to a market that is heading for collapse. Enrollment has declined from a peak of 186,130 lives at the end of 1995 to 84,968 at the end of 2001. In addition, premiums have increased two- to threefold above their early levels. These changes have raised concerns as to whether a comprehensive regulatory effort such as the IHCP can yield a sustainable health insurance market.⁵

That New Jersey has among the highest premiums for individually-purchased health insurance has been observed also in a nationwide survey of such policies by the Center for Policy Research of America's Health Insurance Plans (AHIP)⁶.

The easy embrace by legislators of the individual's right to remain uninsured, coupled with mandated "community rating" and "guaranteed issue" on insurers, appear to spring from a natural suspicion of government-run or heavily government-subsidized private insurance, which, as noted, is routinely decried as "socialized medicine." Perhaps it is not realized by state legislators who adopt this dubious mixture of freedoms and mandates in health insurance that their mandates on private insurers actually convert the latter into quasi-agencies of government, albeit predictably dysfunctional ones.

The reluctance of Americans to countenance government financing of health care outright, by the way, has led them instead to prefer inherently temporary private health insurance tied to a particular job with a particular company (and then to look helplessly for rescue by federal or state governments when, in their 50s and early 60s, they may find themselves structured out of their jobs and the health insurance that came with it and unable to afford coverage in the private insurance market for individuals). When will it dawn on the American voter that, in an age of fierce global competition and ever novel disruptive technology, any individual American corporation is a fragile institution and, at best, a highly unreliable source of health insurance, especially during retirement?

⁵ Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "Community Rating And Sustainable Individual Health Insurance Markets In New Jersey," *Health Affairs*, July/August 2004; 23(4): 167-175.

⁶ American Health Insurance Plans, Center for Policy Research, "Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits," (August 2005), available at website http://www.ahipresearch.com/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf

In short, Governor Corzine, in my professional view, the extraordinarily expensive, often excellent and just as often dysfunctional, confused and confusing American health system is a faithful reflection of the minds and souls making up America's body politic. New Jersey is no exception to this assessment. The Commission has done its best, with the time and resources available for its work, to recommend to you a variety of measures that you may wish to initiate to make New Jersey's health care system function somewhat better than it does today. Alas, no Commission can provide a complete blueprint for a truly *rational* health system for this State – or for any state in the nation – until the citizens of this country reach a politically dominant consensus on a more logically consistent set of preferences for their health system, starting with a consensus on the distributive social ethic that should govern the system. Until that happens, any attempt at “health reform” will always degenerate into mere tinkering at the margin, which means that for the foreseeable future Americans will have to muddle through with the kind of health system we now have.

Finally, this transmittal letter offers a good occasion to express on behalf of the Commission our deep gratitude to each and every one of your Administration's staff for the high motivation and dedication with which they have supported the Commission's work throughout the year. They are identified by name at the end of the Executive Summary of this report.

As noted earlier, it seems part of American folklore that government “cannot walk and chew gum at the same time” (to quote the late President Lyndon Johnson's famous dictum) and that government “bureaucrats” are slothful and unimaginative. My experience working with your staff has been completely at variance with that folklore. What is often not appreciated by the public is that, by comparison with the private sector, the work of civil servants is unusually complex and time consuming, because all of their activities must transparently be seen to be exquisitely fair to all members of society, and they must at all times be openly accountable to the public for all of their actions. Such constraints are not typically imposed on the private sector.

Respectfully submitted, with my best personal regards and good wishes,

Uwe E. Reinhardt

James Madison Professor of Political Economy
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Chair of the Commission

Executive Summary

I. The Commission

On October 12, 2006, Governor Jon S. Corzine created with Executive Order No. 39 the New Jersey Commission on Rationalizing Health Care Resources. That Order set forth 10 specific areas of interest that can, however, be distilled into three major areas of inquiry, to wit:

1. A description of the current economic conditions of New Jersey's health care system, with particular emphasis on its hospital system;
2. An inquiry into the forces that have led so many of the State's hospitals into financial difficulties;
3. An analytic algorithm for assisting the Governor in the rational allocation of the limited state budget available for providing financial assistance to financially distressed hospitals in New Jersey.

The Commission's Modus Operandi

During late Fall of 2006 the Governor's office, in close coordination with the Department of Health and Senior Services (DHSS), selected a group of Commissioners from a variety of professional backgrounds and walks of life. Each Commissioner helped illuminate the issues before the Commission through the particular prism of his or her background. The Commission was ably supported by staff drawn from various departments of the Governor's administration—some on a permanent basis, others on an ad-hoc basis. With the guidance of the Commission, most of the data retrieval and analytic work was done by Navigant Consulting, Inc., a major, national research consulting firm known for its work in the analysis of health systems.

The full Commission held monthly meetings during which broader issues were discussed and representatives from a variety of stakeholders were heard. Early on in

its work, however, the Commission also established six subcommittees composed of one or two members of the Commission and additional members drawn from the larger community of stakeholders with special expertise on the subjects before the subcommittees. The purpose of these subcommittees was to explore some issues in greater depth than was feasible at full Commission meetings, and also to enlist the perspective and good counsel of a wider range of members of the New Jersey citizenry. The subcommittees met frequently during the spring and summer months and issued their written final reports in the fall, for review by the full Commission. These subcommittee reports became a major source for the Final Report transmitted herewith. The Commission and the citizens of New Jersey owe the dedicated volunteers who gave so much of their time and expertise to this work a deep debt of gratitude.

In June of 2007, the Commission issued an Interim Report to the Governor. That report was subsequently posted on the Commission's website and received a great number of comments, which were carefully considered by the Commission. The current report is the Commission's Final Report. Its 16 chapters fall into four major sections, which cover the three major points listed above and include, in Section IV, a vision for the kind of health information infrastructure that will be the *sine qua non* of first-rate, 21st Century health care systems around the world. If New Jersey chose to do so, it could become a leader in the development of such a system within the United States and elsewhere, but that decision would entail a firm commitment of substantial financial resources from both the State and the private sector and close cooperation toward a common goal by both sectors.

In what follows, the Commission presents its major findings and recommendations to the Governor, chapter by chapter, followed by some concluding observations.

II. New Jersey's Health Care System – An Overview (Chapters 2-5)

As an initial step, the Commission undertook a comprehensive review of the hospital market in New Jersey. This included an examination of the population served, measures of current supply and utilization, projected future supply and utilization, and the current financial condition of hospitals.

Chapter 2: The Population Served by New Jersey's Health System

Major Findings:

The population served by New Jersey's health care system is not sufficiently different from the nation as a whole to account for the economic challenges facing hospitals in New Jersey.

Although New Jersey has one of the highest median incomes in the nation, the percent without health insurance is comparable to the national average.

The age structure of New Jersey's population is virtually identical to that of the U.S. population as a whole, as is the race and ethnic composition of New Jersey's population.

Only 13% of New Jersey residents live in families below 100% of the Federal Poverty Level (FPL). The corresponding national average is 17%. Fewer New Jersey residents live in families between 100% and 199% of the FPL than the national average (15% vs. 19%). Consequently, a higher percentage of New Jersey residents live in families above 200% of the FPL (73% vs. 64%).

In short, New Jersey residents are not poorer, older or more heavily uninsured than the rest of the nation.

Chapter 3: The Supply and Utilization of Acute Care Hospitals in New Jersey

The Commission examined the supply and utilization of hospital-based services. As a first step, eight hospital market areas were defined for the purposes of analysis. These definitions were adapted from the highly regarded work of the Dartmouth Atlas Project and are

based on actual patterns of care as opposed to arbitrary governmental boundaries.

Major Findings:

- The Commission found that New Jersey has slightly fewer hospital beds per population compared to the national average. This does not mean, however, that New Jersey has a relative shortage of beds. In fact, it has an overall hospital bed surplus, as does the nation as a whole. In 2003, the national average hospital occupancy ratio was only 65%, down from 80% in 1980, 73% in 1990 and 68% in 2000⁷. The current ratio is much below the 80% to 85% considered among the experts to be “full occupancy” for a hospital ready to cope with normal day-to-day volatility in admissions⁸. As is shown in Table 4.1 of Chapter 4 of this report, the overall average occupancy ratio of New Jersey hospitals is above the national average, but in every hospital market area of New Jersey it is still below the normative 80% to 85% range considered “full occupancy.” It implies that every hospital market area in New Jersey has a surplus of hospital beds (see Figure 4.12), which varies from market area to market area. Some areas of the State have a bed-to-population ratio far above the national average.
- In addition, hospital services in New Jersey are utilized at a higher level⁹ than much of the nation, as measured by overall number of admissions, physician visits, medical and surgical procedures, and use of high intensity services such as intensive care unit (ICU)-level care. Chronically ill seniors in New Jersey covered by Medicare see more physicians in a year than seniors in any other state in the nation.

Chapter 4: Analyzing the Future Supply of and Demand for Acute Care Hospitals in New Jersey

The Commission also engaged its technical consultants to make projections of future supply and demand for hospital services in New Jersey. This analysis is essential to place current health policy decisions into a

⁷ See *Health, United States 2005*, Table 112; <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=healthus05.table.460>

⁸ See http://www.medscape.com/viewarticle/546181_4

⁹ See Avalere Health LLC, 2006 New Jersey Health Care Almanac—Summary, November 2006: Chapter 2.

future context, based on anticipated trends in the population as well as in clinical care.

Major Findings:

- The analysis revealed that the State currently faces an oversupply of hospital beds that is manifest in every market area of the State, but most pronounced in the Hackensack, Ridgewood and Paterson and the Newark/Jersey City market areas. (See Chapter 4 of the Commission's Final Report). The estimated bed surplus in the Hackensack, Ridgewood and Paterson area is the equivalent of between 2 and 3 hospitals of the average bed size of hospitals now in that market area. Although these numbers do not necessarily imply that 2 to 3 hospitals could be closed in the area without depriving New Jersey residents in the area of essential hospital services, it does suggest considerable slack in the market such that the patient loads of one or two "non-essential" hospitals could be absorbed by other hospitals in the market area.
- The current bed surplus in New Jersey is projected to increase between now and 2015 in all hospital market areas of the State. As is currently the case, excess bed supply is most pronounced in the northeastern section of the State. Declining average length of stay combined with relatively stable or slowly increasing admissions accounts for some of the projected surpluses; but the existing surplus capacity is a platform on which the projected, growing future surplus would build.

Chapter 5: Assessing the Financial and Operational Conditions of New Jersey Hospitals

The Commission has closely examined the current financial conditions of New Jersey hospitals, which seem out of step with financial conditions of hospitals elsewhere in the nation.

Major Findings

- The Commission found that many are in poor financial condition when measured against national benchmarks and common financial indicators used by creditors. This comes at a time when, on average, hospitals across the nation are generally doing well financially.

- While not currently in financial distress, a large number of hospitals appear headed toward distress in the next few years. This situation is unlikely to improve absent closure of some non-essential facilities and other important changes that are both external and internal to hospitals. These proposed changes will be described later in the Executive Summary.

The Commission identified a number of factors common to the most financially distressed hospitals. Many of them are located in the northeastern region of the State, have a high volume of publicly-insured patients, have a low volume of surgical cases, and are small to medium in size. These findings reflect the detrimental impact that an oversupply of beds, underpayment by public insurers, and poor compensation for medical vs. surgical care has on the economics of hospitals. In addition, it emphasizes the importance of size and scale in improving profitability.

III. Factors Affecting the Economics and Performance of New Jersey Hospitals (Chapters 6-11)

Chapter 6: Hospital Economics 101

To understand the economic condition of New Jersey's hospital sector, and of the American hospital market in general, it is helpful to review briefly the peculiarities of American hospital economics, which are quite unlike the economics of normal economic sectors in the United States, and also quite unlike the economics of the hospital sectors in other nations' health systems. Chapter 6 of the Commission's Final Report, therefore, provides a small primer on hospital economics.

Major Findings:

- Unlike hospital-based physicians in most other nations, who are full-time hospital employees, American physicians are self-employed professional business people. In that role they can use the hospitals with which they are affiliated as free workshops whose resources they can enlist in the treatment of their patients more or less as these physicians see fit. Remarkably, in that arrangement, affiliated physicians do not usually render formal

accountability for their use of hospital resources in the treatment of their patients.

- Because affiliated physicians are the major source of revenue for hospitals, hospital managers have little economic leverage over affiliated physicians in efforts to control the physicians' use of hospital resources.
- The extraordinary autonomy that self-employed American physicians enjoy in their hospital-based work can help explain the enormous geographic variations in the per-capita use of health care spending – and of the use of hospital resources – within regions even as small as the State of New Jersey (see Table 1 below). Research by physician and epidemiologist John H. Wennberg and his associates at the Dartmouth University Medical

School, which has yielded the data shown in Table 1, suggests that, nationwide, these enormous geographic variations in the use of health care resources are uncorrelated with variations in the quality of medical care processes, in clinical outcomes and in patient satisfaction (see Chapter 6 for more detail). Some research even suggests a negative correlation between resource use and quality¹⁰. The Technical Quality Scores published by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) conveys a similar impression. A justification of these geographic variations in the use of health care resources and in per-capita health spending, with appeal to either patient characteristics or the quality of care, remains a major challenge for the medical profession.

Table 1:
Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries
(Ratio of New Jersey Hospitals' Data to Comparable U.S. Average, 1999-2003)

	Inpatient Reimbursements	Hospital Days	Reimbursements per Day	CMS Technical Quality Score
St. Michaels Medical Center	3.21	2.34	1.37	0.91
Kimball Medical Center	2.32	1.26	1.83	0.95
Raritan Bay Medical Center	1.86	1.85	1.01	0.81
Christ Hospital	1.83	1.83	1	0.59
St. Mary's Hospital Hoboken	1.75	1.72	1.02	0.74
Beth Israel Hospital	1.58	1.86	0.85	0.83
Overlook Hospital	1.27	1.36	0.94	0.90
Medical Center at Princeton	1.17	1.26	0.93	0.94
Atlantic Medical Center	1.11	1.12	0.97	0.89

Source: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

¹⁰ Katherine Baicker and Amitabh Chandra, "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care," *Health Affairs* Web Exclusive, April 7, 2004.

- Most New Jersey hospitals are non-profit institutions with self-perpetuating boards of directors. Many of the boards appear not to have kept pace with recent changes in best practices for governance, despite the increasing complexity and scope of health care institutions.
- Unlike investor-owned institutions, New Jersey hospitals are not required to post their annual financial reports and submissions to the Internal Revenue Service (Form 990) on their websites.
- In the short run, hospitals have high-fixed costs relative to variable costs, which makes possible widespread price discrimination, meaning that the identical services are sold to different customers (patients or their insurers) at vastly different prices. All over the United States, and in New Jersey as well, the payments hospitals receive vary from payer to payer (and even for a given private insurance carrier) and from insurance product to insurance product.
- As a result of the widespread price discrimination, the prices charged by hospitals for given health services bear little relationship to their costs.
- As a result of widespread price discrimination it is also impossible to gain transparency over prices. Indeed, the prices negotiated between individual insurers and individual hospitals are closely guarded, proprietary secrets. Furthermore, New Jersey hospitals are not required to post their list prices (charge masters) on their websites. Few other industries can operate under this veil of secrecy over prices.
- Once again as a result of price discrimination, hospitals function as a “financial hydraulic system” under which they continually attempt to shift costs from one payer to another or from one service line to another, depending on willingness and ability to pay. Underpayment by public payers, particularly Medicaid, leads to intense efforts to shift costs onto private payers – including the uninsured.
- American health policy suffers from “half-hearted competition” and “half-hearted regulation” – a combination that cannot be expected to produce a rational system.

Recommendations to the Governor:

- As part of its work, the Commission had a presentation on software capable of tracking the order entries of every physician for every medical case by type of service or supply ordered in a hospital. The Commission recommends that the State, in cooperation with leaders of the hospital industry and the medical profession, explore the availability of such software from sundry sources and its adaptability to New Jersey hospitals, with the aim of enabling every hospital to track, for every physician affiliated with the hospital, the average cost per well-identified inpatient case by severity-adjusted diagnosis related group, or DRG, (it being understood that exceptions must be made for so-called non-standard “outlier” cases). If such an information infrastructure is feasible, all New Jersey hospitals should be required to use it, and financial assistance of hospitals by the State should be made contingent on the submission of such information to the State.
- In its Chapter 10 on *The Governance of New Jersey Hospitals*, the Commission recommends that all New Jersey hospitals should be required by the State to post on their website their annual financial reports and their Form 990 for the prior three years.
- In its Chapter 10 on *The Governance of New Jersey Hospitals*, the Commission recommends that all New Jersey hospitals be required by the State to post their charge masters on their websites, along with their sliding scales of prices for uninsured New Jersey residents.
- The Commission recommends that the State should commission a major study by outside expert consultants on the efficiency of all New Jersey hospitals relative to recognized national and regional benchmarks. Such a study should put in place a process of *continuous* monitoring of the relative efficiency of all New Jersey hospitals. The results from this monitoring process should be available to the public. Robust data on the relative efficiency of New Jersey hospitals are essential to a yearly hospital-by-hospital assessment of shortfalls in Medicaid payments relative not to *actually* reported costs, but to *efficient* costs.

Chapter 7: State Funding for New Jersey Hospitals

There are two principal sources of state revenue for New Jersey hospitals: Medicaid and Disproportionate Share Hospital (DSH) payments (predominantly the “Charity Care” system). While these programs provide critical support to hospitals, they generally pay hospitals less than the full cost of services. This underpayment varies by hospital depending on other subsidies, but for many it is estimated at just over 70 cents for every dollar of costs. This underpayment combined with other strains on hospitals led the Commission to recommend changes in how these funds are distributed to hospitals.

Major Findings:

- Regular payments by Medicaid, combined with Disproportionate Share Payments (DSH), will provide hospitals with nearly \$3 billion in annual payments in State Fiscal Year 2008 for Medicaid patients (62% regular Medicaid service payments, 38% additional DSH subsidies).
- New Jersey’s ability to tap additional federal funding is limited. The State can only do so by committing additional State funds. Complex federal regulations limit the flexibility of states to consolidate funding streams.
- Consolidation of the Hospital Relief Subsidy Fund and Graduate Medical Education funds would ensure optimal distribution of these funds and facilitate appropriate annual increases in funding levels.
- Additional funding is needed to address shortages of acute and intermediate care mental health beds for community-dwelling individuals.
- Hospital efficiency is not currently a consideration when public funds are dispensed to hospitals. As a result, the State may be subsidizing inefficient hospitals.

Recommendations to the Governor:

- The Commission recommends consolidation of the Hospital Relief Subsidy Fund and Graduate Medical Education funds into Medicaid direct payments.
- The Commission recommends shifting some funds from the Hospital Relief Subsidy Fund to the Hospital Relief Subsidy Fund for Mental Health to ensure that existing beds are maintained and to provide financial incentives for the additional new beds to address current shortages.
- The State should develop a payment system for Medicaid and Charity Care that includes incentives for efficiency and high-quality health care.
- The State should further examine and resolve the issue whether the Charity Care program should be based on an insurance model, in which case public subsidies would travel with the patient to whichever hospital he or she used, or an institutional model, under which the Charity program would concentrate State subsidies on essential hospitals in financial distress, rather than having them travel with the patient.

Chapter 8: The Relationship of Hospitals and Physicians

The hospital-physician relationship differs in many ways from other sectors of the economy. There are few examples of a relationship where one party uses the resources of another but bears no direct financial responsibility. The long-standing tradition of private-practice physicians with “hospital privileges” produces this exact situation and has made it very difficult for hospitals to manage the medical staff and the use of resources ordered by that staff. Hospitals ultimately bear financial responsibility but are often in a weak negotiating position with physicians, since the hospital is dependent on them referring physicians as a source of patient volume. This peculiar relationship produces many opportunities for the interests of physicians and hospitals to be misaligned.

Major Findings:

- As already noted in Chapter 6, hospitals and physicians do not operate on a common or

compatible set of practice-oriented and financial concerns with respect to the medical management of patients and the provision of in-patient services.

- Ambulatory care facilities have created new economic challenges for hospitals. These centers, generally owned in part by physicians, do not have the same regulatory requirements as hospitals, and they place hospitals at a competitive disadvantage.
- Physicians face little accountability for conscripting a hospital's resources with their orders. Validated performance measures are needed to begin a program of public reporting to increase quality and cost-effectiveness of care.
- Hospital costs are generally unknown to providers and patients.
- There are many opportunities to improve efficiency and quality of inpatient hospital care.
- The providers of health care do not face financial incentives to coordinate care or to make sure that patients have access to continued care once they leave the hospital.
- The State should require public posting of list prices (charge masters) and prices charged to uninsured patients by all ambulatory care facilities.
- The State Board of Medical Examiners should require that physicians and other licensees of the Board provide written notice to patients of any significant financial interest held by that physician or his or her practice in a health care entity to which the practitioner refers patients.
- The State's health care system must in the long-run be required by the State to move toward a publicly transparent system of measuring provider quality of care. While technically difficult, efforts should be undertaken to work toward developing a properly validated, well-accepted, independently-compiled, and publicly-available physician report card system that measures performance and outcomes on critical, evidence-based standards of acute care practice.
- Hospital managers should be required by the State to standardize physician obligations and expectations with respect to emergency department (ED) services to ensure adequate medical coverage and fulfillment of statutory mandates. These obligations should be part of hospital and physician licensure requirements through action by the Department of Health and Senior Services and the State Board of Medical Examiners.

Recommendations to the Governor:

- The State should encourage or support the development of new provider payment models for acute hospital care that better align financial incentives for physicians and hospitals.
- The State should eliminate the licensure exemption for single operating room surgical practices. The Department of Health and Senior Services should assume responsibility for licensure. All surgical facilities in New Jersey should be required to meet nationally-recognized accreditation standards.
- The State should require all ambulatory care facilities to report cost and quality data similar to requirements currently imposed on hospitals. Regulatory and reporting requirements should be evenly applied across facilities.

Recommendations for Hospital Managers:

- Hospitals managers should define and adopt standards of operation for an expanded range of services that optimize utilization of physical plant and human resources on a 365-day basis.
- Adoption or implementation of an Intensivist Model of ICU Care should be a priority for acute care hospitals statewide and especially for financially distressed institutions.
- Hospital management should explore and expand the use of practice extenders and other options for leveraging, extending and augmenting the professional presence and expertise of physicians.

- Hospital managers should encourage coordinated care through a system of appropriate incentives and standards for achieving measurable results that will assure patients are admitted to the most medically appropriate service, require ED physicians to manage patients to an appropriate point of transfer, and establish discharge procedures that provide for appropriate follow-up. Each acute care hospital should develop specific guidelines for implementing coordinated care.

Chapter 9: State Regulation Impacting Acute Care Hospitals

The Commission examined two specific areas of regulation that impact the economics of hospitals, Certificate of Need (CN) and facility licensure programs. Both programs seek to improve quality, and CN also looks to control costs and maintain access to services. The CN program raises two distinct questions. First, should it exist at all? Second, if it should exist, should it be applied evenly to all relevant providers of care? The Commission debated the first issue but did not arrive at a consensus on it, other than to accept the status quo. Instead, the Commission focused on the second question.

The Commission was most concerned with regulations that are unevenly applied across facilities that provide similar services. This situation is particularly evident when looking at the regulatory requirements of hospitals compared to ambulatory care facilities, particularly ambulatory surgery centers. When such uneven regulations exist, they place one party at a competitive disadvantage to the other. The Commission found this to be the case with certain aspects of Certificate of Need, as well as licensure, requirements.

Key Findings:

- The current CN program places hospitals at a competitive disadvantage relative to freestanding facilities.
- CN requirements have not kept pace with changes in the health care system.
- Current licensure exemptions for surgical practices with single operating rooms are not justified on either quality or safety grounds.
- The limited focus of current data collection efforts on hospitals is too narrow for modern health system planning and evaluation.

Recommendations to the Governor:

- The Department of Health and Senior Services should conduct a comprehensive review of the CN and licensure programs to ensure that regulatory requirements do not place hospitals at a competitive disadvantage. CN requirements should be subject to a regular review process to respond to changes in the health care system.
- The Department of Health and Senior Services should require licensure for *all* ambulatory surgery centers and surgical practices with operating rooms.
- The Department of Health and Senior Services should compile and maintain an inventory of non-hospital health care resources and a database to assess their use.

Chapter 10: Governance of New Jersey Hospitals

Nearly all New Jersey hospitals are non-profit institutions governed by boards whose members serve without compensation. However, some of these boards have failed to keep pace with best practices for non-profit governance. This has negatively affected hospital performance and in some cases led hospitals to near bankruptcy with little warning. As community assets, non-profit hospitals need boards that follow best practices in non-profit governance to ensure that community interests are protected. Poor governance and oversight breach trust and compromise the interests of patients, hospital employees, and the community at-large. The Commission adopted a set of principles for effective governance as set forth below, followed by extensive recommendations that would put such principles into operation.

Recommended Principles for Effective Hospital Governance:

- The composition of hospital boards helps ensure that the hospital is responsive and accountable to the community. Hospital boards need to be representative of key stakeholders including

employees, such as nursing staff, complemented by adequate technical expertise in key areas of oversight.

- Transparency helps ensure community accountability. Hospital boards need to maximize transparency to the public of financial performance data, as is routinely required of for-profit entities, and measures of clinical quality.
- Conflicts of interest can threaten the integrity of the governance process. Hospital boards need strong and explicit conflict of interest policies and public disclosure of such conflicts.
- Effective oversight requires that hospital boards are adequately trained and engage in best practices for financial oversight.

Recommended Best Practices for Hospital Governance:

Board Composition – Recommended Best Practices

- Hospital boards should be limited in size proportionate to the scope of its enterprise, but ordinarily to no more than 20 members.
- Members should serve fixed terms of three years.
- Members should be limited to three consecutive three-year terms, and may be reappointed to another term only after a three-year period off the board.
- The terms of board members should be staggered to foster continuity.

Board Composition – Recommended Regulations

- The board should publish a notice of board membership openings at a time and in a manner calculated to generate meaningful community input (e.g. local newspapers, hospital website, and other forms of outreach that would be expected to reach target representative constituencies). The notice should identify the target representative constituency and/or expertise category, as relevant, that the board seeks to satisfy with the noticed appointment.

- Potential board members should complete an application that identifies the extent to which the candidate meets the criteria set by the board; assures the candidate's commitment to the hospital's mission; provides references; and identifies any possible conflicts that may interfere with the candidate's board service.
- The candidate may not be, or have a conflicted relationship with, the hospital's auditor.
- The board should explore the feasibility of including an employee as a member.

Board Education – Recommended Best Practices

- Candidates for the board should be provided with the requirements of service:
 - Attendance at a general orientation on nonprofit governance (as required by New Jersey law), as well as an orientation specific to the entity s/he will be serving;
 - Number of hours per month required to prepare for and attend meetings;
 - That the board member will be automatically terminated upon absence from a certain percentage of meetings, or failure to comply with the conflict of interest policy.
- New board members should be provided:
 - The entity's most recent annual report to the Secretary of State, audited financial statement and Form 990;
 - An organizational chart, the names and contact information for every corporate member, director and officer, the identity and contact information for the board "staff person," and the composition of each board committee;
 - The articles of incorporation and corporate bylaws;
 - The medical staff bylaws;

- The charters for each committee to which the director is assigned, as well as the Joint Commission standards that apply to that committee's work;
- The prior year's board minutes as well as the minutes of each committee to which the board member is assigned;
- The names of hospital and medical staff leadership as well as general descriptive information including the number of beds and available services;
- The hospital's code of ethics;
- The hospital's corporate compliance and whistle-blower protection policy.
- Meet with the audit firm in executive session to discuss, at a minimum, the audit letter;
- Ensure that the Compensation Committee has reviewed key officers' compensation packages, including (non-qualified) deferred compensation and income from other sources for hospital work, as well as non-taxable fringe benefits and expense reimbursements over certain amounts;
- Be empowered to receive reports on the contracting and compensation processes for the hospital's most significant independent contracts, including those receiving more than \$100,000 in compensation in any year;
- Any contribution received from a vendor or contractor to the hospital should be reported to the hospital board.

Board Functions – Recommended Regulations:

- The board should establish and adopt a written conflict of interest policy and procedure for board members, create and disseminate to all employees a written whistle-blower policy, create and adopt a written document retention and destruction policy, and review and approve the Form 990 prior to its submission to the IRS.
- The board should impose such requirements on the Audit and Compliance Committee:
 - Be comprised of independent (non-employee) members;
 - Be governed by a charter enumerating its duties to oversee and ensure the existence of reliable internal financial controls, receive complaints or concerns from the internal auditors, and oversee the annual independent audit;
 - Be vested with the authority to select an independent auditor, receive the audit letter at the conclusion of the audit, and retain its own legal counsel;
 - Ensure rotation of the audit partner or firm every four years;

Board Functions – Recommended Best Practices

- The board should approve management's recommendation of legal counsel to the hospital.
- Management should fully discuss the process for retention of the hospital's legal counsel when seeking board approval.

Transparency – Recommended Regulations

- All community members should have access through a prominent section of the hospital's web page (e.g. Community Relations), and upon request from the hospital's public information office, to important institutional documents including:
 - The articles of incorporation, including the corporate mission statement;
 - The members of the board of directors, their terms of office, and a brief biography of each member;
 - The board bylaws;

- The medical staff bylaws;
 - The three most recent Forms 990;
 - Management compensation, both direct and indirect;
 - The three most recent annual reports;
 - The board's conflict of interest policy;
 - Strategic plans approved by the board that significantly affect the provision of services in the community;
 - The hospital's charge master and its sliding fee provisions for the uninsured as well as the hospital's billing and collection practices for the uninsured.
- In addition, the web site should contain in readily accessible formats, health quality and price information, as the Department of Health and Senior Services deems appropriate. This information should be required to include:
 - Reports on infection rates in formats approved by the Department;
 - Quality measures and outcomes as approved by the Department;
 - Information on sentinel events as approved by the Department;
 - Pricing information for a sample of services approved by the Department;
 - Information regarding the availability of charity care.

Additional Governance Reforms – Recommended Regulations:

- The Department of Health and Senior Services should review guidance on the application of Sarbanes-Oxley principles to hospital governance, discuss possible reforms with interested parties, and adopt by regulation those additional requirements that will ensure the integrity and transparency of hospital governance in New Jersey.

Chapter 11: Adequacy of the Ambulatory Care Safety Net and Other Access Barriers

The ambulatory care safety net and acute care hospitals are dependent on one another to provide comprehensive health care to all New Jersey residents. This dependence is also economic – a robust ambulatory system with safety net services for the uninsured can be an important source of ongoing care that prevents emergency department visits and/or exacerbations of chronic illnesses.

Unfortunately in New Jersey and elsewhere in the nation, many people are uninsured and lack access to a regular source of care. In addition, vulnerable populations face unique barriers beyond insurance status related to disabilities or difficulty finding willing providers when public insurance programs, such as Medicaid, pay providers so poorly.

Major Findings:

- Many patients come to emergency departments with conditions that are preventable or best treated by a primary care provider – this is due in part to deficiencies in the ambulatory safety net.
- Ambulatory safety net clinics have limited access to specialty care creating access barriers for vulnerable populations.
- Mental health and substance abuse are major public health issues and a common cause of ED visits and inpatient admissions.
- Low Medicaid rates limit physician willingness to care for Medicaid patients.
- Uninsured patients unfairly face the highest prices for hospital-based care.
- Special-needs populations face unique barriers to accessing care.
- Accommodations for special-needs populations (such as communication support, barrier-free access, and specialized care) are not always costly and should be prioritized.

Recommendations to the Governor:

- State health policy should expand mental health and substance abuse capacity in the community, prioritize funding for mental health and substance abuse services, and insist on tailoring services to patients' wellness and recovery needs. In addition, it is also critical that acute psychiatric and detoxification services, emergency and acute hospital inpatient care continue to be available in a hospital setting.
- New Jersey should set payment rates for physicians for Medicaid patients and other state-funded health care services at 75% or more of current Medicare rates, to improve the availability of quality care to Medicaid patients.
- The State should require that uninsured patients who are residents of New Jersey be charged by providers of health care on a sliding scale based on income, with a maximum set at the price Medicare pays hospitals for the same services. A provider's sliding scale policy (i.e., prices charged to the uninsured) should be publicly available on the hospital's website.
- The State should require that New Jersey's health care system provides appropriate *professional* interpretation and translation services, along with outreach and educational materials, in the language of patient populations. The providers of health care, however, should be reimbursed for the cost of such services by all payers.

The *Subcommittee on Access and Equity for the Medically Underserved* further identified a number of desirable features that a rational health system for New Jersey would have, without formulating them as concrete, actionable recommendations specifically to the Governor. Among these *desiderata*, recommended to the leaders of New Jersey health care at large, are:

- Successful patient case management models should be supported and replicated in order to address the large volume of ambulatory care sensitive conditions in Emergency Departments.

- Increase the primary care infrastructure and supply of specialty care to patients served by federally qualified health centers (FQHCs) and community-based clinics. This effort will require identifying willing providers and financing such care.
- Institute a community-based health planning process that encourages partnerships and includes community resources so that access to basic and essential healthcare services is a proactive, rather than reactive, endeavor.
- The health care community should be engaged in the "United We Ride" planning initiatives to ensure the transportation needs of the medically underserved are addressed.
- Accommodations for special-needs populations (such as communication support, barrier-free access, and specialized care) are not always costly and should be prioritized.
- The establishment of Centers of Excellence for medical, mental health and dental care for individuals with developmental disabilities should be explored.
- New Jersey's health care system must provide appropriate *professional* interpretation and translation services, along with outreach and educational materials, in the language of patient populations and should be reimbursed for such services by all payers.

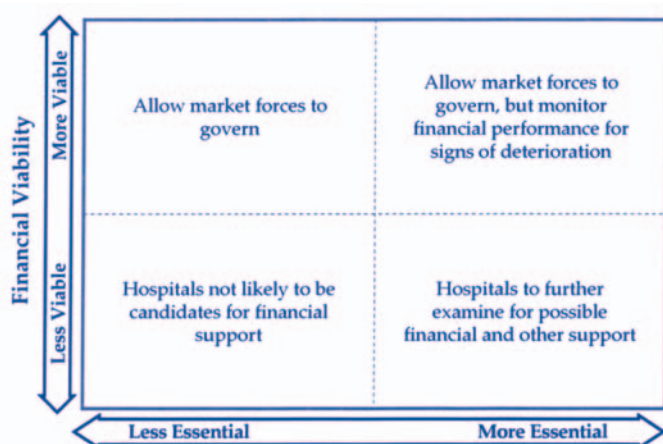
The Subcommittee's full report to the Commission is included in this report under Appendix 8.

IV. Prioritizing Financial Assistance to Financially Distressed Hospitals – A Framework for Essentiality and Financial Viability

A principal task of the Commission was to develop a framework for determining which New Jersey hospitals should receive State support in the face of financial distress. The Commission adopted a framework that defines hospitals as essential or non-essential and financially viable or not viable. The obvious implication of this work is the development of public policy to support essential hospitals that experience financial distress while allowing other hospitals to be subjected to market forces and to potentially close. Evaluating hospitals on such criteria is a dynamic process meaning that hospital ratings will change based on factors both internal and external to the hospital itself, such as the closure of an area hospital. For this reason, publishing a list of financially distressed hospitals serves no immediate public policy purpose and would, in fact, be outdated in a rather short period of time. The Governor's office has been provided with software to implement the Commission's framework in a dynamic manner as the need arises and as the latest data becomes available.

Chapter 12: Identifying New Jersey's Essential Hospitals

The Commission adopted a set of criteria to evaluate hospitals based on their "essentiality" and "financial viability." The general schema is presented below:



Financially distressed hospitals that are deemed more essential should be the focus of the State's efforts to support distressed hospitals. Market forces should be allowed to govern other hospitals including situations where closure seems likely. In those cases, the State's role would be limited to helping facilitate a smooth closure and transition of services to area institutions.

The criteria to determine essentiality include: the level of care provided to financially vulnerable populations, the provision of certain essential services such as trauma, and the fraction of health services provided by the hospital in their market area. Financial viability is determined by three measures: profitability (operating margin), liquidity (days cash-on-hand), and capital structure (long-term debt to capitalization). These evaluative criteria are displayed in the tables below.

The Commission strongly feels that qualitative factors ought to be important considerations in the final policy determination of whether a given hospital should receive support and has provided a list of potential factors. Examples of the types of factors the Commission encourages the State to consider include travel time to alternative sources of care, new barriers for vulnerable populations, and impact on local employment, among others.

Quantifiable Criteria and Metrics for Identifying Essential Hospitals

Criterion / Metric	Data Source
Care for Financially Vulnerable Populations	
Medicaid and Uninsured Discharges	2006 UB-92 Patient Discharge Data from New Jersey Department of Health and Senior Services
Medicaid and Uninsured ED Visits	2006 UB-92 Emergency Department Data from New Jersey Department of Health and Senior Services
For Medicare Disproportionate Share Hospitals, their ratio of patient days for Medicare dual eligible patients to total Medicare patient days	2006 Medicare Cost Reports, as available and 2005 Medicare Cost Reports otherwise
Provision of Essential Services	
Trauma Center Designation	New Jersey Department of Health and Senior Services
Utilization	
Percent of the Dartmouth Atlas-defined Hospital Service Area's Total ER Visits	Analysis of 2006 UB-92 Emergency Department Data from New Jersey Department of Health and Senior Services
Inpatient Occupancy	Analysis of Acute Care Maintained Beds and Patient Days from 2006 B2 Reports submitted by hospitals to the New Jersey Department of Health and Senior Services
Total Patient Days and ED Visits	2006 B2 Reports for Patient Days and 2006 UB-92 Emergency Department Data from New Jersey Department of Health and Senior Services for ED Visits

Criteria and Metrics for Identifying Hospital Financial Viability

Criterion	Metric	2006 Statewide Average for Metric
Profitability	Operating Margin	- 0.9%
Liquidity	Days Cash-on-Hand	124
Capital Structure	Long-term Debt to Capitalization	51.2%

Chapter 13: Supporting Essential, Financially Distressed Hospitals

Implicit in the Commission's framework of evaluating hospitals is the need to develop specific public sector strategies to support essential, financially distressed hospitals. The Commission proposes several specific strategies to assist such hospitals. That support, however, should not be unconditional. It should come with specific requirements put on the management and the board, such as conditions related to management and governance. Furthermore, such hospitals should be subject to close monitoring of their efficiency, the quality of their services, and their overall financial health.

Recommendations to the Governor:

- The State should consider a supplemental add-on payment to the Medicaid fee-for-service base DRG rate for essential hospitals in financial distress.
- The State should create a Distressed Hospital Program focused on providing financial support to financially distressed, essential hospitals. The program would be financed through an increase in the Ambulatory Assessment (which would be used to service debt financed by New Jersey Health Care Facilities Financing Authority-backed bonds).
- The State should provide time-limited grants and/or zero interest loans for operating and financial performance improvements to essential, financially distressed hospitals.
- The State should establish a capital grant program for hospital facility renovation and information technology investment to essential, financially distressed hospitals.

Chapter 14: Facilitating the Closure of Non-Essential, Financially Distressed Hospitals

A key finding of the Commission's work is that there is an oversupply of hospital beds in all regions of New Jersey, with surpluses most evident in the northeastern area. This oversupply is apt to contribute to the negative financial performance of many hospitals, as too many of them must share a more limited patient load. Closures of some non-essential hospitals have the potential to significantly improve the financial situation of surviving

hospitals in an area of a recent closure. Therefore, it is in the public and State's (i.e., the taxpayers') interest to allow non-essential hospitals to close when confronting financial difficulty. However, the State needs to play an important role in facilitating a smooth closure with minimal disruption of services.

Key Findings:

- A Certificate of Need (CN) application is necessary for a hospital closure; however, the current process occurs relatively late in the course of a hospital's period of distress.
- The costs associated with closure are substantial – state assistance is warranted for some but not all of these costs.

Recommendations to the Governor:

- The State should develop and fund a program to help pay some of the costs of closing a hospital.
 - The program should not pay for what is often the largest cost associated with closing a hospital, namely, the hospital's debt obligations financed through bond issues. Bondholders assume risk when they purchase bonds, and default is clearly one of those risks. It is not the State's (i.e., the taxpayers') responsibility to provide a bailout for investors who willingly assume such risks.
 - Hospital employees should be provided appropriate economic protection when a hospital closes. They should receive severance pay for a similar duration as the hospital's top executives.
- The State should review the CN hospital closure process. It should be streamlined and refocused to permit a more rational closure and realignment process than results from normal markets forces and the bankruptcy process.
- The State should help facilitate re-use of closed hospital facilities for other purposes.

Chapter 15: Improving State Oversight to Provide Greater Accountability for State Resources

In recent years, the State has been faced with urgent requests for funding for hospitals in dire financial circumstances. Too often, decisions must be made in a moment of crisis, leaving little opportunity to create

accountability for public dollars. The State needs to be in a position to monitor the performance of all hospitals and also have early warning signs well before a hospital actually reaches a point of financial distress to allow for early intervention.

Recommendations to the Governor:

- The Commission recommends that the State create a “Hospital Performance Dashboard” to monitor the quality of care rendered by facilities and the efficiency with which it is produced and delivered. These metrics would be particularly important as a monitoring tool for essential hospitals that receive state support, to ensure the efficient provision of high quality clinical services by these hospitals.
- The Department of Health and Senior Services should implement an Early Warning System focused on monitoring the financial health of hospitals and intervene in a graduated fashion based on the severity of financial difficulties and the response of management.

V. A Vision for a 21st Century Health Care System – A Health Care Information Infrastructure for New Jersey (Chapter 16)

Data and information is central to any effort to improve provider accountability and provide consumers with meaningful information about their health care system. Yet the health care system in 2007 has virtually no information technology capacity and underachieves relative to most other sectors of the economy in this regard. Recent attempts by the private sector to develop so-called Regional Health Information Organizations (RHIOs) had looked promising at first, when they were launched several years ago, but most of these RHIOs have failed to live up to that promise and many of them are now defunct¹¹.

¹¹ See Julia Adler-Milstein, Andrew P. McAfee, David W. Bates, and Ashish K. Jha, “The State Of Regional Health Information Organizations: Current Activities And Financing,” *Health Affairs Web Exclusive*, December 11, 2007; http://content.healthaffairs.org/cgi/search?ck=nck&andorexactfull-text=and&resourcetype=1&disp_type=&author1=&fulltext=RHIO&s&pubdate_year=&volume=&firstpage= .

Yet, a visionary information infrastructure is needed to overcome information barriers and realize the potential of a 21st Century health care system. On that realization, nations in Europe and Asia are now forging ahead in developing such systems. A sketch of such an information system is provided in Chapter 16.

Health information systems possess many of the characteristics of a public good – meaning the private sector will tend to under-invest in such a system. Mandatory participation by the providers of health care in information infrastructures are needed to develop and support sustainable information systems. Making payment for health care by the public sector contingent on participation in such systems provides a business case for that course of action. In return, however, the development of such a system and its operation will require annual public subsidies, as is routinely recommended by economists for public goods.

Recommendations to the Governor:

- Developing and sustaining a full-fledged health information system is a very difficult task, but one that holds great potential to improve health system performance. Therefore, the Commission recommends that the State should form a new commission charged with developing the framework and policies around the development of a regional health information system, drawing where appropriate on similar efforts elsewhere in the United States and abroad. Such a commission needs to engage many key stakeholders to overcome these challenges.
- In view of the decade-long failure, to this day, of the private sector to develop such an information infrastructure (e.g., the much heralded the Regional Health Information Organizations (RHIOs) started several years ago by stakeholders in the private sector, but without much success in the meantime), the State should take an active, leading role in the development of such a system, financing both the research and the development efforts to establish such a system. Eventually, participation by all providers of health care in such a system should be mandatory.
- To maximize its effectiveness, a 21st Century future health information system for New Jersey should be based on standardized software and nomenclature. It should also be transparent and easily accessible to a

variety of users. It should be managed by a public-private organization chartered by the State and, in view of the public-goods nature of the enterprise, be supported by State funds.

VI. KEY CONCLUSIONS FROM THE COMMISSION'S WORK

- **The *most important conclusion* to emerge from the Commission's work is that a large number of New Jersey hospitals are truly in poor financial health.**

This downward trend in the finances of hospitals in New Jersey comes at a time when hospitals nationwide are doing exceptionally well. This points to fundamental problems in the hospital market in

New Jersey that must be remedied if hospitals are to regain their footing.

- **Based on the current financial picture, the residents of New Jersey should expect a wave of additional hospitals that will face financial distress in the next few years.**
- **In cases where a hospital is not deemed essential, closure should be allowed to happen with the State's role limited to facilitating the process to minimize disruption to the community.**
- **In cases where a hospital is deemed essential, the State should assume a prominent role in providing financial support that is conditioned on the hospital meeting certain performance benchmarks.**

Major Causes of Hospitals' Current Poor Financial Health

- **Lack of universal coverage – many of the financial challenges hospitals are currently facing can be traced back to the lack of insurance for many New Jersey residents.**
- **Underpayment by public payers – public insurance programs (i.e. Medicaid and Charity Care) reimburse many hospitals below cost resulting in intense but not completely successful efforts to shift those costs onto private payers. Hospitals treating relatively few uninsured patients and with a case mix heavily weighted with commercially insured patients in certain parts of the State tend to be insulated from these forces while others are more vulnerable.**
- **Misaligned incentives and interests between physicians and hospitals – different financial incentives and complex relationships between physicians and hospitals contribute to over-utilization and variations in clinical practice that in many cases appear to be without justification.**
- **Lack of transparency of performance or cost – the health care system has been slow to measure and report performance and cost data, which contributes to the slow progress in performance improvement.**
- **A need for more responsible governance at certain hospitals – non-profit hospital boards in some cases do not provide the proper level of oversight of hospital finances and management needed to ensure accountability to the community for valued community assets.**
- **Excessive geographic hospital density – A large number of hospitals are in relatively close geographic proximity to one another compromising their market power with respect to payers and physicians – this impacts negotiations over payment rates and limits the ability of hospital managers to influence physician practice behaviors.**

In conclusion, it may be observed that, while on average New Jersey's hospitals are in worse financial condition than are hospitals nationwide, the American health care system in general, and thus New Jersey's, suffers from several major shortcomings that will plague the health care sector as long as they persist:

- An unwieldy system of pervasive price discrimination that completely decouples the payments made to hospitals for their services from the cost of these services to the hospital, that provides perverse incentives for the nature of medical treatments dispensed and for the location of their production, and that defeats any attempt at price transparency;
- A reliance on the hospital system as a major receptacle for the social pathos begotten by a highly competitive, dynamic economy with a highly unequal income distribution, a large population of undocumented and typically uninsured immigrants handicapped by language barriers, and inadequate ambulatory mental health care;
- A reliance on the hospital sector to operate an ad-hoc catastrophic health insurance system for

critically ill, uninsured and predominantly poor residents, coupled with the tacit assumption that each hospital can somehow finance the cost of this ad-hoc catastrophic insurance system through a pin-the-tail-on-the-donkey game in which commercially insured or some self-paying patients can be made to pay the premiums for this ad-hoc insurance system through the payment of higher prices;

- A nationwide, almost complete lack of transparency on the prices and the quality of the health services rendered by hospitals and physicians, which makes it virtually impossible to hold the main decision makers of the health-care delivery properly accountable for the resources entrusted to them and for the cost-effectiveness and quality of the care they render.

As long as these conditions remain in place, the search for a rational health system will be chasing the will-o'-the-wisp, in New Jersey as well as the rest of the nation. In the Commission's considered judgment, the best that can be done under these conditions is to move the system somewhat closer to a truly rational system, by adopting the recommendations made by the Commission.

VII. Acknowledgements

The Commission offers special thanks to the members of the Governor's cabinet and staff that participated with tremendous energy, vision, and dedication. Commissioner Fred Jacobs (Department of Health and Senior Services) was a major guiding light throughout the Commission's work along with Commissioner Jennifer Velez (Department of Human Services) and Commissioner Steven Goldman (Department of Banking and Insurance). The Commission also offers special thanks to its full-time staff, Michele Guhl (Executive Director) and Cynthia McGettigan (Executive Assistant), for their tireless work in guiding and supporting this process to completion.

The Commission also benefited from the wisdom and expertise of many staff from the Governor's office and various state agencies including: Heather Howard (former Policy Counsel, Office of the Governor, now Commissioner of the Department of Health and Senior Services), John Jacobi (Senior Associate Counsel, Office of Governor's Counsel), Keri Logosso, (former Health Policy Advisor, Governor's Policy Office, now Director of Children's Health Services, Department of Children & Families), Matthew D'Oria (Deputy Commissioner, Department of Health & Senior Services), John Guhl (Director, Division of Medical Assistance & Health Services (Medicaid) – Department of Human Services), Michael Keevey (Director, Office of Reimbursement, Division of Medical Assistance & Health Service (Medicaid) – Department of Human Services), Stephen Fillebrown (Director of Research, Investor Relations & Compliance, NJ Health Care Facilities Financing Authority), Mark Hopkins (Executive Director, NJ Health Care Facilities Financing Authority), Cynthia Kirchner (Senior Policy Advisor, Department of Health and Senior Services), Carolyn Holmes (Senior Advisor, Department of Health & Senior Services), Ruth Charbonneau (Director – Office of Legal and Regulatory Affairs, Department of Health and Senior Services), and Gabriel Milton (Executive Director/NJCSCR, Department of Health and Senior Services). The Commission also thanks the many highly skilled individuals at Navigant Consulting, Inc., and especially Paula Douglass, Casey Nolan and Henry Miller.

The Commission wishes to thank Stephen Berger, Chair and David Sandman, Ph. D., Executive Director of the New York State *Commission Health Care Facilities in the 21st Century* for the helpful advice and insights they kindly offered our Commission at the beginning of its work. The New York Commission published its final report in December, 2006. Unlike New Jersey's Commission, it was created by statute of the legislature and was charged with identifying health care facilities for closure or conversion, for an up-or-down vote by the legislature.

Special thanks are due to David Grande, M.D., M.P.A., Instructor of Medicine at the University of Pennsylvania, who was recruited by the Commission to draft this Final Report. Dr. Grande worked tirelessly studying the sundry subcommittee reports, sitting in on many Commission meetings and conference calls, and spending many hours drafting this report. His good work is very much appreciated by the Commission and its staff.

Finally, the Chair of the Commission wishes to thank Dean Anne-Marie Slaughter and Acting Dean Nolan M. McCarty of Princeton University's Woodrow Wilson School of Public Affairs and International Affairs for their encouragement and support of the Chair's work on the Commission, in keeping with the School's public-service mission.



Section I:

Introduction



Chapter 1: The Commission's Tasks

I. Establishment of the Commission

Governor Jon S. Corzine created The Commission on Rationalizing Health Care Resources by executive order on October 12, 2006. Executive Order No. 39 set out ten tasks:

1. Assess the financial and operating condition of New Jersey's general acute care hospitals by benchmarking them against national performance levels; compare the performance of New Jersey's general acute care hospitals to the performance of general acute care hospitals in a group of similar states; compare the array of programs and services offered by a hospital with the core mission of that hospital and the existing availability of those services at other hospitals within their region; and evaluate the effectiveness of established programs in meeting their intended objectives;
2. Analyze the characteristics of New Jersey's most financially distressed hospitals to identify common factors contributing to their distress including the availability of alternative sources of care such as federally qualified health centers and other ambulatory care providers;
3. Determine appropriate geographical regions throughout New Jersey for provision of access to medical care for the residents of New Jersey, including those who are low-income and medically underserved, and assess the current and projected future demand for physician, hospital, federally qualified health center and other ambulatory care providers in each such region and compare that future demand with existing capacity;
4. Develop criteria for the identification of essential general acute care hospitals in New Jersey and use the criteria developed to determine whether a financially distressed hospital at risk of closing is essential to maintaining access to health care for the residents of New Jersey;
5. Make recommendations for the development of State policy to support essential general acute care hospitals that are financially distressed including the development of performance and operational benchmarks for such hospitals;
6. Make recommendations on the effectiveness of current State policy concerning assistance to financially distressed hospitals that are non-essential and that seek to close but require debt relief or other assistance to enable them to do so, and make recommendations on ways to improve State policy to facilitate such closures;
7. Evaluate appropriate alternative uses to which such facilities might be put, including but not limited to, their potential redeployment as federally qualified health centers, other ambulatory care providers, physician offices and treatment facilities;
8. Develop and publish a State Health Care Resource Allocation Plan to promote the rational use of public and private health care resources, labor, and technology and to serve as the basis for reviewing and approving the development and/or redeployment of health care assets and services around the State;
9. Review existing Certificate of Need statutes and regulations to ensure consistency with the State Health Care Resource Allocation Plan and recommend amendments and/or revisions to achieve that objective if necessary;
10. Make recommendations to strengthen State oversight and ensure greater accountability of State resources; and
11. Issue a written report of its findings and recommendations no later than June 1, 2007, to the Governor, the Senate President, the Senate Minority Leader, The Assembly Speaker, and the Assembly Minority Leader.

Although Executive Order No. 39 originally called for the final report by June 1, 2007, the Governor subsequently extended the time for the Commission to file its final report to December, 2007 and requested that the Commission provide an interim report, which was released on June 26, 2007.

Here it should be emphasized that Executive Order No. 39 does not envisage the New Jersey Commission to be a hospital-closing commission, as was New York State's recently completed *Commission on Health Care Facilities in the 21st Century* (the "Berger" Commission). Unlike New Jersey's Commission, established by the Governor's executive order, New York's commission had been established by statute of the legislature and was tasked with identifying hospital candidates for closure, for conversion into other health-care facilities or for consolidation into other hospitals. The New York Commission's recommendations were to be approved or rejected by the legislature in an up-or-down vote, just like an army base closing commission. By contrast, the New Jersey Commission is an advisory body established to make recommendations on the allocation of scarce state assistance funds to hospitals on

an objective, evidence-based platform that can help the State's government allocate these funds more rationally.

The Governor appointed Dr. Uwe E. Reinhardt to serve as Chair of the Commission. Dr. Reinhardt is the James Madison Professor of Political Economy and Professor of Economics and Public Affairs at Princeton University's Woodrow Wilson School of Public and International Affairs.

The Governor appointed eight other experts to serve as voting members, and the Commissioners of Health and Senior Services, Human Services, and Banking and Insurance to serve as non-voting members.

II. The Commission's Modus Operandi

The Commission's work was supported by an Executive Director, as well as staff from New Jersey's Departments of Health and Senior Services and Human Services and from the New Jersey Health Care Facilities Financing Authority and the Office of the Governor. A list identifying the Commission members is presented in Figure 1.

Figure 1
Commission Members

**Uwe E. Reinhardt, Ph.D.,
Chairman**

The James Madison Professor of Political Economy
Professor of Economics and Public Affairs
Woodrow Wilson School of Public and International Affairs
Princeton University

Joel C. Cantor, Sc.D.

Director, Center for State Health Policy
Professor of Public Policy
Edward J. Bloustein School of Planning and Public Policy
Rutgers, the State University of New Jersey

Debra P. DiLorenzo

President
Chamber of Commerce of Southern New Jersey

Linda M. Garibaldi, J.D.

Senior Attorney
Legal Services of New Jersey

Gerry E. Goodrich, J.D., M.P.H.

Director of Practice Operations
Weill Medical College
Cornell University

David P. Hunter, M.P.H.

Health Care Consultant

Risa Lavizzo-Mourey, M.D.

President and CEO
The Robert Wood Johnson Foundation

JoAnn Pietro, R.N., J.D.

Partner
Wahrenberger, Pietro and Sherman LLP

Peter R. Velez, M.P.H.

President and CEO
Newark Community Health Centers, Inc.

Bruce C. Vladeck, Ph.D.

(Former Interim President, University of Medicine and Dentistry of New Jersey)
Senior Health Policy Advisor
Co-Director, Academic Medical Ctrs Service Line
Health Sciences Advisory Services
Ernst & Young LLP

Fred M. Jacobs, M.D., J.D.

EX-OFFICIO

Commissioner
Department of Health and Senior Services

Steven M. Goldman, J.D., L.L.M.

EX-OFFICIO

Commissioner
Department of Banking and Insurance

Jennifer G. Velez, J.D.

EX-OFFICIO

Commissioner
Department of Human Services

Michele K. Guhl

Executive Director

NJ Commission on Rationalizing Health Care Resources

Cynthia McGettigan

Executive Assistant

NJ Commission on Rationalizing Health Care Resources

The Commission received a broad mandate in Executive Order No. 39. The Commission addresses the tasks in this final report to the Governor and legislative leaders. The charge of the Commission was not to create a centralized, prescriptive plan for the provision of health care in New Jersey. That project is beyond the Governor's charge and would fit uncomfortably in today's context of governmental and market influences on health care delivery. Instead, the Commission is providing advice on the means by which New Jersey might take steps as a purchaser, grantor, and regulator to improve the health of New Jersey's hospitals for the benefit of the people of New Jersey.

It should also be noted that there were several tasks in the Executive Order that proved to be beyond the resources of the Commission. For example, the Commission conducted a comprehensive assessment of the financial and operating conditions of all general acute care hospitals and benchmarked them against the national level. However, assessing each hospital's programs and services relative to their mission was simply too extensive of a task and the Commissioners generally felt it would not add substantial value to the final report and recommendations. In addition, one section of the Executive Order called for a State Health Care Resource Allocation Plan. The critical situation facing hospitals in New Jersey was the most pressing issue the Commission explored and limited the ability to conduct a comprehensive assessment of every element of the health care system. Nonetheless, the focus on the hospital sector did require consideration of issues related to health care providers and ambulatory health care facilities.

The Commission did not start its work with a blank slate. In December 2006, New York State concluded a lengthy process of reviewing the state of New York State's hospital sector through the *Commission on Health Care Facilities in the 21st Century*, chaired by Stephen Berger (hence, the "Berger" Commission). While its charge differed from the New Jersey Commission's charge, and notwithstanding these differences, the Commission benefited from reviewing the New York Commission's report and from the consultation generously offered by its Executive Director, David Sandman, Ph.D. In addition, we benefited from the extensive work done over many years by the Dartmouth Atlas Project at Dartmouth

Medical School. The Dartmouth Atlas Project has produced extensive data on health care utilization trends and, in particular, on geographic differences in health care utilization.

Our Commission also benefited in its deliberations from other prior, relevant research, notably:

- The *2006 New Jersey Health Care Almanac* (October 2006) by the Washington, D.C. based consulting firm Avalere Health LLC, supported by research grants from the Robert Wood Johnson Foundation and Horizon Blue Cross Blue Shield of New Jersey;
- *New Jersey Acute Care Hospitals Financial Status* (2006), a report commissioned by the New Jersey Hospital Association;
- New Jersey Department of Health and Senior Services, *New Jersey 2006 Hospital Performance Report*;
- Hospital Alliance of New Jersey, *Examining the State of Our Health Care System: The Unique Challenges Facing Urban Hospitals and their Importance in our State* (October, 2006); and
- Sundry other documents, newspaper articles and commentaries that bear on the task before the Commission.

The entire Commission met in person on 14 occasions, and conducted numerous telephone conferences. Working with its technical consultants and State staff, the Commission worked through the Executive Order's charge. The Commission devoted a series of meetings to hear from the four hospital associations in the State (New Jersey Hospital Association, the New Jersey Council of Teaching Hospitals, the Hospital Alliance of New Jersey, and the Catholic Health Care Partnership of New Jersey); the New Jersey Association of Health Plans; representatives of free standing diagnostic imaging facilities in New Jersey; the State Divisions of Mental Health Services and Addiction Services; the Association of Financial Guaranty Insurers (bond insurers); and representatives of ambulatory surgery centers in New Jersey.

The Work of Subcommittees

The Commission created subcommittees in the following areas:

- Access & Equity for Medically Underserved
- Benchmarking for Efficiency & Quality
- Infrastructure of Health Care Delivery (with emphasis on Information Technology)
- Reimbursement/Payers
- Regulatory & Legal Reform
- Hospital/Physician Relations and Practice Efficiency

Each of these subcommittees comprised of a wide range of experts and representatives of stakeholders and the public and was staffed by experts from State agencies and co-chaired by members of the Commission. The subcommittees were charged with examining sets of technical issues central to the Commission's charge, and with deliberating and providing a report and recommendations to the Commission on its substantive area.

The Commission also conducted three public hearings during the summer months. These hearings were in the Northern, Central, and Southern parts of New Jersey. The hearings provided the public an opportunity to provide additional information to the Commission, and for the Commission to hear the concerns of the people of New Jersey well in advance of preparing its final report. The public was also invited to submit comments on the Commission's website, www.nj.gov/health/rhc.

III. Major Conclusions Emerging from the Process

The members of the Commission have brought a great deal of expertise and information to the process. They have also benefited a great deal by information provided from many sources, including hospital organizations, payer organizations, professional organizations, consumer groups, and others. In addition, staff and the Commission's technical consultant, Navigant Consulting, have provided valuable information.

- **The most important conclusion to emerge from the Commission's work is that a large number of New Jersey hospitals are truly in poor financial health.**

This downward trend in the finances of hospitals in New Jersey comes at a time when hospitals nationwide are doing exceptionally well. This points to fundamental problems in the hospital market in New Jersey that must be remedied if hospitals are to regain their footing.

- **Based on the current financial picture, the residents of New Jersey should expect a wave of additional hospitals that will face financial distress in the next few years.**
- **In cases where a hospital is not deemed essential, closure should be allowed to happen with the State's role limited to facilitating the process to minimize disruption to the community.**
- **In cases where a hospital is deemed essential, the State should assume a prominent role in providing financial support conditioned on the hospital meeting certain performance benchmarks.**

Major Causes of Hospitals' Current Poor Financial Health

- **Lack of universal coverage** – many of the financial challenges that hospitals are currently facing can be traced back to the lack of insurance for many New Jersey residents.
- **Underpayment by public payers** – public insurance programs (i.e. Medicaid and Charity Care) reimburse many hospitals below cost resulting in intense but not completely successful efforts to shift those costs onto private payers. Hospitals treating relatively few uninsured patients and with a case mix heavily weighted with commercially – insured patients in certain parts of the State tend to be insulated from these forces while others are more vulnerable.
- **Misaligned incentives and interests between physicians and hospitals** – differential financial incentives and complex relationships between physicians and hospitals contribute to over-utilization and variations in clinical practice that in many cases appear to be without justification.
- **Lack of transparency of performance or cost** – the health care system has been slow to measure and report performance and cost data, which contributes to the slow progress in performance improvement.
- **A need for more responsible governance at certain hospitals** – non-profit hospital boards in some cases do not provide the proper level of oversight of hospital finances and management needed to ensure accountability to the community for valued community assets.
- **Excessive geographic hospital density** – A large number of hospitals are in relatively close geographic proximity to one another compromising their market power with respect to payers and physicians – this impacts negotiations over payment rates and limits the ability of hospital managers to influence physician practice behaviors.

The Commission, in consultation with its technical consultants, adopted a framework to measure hospitals' essentiality and financial viability. This framework provides the basis by which the Commission believes the State should respond to financial distress at a given hospital. The Governor's office has been provided software that permits hospitals to be evaluated on an ongoing basis on essentiality and financial viability criteria. Those meeting the criteria for essentiality

would be prioritized for financial assistance. The Commission did not believe there was value in publishing a current categorized list of hospitals based on these criteria. Such an assessment would represent only a particular point in time and the dynamic nature of the criteria means that hospitals will shift based on a range of factors such as the closure of an area hospital or successful performance improvement initiatives.

IV. The Commission's Report

The Commission's Report is divided into three additional sections following the introduction (Sections II-IV). Section II (Chapters 2-5) provides a descriptive analysis of the health care system in New Jersey focusing on the hospital sector. Chapter 2 reviews the demographics and health insurance coverage rates in New Jersey. Chapter 3 examines the supply and utilization of hospitals in New Jersey and defines hospital market areas for the purpose of planning and analysis. Chapter 4 projects the future demand for hospitals in New Jersey. The final chapter of this section (Chapter 5) probes deeply into the current finances of New Jersey hospitals and examines the characteristics in common for financially distressed hospitals.

Section III is focused on various factors that influence the economics and performance of hospitals. Chapter 6 is an introduction to hospital economics and describes the peculiar nature of hospital financing in the U.S. Chapter 7 examines the various streams of revenue for hospitals from state programs. Chapter 8 explores how the unique relationship between physicians and hospitals impacts financial and clinical performance. Chapter 9 assesses the current State regulatory landscape affecting New Jersey hospitals. Chapter 10 provides a comprehensive set of recommendations to reform the

governance of hospitals. Chapter 11 looks at the ambulatory care safety net and other special needs and issues affecting vulnerable populations and compromising health equity.

Section IV presents a framework for measuring essentiality and financial viability of hospitals and includes recommendations for support that should be provided to essential hospitals and non-essential hospitals in financial distress. Chapter 12 provides the criteria to define essential hospitals. Chapter 13 makes recommendations on how financially distressed essential hospitals should be supported. Chapter 14 discusses methods by which the state can help facilitate a successful closure of a financially distressed, non-essential hospital. Chapter 15 provides a series of quality, efficiency and financial measures for regular monitoring and proposes a set of graduated interventions.

Section V is focused on a long-run vision for enhanced transparency, accountability, and quality. This is outlined in Chapter 16 where the framework is provided for a health information system that would serve at the core of such an effort.



Section II:

New Jersey's Health Care System – An Overview

The Commission's principal task was to evaluate the economics of the acute care hospital sector in New Jersey and provide recommendations to the Governor on how hospitals should be supported in the future in response to financial distress. This section of the report provides a descriptive view of the hospital market in New Jersey examining factors such as the supply, distribution and use of hospital-based services. In addition, the section provides a closer look at the financial situation facing the State's hospitals. The Commission's findings clearly and unambiguously show that many hospitals in the State are in poor financial condition and a wave of more closures appears likely. This section is a precursor to the following section that provides the Commission's assessment of the factors affecting the financial and clinical performance of hospitals.

Chapter 2 provides an overview of the demographics and health insurance coverage rates in New Jersey to provide a sense of the population served by New Jersey's health care system relative to the nation. Chapter 3 provides measures of the supply of acute care hospital facilities in the State along with definitions of regional hospital market areas adopted by the Commission. Chapter 4 projects future supply and demand of hospital beds in New Jersey to assess for excess capacity by region. Chapter 5 provides an analysis of the financial condition of New Jersey's hospitals and identifies common characteristics of hospitals in financial distress in the current environment.



Chapter 2: Population Served by New Jersey's Health Care System

Key Points

- **New Jersey residents have a similar age, racial, and ethnic distribution as the nation as a whole.**
- **Although New Jersey has one of the highest median incomes in the nation and a relatively low poverty rate, the percent without health insurance is similar to the national average.**
- **New Jersey enjoys a higher rate of employer-based health insurance in comparison to the nation.**
- **The demographics of New Jersey are not sufficiently different from the nation to account for significant differences in demands on the health care system.**

As a precursor to carrying out its charge to assess whether New Jersey's health system is best configured to respond to community needs, it is important to understand the underlying demographics of New Jersey, as demographic factors largely determine community need. This section provides a high-level profile of New Jersey's population along with comparisons to the United States as a whole, including information on age distribution, poverty levels, income levels, and health insurance coverage levels, to provide a context for the populations that New Jersey's health care system is serving.

I. Demographics and the Economy

New Jersey's population of approximately 8.7 million people is comparable to the overall population of the United States in age distribution and racial/ethnic composition, as shown in Tables 2.1 through 2.4. The State's poverty rate is somewhat lower than the national average.

Table 2.1:
Population Distribution by Age, New Jersey and the United States (2006)¹²

Age Group	New Jersey		United States	
	Total	Percent of Total	Total	Percent of Total
Children 18 and under	2,249,548	26%	78,204,774	26%
Adults 19-64	5,343,876	62%	181,817,020	61%
65+	1,089,720	13%	36,035,042	12%
65-74	554,887	6%	18,997,864	6%
75+	534,833	6%	17,037,177	6%
Total	8,683,143	100%	296,056,836	100%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

Table 2.2:
Population Distribution by Race/Ethnicity, New Jersey and the United States (2006)¹²

Race/Ethnicity	New Jersey		United States	
	Total	Percent of Total	Total	Percent of Total
White	5,347,630	62%	195,720,465	66%
Black	1,122,340	13%	35,877,972	12%
Hispanic	1,446,359	17%	44,772,587	15%
Other	766,815	9%	19,685,812	7%
Total	8,683,143	100%	296,056,836	100%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

¹² Totals may not add up due to rounding.

Table 2.3:
Distribution of Total Population by Federal Poverty Level, New Jersey and the United States (2006)¹²

Relation to Federal Poverty Level	New Jersey		United States	
	Total	Percent of Total	Total	Percent of Total
Under 100%	1,099,087	13%	50,107,136	17%
100-199%	1,260,042	15%	55,558,201	19%
<i>Low Income Subtotal (199% and Under)</i>	<i>2,359,129</i>	<i>27%</i>	<i>105,665,337</i>	<i>36%</i>
200% or more	6,324,014	73%	190,391,488	64%
Total	8,683,143	100%	296,056,836	100%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

Table 2.4:
Poverty Rate by Race/Ethnicity, New Jersey and the United States (2006)¹²

Race/Ethnicity	New Jersey		United States	
	Total	Percent of Total	Total	Percent of Total
White	387,891	7%	22,278,378	12%
Black	291,877	25%	11,352,348	33%
Hispanic	351,302	26%	12,654,058	29%
Other	NSD	NSD	3,822,351	20%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org. NSD means Not Sufficient Data

In 2005, New Jersey's median household income (\$59,989) exceeded the national median (\$46,037) by 30 percent, making New Jersey one of the wealthiest states in the country. State tax collections per capita in 2005 (\$2,631) exceed the comparable national average (\$2,191) by 20 percent. These taxes include all property taxes, sales and gross receipts, licenses, income taxes, and other taxes. New Jersey State per capita spending from its general fund, federal funds, other state funds and bonds in 2005 (\$4,769) exceeded the comparable national average (\$4,175) by 14 percent. In sum, New Jersey is a relatively affluent state whose taxes and per capita spending exceed the national average by sizeable margins.

II. Health Insurance Coverage

In comparison to the United States as a whole, New Jersey's residents have slightly better health insurance coverage, with a higher proportion of New Jersey's population covered through employers. As is the case nationally, a large proportion of the New Jersey's residents (15 percent) are uninsured, and these residents are concentrated in the lower income strata. Data about health insurance coverage for New Jersey and the United States is presented below in Tables 2.5 through 2.7.

Table 2.5:
Population Distribution by Race/Ethnicity, New Jersey and the United States (2006)¹³

Coverage	New Jersey		United States	
	Total	Percent of Total	Total	Percent of Total
Employer	5,423,384	62%	158,515,473	54%
Individual	248,421	3%	14,515,865	5%
Medicaid	662,950	8%	37,994,482	13%
Medicare	1,017,998	12%	35,049,875	12%
Other Public	27,411	0%	2,986,514	1%
Uninsured	1,302,978	15%	46,994,627	16%
Total	8,683,142	100%	296,056,836	100%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

¹³ The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

Table 2.6:**Uninsured Rates for the Non-elderly by Federal Poverty Level (FPL), New Jersey and the United States (2006)¹⁴**

Relation to Federal Poverty Level	New Jersey		United States	
	Total	Percent of Total	Total	Percent of Total
Under 100%	404,194	43%	16,619,984	37%
100-199%	307,963	31%	13,631,998	30%
<i>Low Income Subtotal (199% and Under)</i>	<i>712,157</i>	<i>36%</i>	<i>30,251,982</i>	<i>33%</i>
200% or more	558,611	10%	16,201,429	10%
Total	1,270,768	17%	46,453,411	18%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org**Table 2.7:****Distribution of the Non-elderly Uninsured by Federal Poverty Level (FPL), New Jersey and the United States (2006)¹⁵**

Relation to Federal Poverty Level	New Jersey		United States	
	Total	Percent of Total	Total	Percent of Total
Under 100%	404,194	32%	16,619,984	36%
100-199%	307,963	24%	13,631,998	29%
<i>Low Income Subtotal (199% and Under)</i>	<i>712,157</i>	<i>56%</i>	<i>30,251,982</i>	<i>65%</i>
200% or more	558,611	44%	16,201,429	35%
Total	1,270,768	100%	46,453,411	100%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

Although a higher percentage of New Jersey residents obtain their health insurance coverage at their place of work than do Americans in general, the percentage of companies with more than 50 employees offering coverage is roughly comparable to United States level. A higher percentage of New Jersey firms with fewer than 50 employees offer health insurance to their employees than is the case among similarly sized

employers nationally. Health insurance premiums for employment-based health insurance tend to be higher than the comparable national average, although New Jersey employers appear to pay for a somewhat higher fraction of those premiums. Data on health insurance coverage in the place of work and health insurance premiums are provided in Tables 2.8 through 2.10 below.

¹⁴ Totals may not add up due to rounding.¹⁵ Totals may not add up due to rounding.

Table 2.8:

Percent of Private Sector Establishments that Offer Health Insurance to Employees, by Firm Size, New Jersey and the United States (2003)

Firm Size	New Jersey	United States
Firms with Fewer than 50 Employees	51.6%	43.2%
Firms with 50 Employees or More	94.4%	95.4%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org.

Table 2.9:

Average Single Premium per Enrolled Employee for Employer-Based Health Insurance, New Jersey and the United States (2004)

Contributor	New Jersey		United States	
	Average Premium	Percent of Total	Average Premium	Percent of Total
Employee Contribution	\$613	16%	\$671	18%
Employer Contribution	\$3,269	84%	\$3,034	82%
Total	\$3,882	100%	\$3,705	100%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org.

Table 2.10:

Average Family Premium per Enrolled Employee for Employer-Based Health Insurance, New Jersey and the United States (2004)

Contributor	New Jersey		United States	
	Average Premium	Percent of Total	Average Premium	Percent of Total
Employee Contribution	\$1,886	17%	\$2,438	24%
Employer Contribution	\$9,539	83%	\$7,568	76%
Total	\$11,425	100%	\$10,006	100%

Source: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org.

III. Conclusion

In terms of age and race/ethnicity, the population that New Jersey's health system serves is not significantly different from the overall population of the United States. New Jersey's median household income, however, exceeds the national median by 30 percent, making New Jersey one of the wealthiest states in the

country. In terms of health insurance coverage, overall coverage levels are slightly better than the nation as a whole, although, similar to other parts of the county, large numbers of uninsured are concentrated at the lower income levels.



Chapter 3: Supply and Utilization of New Jersey Acute Care Hospitals

Key Points

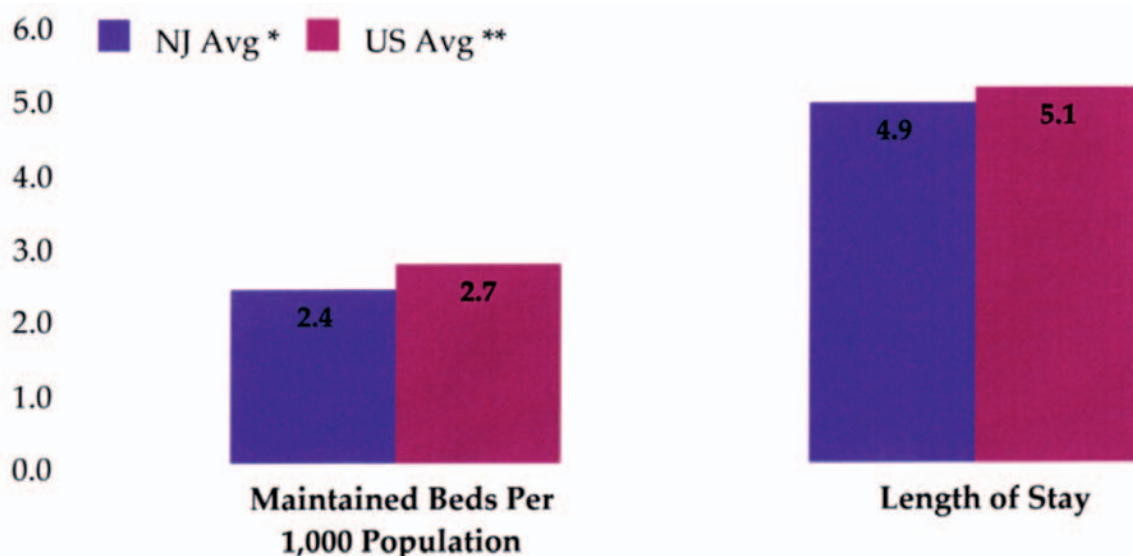
- While New Jersey's supply of acute care hospital beds is less than the national average, there is considerable geographic variation across the state with some counties far above the national average.
- Hospital services are utilized at a higher level than much of the nation – this is evident in the overall number of admissions, physician consultations, and use of ICU care.
- For the purposes of analysis and planning, the Commission defined eight hospital market areas in New Jersey – these definitions are adapted from the highly regarded work of the Dartmouth Atlas Project.

I. State-wide Supply of Acute Care Hospital Beds

In 2005, New Jersey had about 25,000 licensed beds in general acute care hospitals, of which only about 20,000 were “maintained,” that is, staffed for potential

occupancy.¹⁶ That endowment represents about 2.4 beds per 1,000 population, compared to the U.S. average of 2.7 (Figure 3.1).

Figure 3.1:
New Jersey Hospital Utilization - 2005 Data



Source: NJ Department of Health and Senior Services Quarterly Hospital Utilization Data and Kaiser State Health Facts. (Note: This graph contains additional average utilization statistics for NJ acute care hospitals compared to the national average. Maintained Beds and Length of Stay are common rate statistics that provide efficiency information. Generally, a lower statistic value is related to greater hospital efficiency. Maintained Beds is based on the number of beds maintained by a hospital for active use and is usually less than Licensed Beds. Hospitals often maintain fewer beds than licensed for flexibility in meeting demand while retaining the capacity for surge demand in the event of a large scale health crisis.)

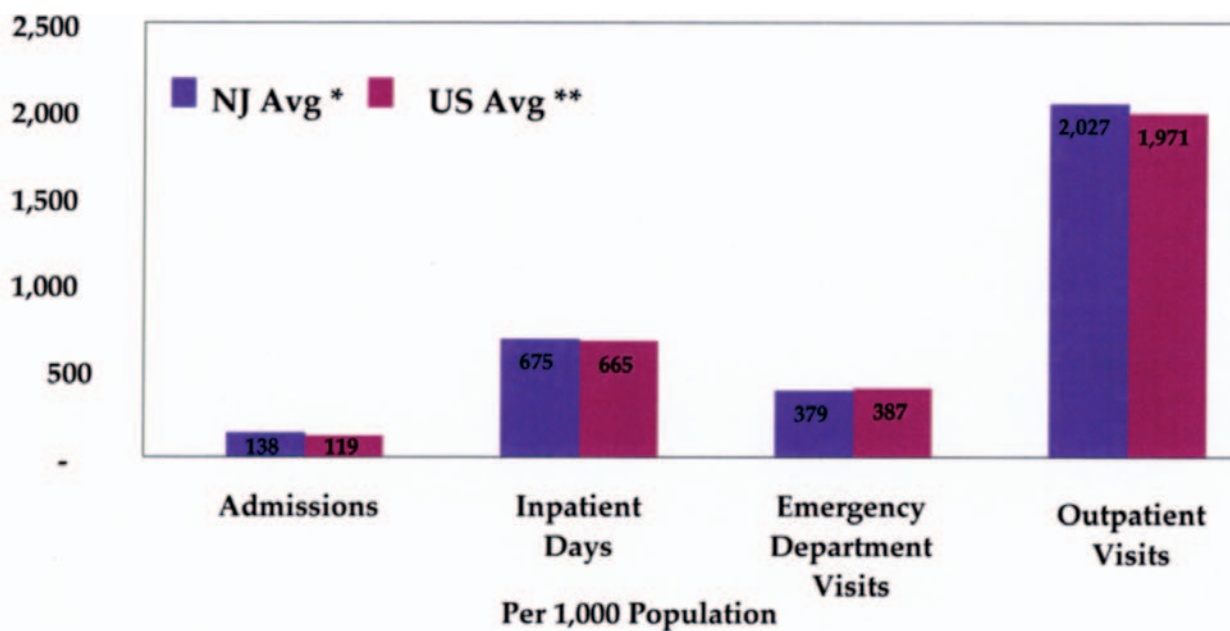
¹⁶ Avalere Health LLC, 2006 *New Jersey Health Care Almanac – Summary* (2006); Figures 1.1 and 1.2

There was, however, considerable variation in this endowment across New Jersey. Essex-Union and Mercer Counties had 20% and 47% more maintained beds per capita than the State average, while Middlesex-Somerset, Cumberland-Gloucester-Salem and Warren-Hunterdon had about 25% fewer maintained beds per capita.¹⁷

In 2004, the average occupancy rate of maintained beds in New Jersey hospitals (74%) was 7 percentage points above the national average (67%), and has trended up gradually since 2001. That average rate, too, varies among regions in New Jersey and among hospitals within regions. In 2005, for example, the occupancy rate of maintained beds was close to 85% in Middlesex-Somerset, but only 60% or so in Mercer County.¹⁸ The overall average per capita utilization of New Jersey hospitals is quite similar to the U.S. average, as is shown in Figure 3.1 and 3.2. A slightly shorter average length of stay appears to offset in part a higher number of admissions.

It bears emphasizing that the slightly lower bed-to-population ratio in New Jersey relative to the overall national ratio does not signify that New Jersey has a relative shortage of hospital beds. In fact, it has an overall hospital bed surplus, as does the nation as a whole. In 2003, the national average hospital occupancy ratio was only 65%, down from 80% in 1980, 73% in 1990 and 68% in 2000¹⁹. The current national ratio of 65% is much below the 80% to 85% considered among the expert to be “full occupancy” for a hospital ready to cope with normal day-to-day volatility in admissions²⁰. While the overall average occupancy ratio of New Jersey hospitals is above the national average, it is still below the normative 80% to 85% range considered “full occupancy” in every hospital market area of New Jersey. It implies that in every hospital market area in New Jersey there is an overall surplus of hospital beds (see also Figure 4.13 of Chapter 4), which varies from market area to market area.

Figure 3.2
New Jersey Hospital Utilization - 2005 Data



Source: NJ Department of Health and Senior Services Quarterly Hospital Utilization Data and Kaiser State Health Facts. (Note: This graph contains average utilization statistics for NJ acute care hospitals compared to the national average. Admissions, Inpatient Days, Emergency Department Visits and Outpatient Visits are common hospital utilization statistics that provide general volume information and are displayed as a per 1,000 population statistic. The data source for the NJ statistics is the B-2 form, a quarterly utilization report, except for Outpatient Visits for which the source is the B-6 form, an element of the annual cost report, all of which are submitted by every acute care hospital to the NJ Department of Health & Senior Services. The data source for the US statistics is the Henry J. Kaiser Family Foundation which sponsors a state health data website project at www.statehealthfacts.org.)

¹⁷ *Ibid.*: Fig. 1.3

¹⁸ *Ibid.*: Fig. 2.11.

¹⁹ See *Health, United States 2005*, Table 112;
<http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=healthus05.table.460>

²⁰ See http://www.medscape.com/viewarticle/546181_4

The use of hospital care by Medicare beneficiaries, however, appears to be very high in New Jersey relative to the U.S. as a whole. Tables 3.1 and 3.2, based on data from the Dartmouth Atlas Project and cited in the previously referenced report by Avalere, illustrates this point. New Jersey seniors near the end of life are likely to spend more days in the hospital and intensive care units and see more physicians. Nearly four in ten

Medicare beneficiaries in New Jersey see ten or more physicians in the last six months of life. On most measures of utilization at the end of life, New Jersey ranks near or at the top of the 50 states. While these measures focus on the end of life, they most likely reflect general patterns of high health care utilization relative to the nation.

Table 3.1:

Rank of New Jersey on Selected Characteristics of Hospital Care for Chronically Ill Medicare Beneficiaries (1999-2003)

Measurement	New Jersey Rate	Rank Among All States
Hospital days* per Medicare decedent during the last two years of life	23.9 days	5 of 51
Hospital days* per Medicare decedent during the last six months of life	15.2 days	4 of 51
ICU days per Medicare decedent during the last two years of life	6.5 days	3 of 51
ICU days* per Medicare decedent during the last six months of life	4.6 days	3 of 51
Percent of Medicare decedents admitted to ICU during their hospitalization* in the hospital in which they died.	25.1%	1 of 51

* Paid under Medicare Part A, including the District of Columbia. Source: The Dartmouth Atlas Project (http://cesweb.dartmouth.edu/release1.1/datatools/profile_s1.php)

Table 3.2:

Rank of New Jersey Among All States on Selected Characteristics of Physician Care for Chronically Ill Medicare Beneficiaries. 1999-2003

Measurement	New Jersey Rate	Rank Among All States
Total physician visits* per decedent during the last 2 years of life	75.9 visits	1 of 51
Medical specialist visits* per decedent during the last 2 years of life	42.7 visits	1 of 51
Primary care physician visits* per decedent during the last 2 years of life	27.3 visits	16 of 51
Total physician visits* per decedent during last 6 months of life	41.5 visits	1 of 51
Medical Specialist visits* per decedent during the last 6 months of life	25.0 visits	1 of 51
Primary care physician visits* per decedent during the last 6 months of life	14.0 visits	7 of 51
Percent of decedents seeing 10 or more different physicians* during the last 6 months of life	38.7%	1 of 51

* Paid under Medicare Part A, including the District of Columbia. Source: The Dartmouth Atlas Project (http://cesweb.dartmouth.edu/release1.1/datatools/profile_s1.php)

Thus, it is not surprising that in 2002, the last year for which these data are conveniently available, total Medicare spending per Medicare beneficiary served in New Jersey (\$8,661) was 27% higher than the national average (\$6,823). The comparable number per beneficiary, served or not, was \$7,834 for New Jersey, which was 25% higher than the comparable national average (\$6,271).²¹

II. Hospital Market Areas

During the course of its work, the Commission determined that for the purposes of assessing the supply of hospital beds and the “essentiality” of individual institutions, it was important to compare hospitals within defined geographic areas that reflect the population’s travel patterns for hospital services. Governmental or political unit boundaries such as cities or counties were considered for this purpose but not selected, as they are somewhat arbitrary definitions and typically do not reflect how and where people utilize health care services. Rather, the Commission used the Dartmouth Atlas Project’s *Hospital Service Areas and Hospital Referral Regions* as a starting point for defining relevant geographic areas. Developed by a research team at Dartmouth University, Hospital Services Areas and Hospital Referral Regions are well recognized by the health-services research community as reflecting actual travel patterns for hospitalization.

The Dartmouth Atlas Project’s work is based on analysis of Medicare patients’ use of local and regional hospital services, using the patient’s residence (zip code) as a basis for developing service areas and referral regions. Based on their analysis of patients’ residence zip codes and where patients were hospitalized, Dartmouth Atlas researchers identified 67 distinct Hospital Service Areas in New Jersey. They then aggregated these 67 Hospital Service Areas into ten Hospital Referral Regions based on Medicare patients’ patterns of use of cardiovascular

surgical and neurosurgery services. (See Appendix 1 for an illustration of the Dartmouth Atlas-defined Hospital Referral Regions for New Jersey.)

In a few of the Dartmouth Atlas-defined Hospital Referral Regions, the referral hospital or hospitals most often used by New Jersey residents of the region are in neighboring states. For example, New Jersey residents in some areas that border Pennsylvania use referral hospitals in Philadelphia and Allentown. Thus, to form defined geographic areas (which we termed “hospital market areas”) that are entirely within the State of New Jersey’s boundaries, the Commission reassigned New Jersey areas that are in a Dartmouth Atlas-defined Hospital Referral Region of a city in a neighboring state to a hospital market area in New Jersey. Reassignments were based on an analysis of where patients from the zip codes that comprise these areas were hospitalized, using 2005 UB-92 patient discharge data for patients in all payer categories discharged from New Jersey acute care hospitals. The analyses were updated using 2006 UB-92 data and there were virtually no differences from the 2005 results.

In addition, the very large Dartmouth Atlas-defined Camden Hospital Referral Region was divided into three hospital market areas (Toms River, Atlantic City, and Camden), and combined three Hospital Referral Regions in the north to form the Hackensack, Ridgewood and Paterson hospital market area, again based on an analysis of where patients from the zip codes that comprise these areas were hospitalized.

Appendix 2 provides a summary of the adjustments made to the Dartmouth Atlas-defined Hospital Referral Regions in forming hospital market areas for purposes of evaluating New Jersey hospitals in terms of essentiality. These adjustments resulted in eight defined geographic areas (“hospital market areas”) that reflect actual patient utilization of hospitals. Figure 3.2 illustrates these hospital market areas.

²¹ The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

Figure 3.3:
New Jersey Hospital Market Areas

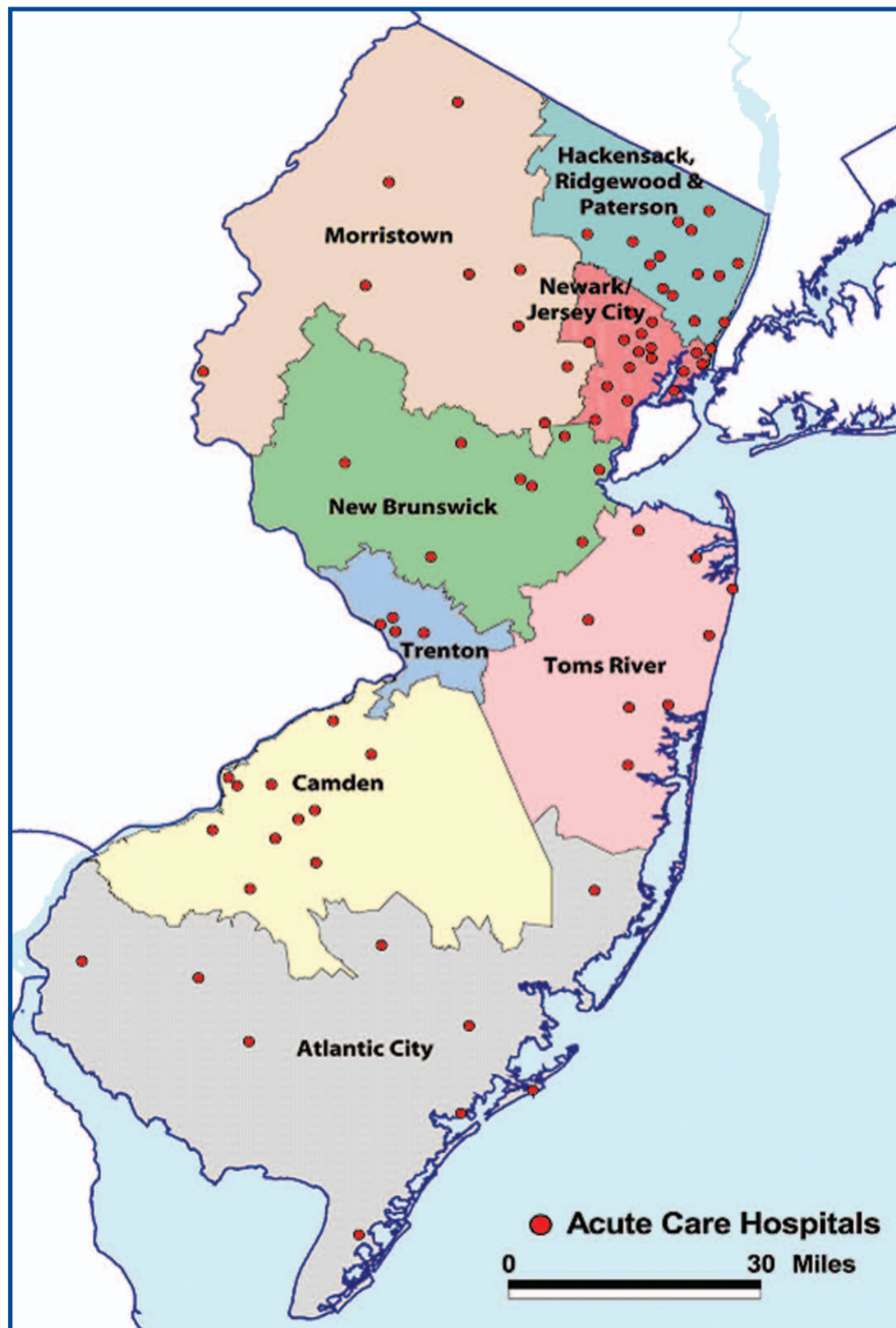


Table 3.3:
Acute Care Hospitals, Discharges and Market Share by Hospital Market Area

Hospital Market Area	Number of Acute Care Hospitals	2006 Discharges from Acute Care Hospitals in Market Area²²	Percent of Patients Hospitalized in the Market Area in which They Reside²³
Atlantic City	9	91,695	86%
Camden	11	152,602	96%
Hackensack, Ridgewood and Paterson	15²⁴	233,457	92%
Morristown	9	109,221	76%
New Brunswick	8	141,665	85%
Newark/Jersey City	16	218,994	85%
Toms River	8	144,862	89%
Trenton	4	43,691	87%

Table 3.3 provides discharges and patient origin information for each of the hospital market areas based on 2006 data. (See Appendix 3 for a listing of acute care hospitals by market area.) As the percentages in the last column in the Table 3.3 indicate, the vast majority of New Jersey residents who remain in-state for their inpatient hospital care are hospitalized in the hospital market area in which they live. This leads us to conclude that the hospital market areas reflect the natural market areas where New Jersey residents

received inpatient care and, therefore, represent appropriately defined geographic areas for purposes of this analysis.

In addition to serving as the relevant areas within which hospitals can be compared in terms of their essentiality²⁵, the hospital market areas also served as the areas for which we project future demand for inpatient hospital services in Chapter 4 of this report.

²² Source: Analysis of New Jersey Department of Health and Senior Services 2006 UB-92 Patient Discharge Data; includes discharges of New Jersey and out-of-state residents. Also includes discharges from two hospitals, South Jersey Healthcare, Bridgeton and Irvington General, which have since closed.

²³ This analysis is based on New Jersey residents who are hospitalized in New Jersey hospitals only and does not include New Jersey residents who are hospitalized in other states.

²⁴ PBI Regional and St. Mary's Hospital Passaic are each counted separately.

²⁵ This analysis has limited applicability in the Atlantic City market area where, with the exceptions of the two hospitals in Atlantic City and Pomona, there is no hospital concentration and all the hospitals are distant from one another.

III. Conclusion

This chapter summarized measures of hospital supply and utilization in New Jersey and defined hospital markets areas for the purposes of analysis and planning based on the pioneering work of the Dartmouth Atlas Project. The Commission found that the supply of hospital beds in New Jersey is slightly less than the national average although there is considerable geographic variation with some counties far above the national average. Notably, the intensity of services in the State is very high according to measures such as

numbers of total physician visits, the number of physicians seen by a patient in the prior year, and use of ICU level care. This seems to reflect an environment of high utilization of health services. In sum, the overall supply of hospitals is not alarmingly high relative to the nation; however, supply that exceeds national averages in certain counties combined with high rates of use of clinical services point to potential causes for high health expenditures in New Jersey.



Chapter 4: Analyzing Future Supply and Demand of Acute Care Hospitals

Key Points

- **New Jersey currently faces an oversupply of hospital beds – this oversupply is projected to increase between now and 2015 in all hospital markets.**
- **Projected hospital bed surpluses are largest in the northeastern section of the State.**
- **Declining average length of stay combined with relatively stable or slowly increasing use rates accounts for some of the projected increases in bed surpluses.**

As the State faces mounting numbers of hospitals in financial distress and threatened closure, it is critical to understand the current supply of hospital beds relative to need. In addition, decisions today have profound implications for the future. Thus, the Commission engaged consultants to assist with projecting future need based on health care industry and population trends.

This chapter presents an analysis of the demand for acute care hospital beds in the eight hospital market areas in New Jersey and compares the demand projections with the current supply of beds. The purpose of this analysis is to identify areas with bed needs or surpluses, and to evaluate areas' capacity to absorb patients of hospitals that may close in the near term. It should be noted that the issue of surge capacity – that is, hospital capacity to deal with natural disasters, bioterrorism, or other large-scale emergencies – was beyond the scope of the Commission's work. Planning for such events requires a separate commission that can focus on the complex issues associated with disaster preparedness.

I. Basic Methodology

At the simplest level, the methodology used in this chapter to estimate a potential surplus or deficit of maintained (staffed) beds in a hospital market area is as follows:

First, for the base year (2005) or a given future year (2010 or 2015), we determine the actual or projected number of patient days demanded in the area. Dividing that number by 365 days per year we arrive at the

average daily census, that is, the average number of occupied beds per day in the area.

Next, we convert the average daily census into the required number of maintained beds in the area if, hypothetically, all hospitals in the area operated at an occupancy rate of 83%. That rate is widely considered among the experts to be "full occupancy" for hospitals poised to cope with some volatility in their daily patient census. For example, if the average daily census in an area were 1,750, then 2108 (i.e., $1750/0.83$) maintained beds would be needed to arrive at an 83% occupancy ratio.

Next, we compare this *normative* bed requirement with the number of maintained beds *actually* available in the area in base year 2005 (or, for future years, projected then to be available in the area). The difference between the *normative* bed requirement and the *actual* current or projected number of maintained beds in the year in question then gives us the bed surplus or deficit for the area in that year.

Finally, we divide the estimated bed surplus or deficit by the current, average number of maintained beds per hospital in the area (or, for comparison, by the median number of beds per hospital in the area²⁶). The resulting ratio indicates very roughly to what number of average sized hospitals in the area the area's bed surplus or deficit is equivalent.

²⁶ If hospitals in an area vary considerably in terms of their number of beds, their average bed size will differ substantially from their median bed size. The average bed size is obtained by dividing the total number of beds in an area by the number of hospitals in the area. The median bed size, on the other hand, is a number such that half the hospitals in the area have a bed size above that number and half below that number.

To illustrate, suppose we were making the estimate for the base year, 2005. Suppose next that a given hospital market area in 2005 had 2,000 maintained beds, but that the area had an average hospital occupancy ratio much below the normative 83%. Suppose next that if all hospitals in the area operated at an 83% occupancy ratio, only 1,700 maintained beds would be needed. Thus we estimate that there was a surplus of 300 maintained beds in the area in 2005. If the average number of beds per hospital in the market area were 300, then the estimated bed surplus would be *equivalent* to 1 averaged sized hospital in the area.

This equivalent number does not, of course, mean that one could eliminate any one of the area's existing hospitals without detrimental impact on the citizenry. Indeed, if all hospitals in the area were deemed essential on the criteria used in this report, then no one hospital should be closed. Instead, hospitals with low occupancy ratios should reduce the number of beds they staff until most or all hospitals in the area approximated an occupancy ratio of 83%.

The bed surpluses or deficits for 2010 and 2015 are estimated in similar fashion. Here the projected number of patient days demanded will be based on projected population growth, in terms of 5 distinct age groups and in terms assumptions about the future rates of hospital admissions and average lengths of patient stay (ALOS).

II. Findings

Analyses of the demand for hospital services indicate that there is currently a surplus of beds in every hospital market area and without a reduction in the supply of hospital beds, estimated bed surpluses will continue in many hospital market areas through 2010 and 2015.

Considering the bed surpluses relative to average and median hospital size, the surplus estimates are particularly noticeable in the Hackensack, Ridgewood and Paterson hospital market area currently and in 2010, and in the Newark/Jersey City and Toms River hospital market areas in 2010. These results suggest that projected demand for inpatient hospital services could be satisfied without at least one of each of these areas' current hospitals. This finding is generally consistent with the financial viability analysis discussed in Chapter 5, in that two of these three hospital market areas – Hackensack, Ridgewood and Paterson and

Newark/Jersey City – have the highest proportions of hospitals below the statewide average financial viability score. This finding also suggests that an oversupply of beds may be one cause of the financial distress that many of the hospitals in these two areas are experiencing.

The sections below provide information on New Jersey's projected population, historical inpatient hospital utilization, and the results of our projections.

A. New Jersey's Demographic Projections²⁷

Because demand is projected at the market level, a brief discussion of New Jersey's population projections and market area variations is warranted. As noted in Chapter 2, the age composition of New Jersey's population is similar to the nation as a whole. Population projections indicate that:

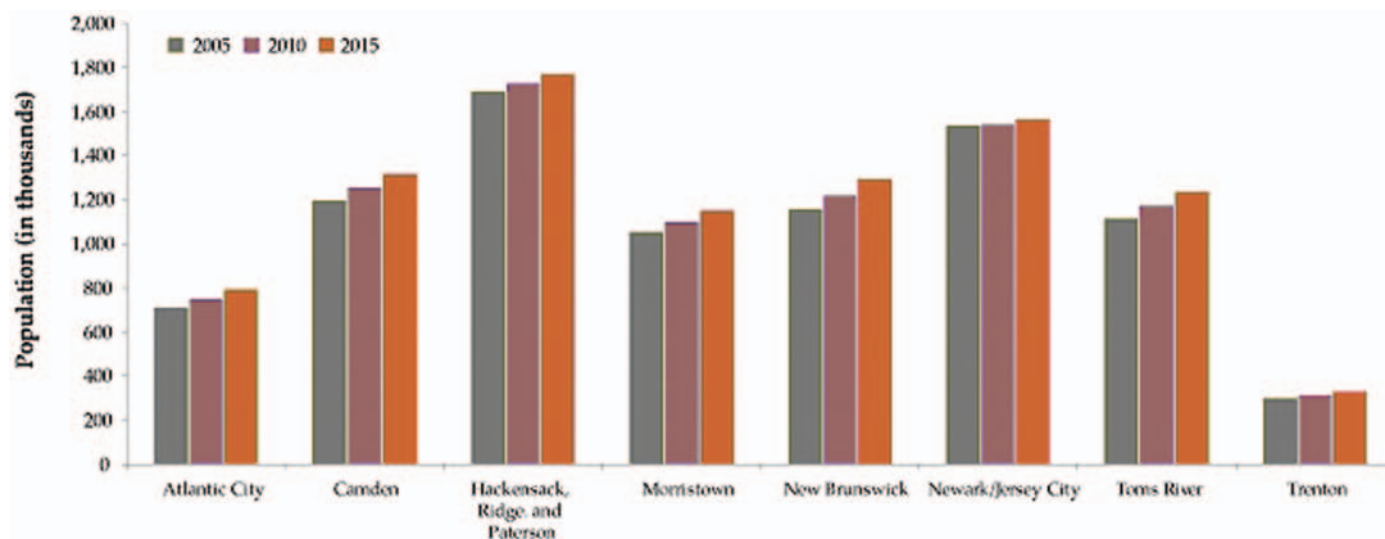
- New Jersey's age composition will also be comparable to that of the United States in 2015, and both New Jersey and the United States will experience aging of their populations.
- New Jersey's population is projected to grow at a slower rate (8 percent) than the nation's (10 percent) between 2005 and 2015.
- In 2015, both New Jersey and the United States are projected to have higher percentages of their populations over the age of 45 than is currently the case.
- New Jersey's proportion of population age 18 to 44 is projected to be slightly smaller than the nation's as a whole in 2015 and its proportion of the population age 45 to 64 slightly larger than the nation's as a whole in 2015.
- All of the other age groups in New Jersey will comprise roughly the same proportion of the population as for the nation as a whole in 2015.

(See Appendix 4 for illustrations of these population projections.)

As Figure 4.1 illustrates, the population in all eight New Jersey hospital market areas is projected to increase by 2015, with growth between 2005 and 2015 ranging from a low of 1.9 percent in the Newark/Jersey City area to a high of 12 percent in the New Brunswick area.

²⁷ Source: Claritas MarketPlace;
<http://www.claritas.com/eConnect2/Content/reports/addNewSite.jsp?back=back>.

Figure 4.1:
Population by Market Area (2005 and projected 2010 and 2015)



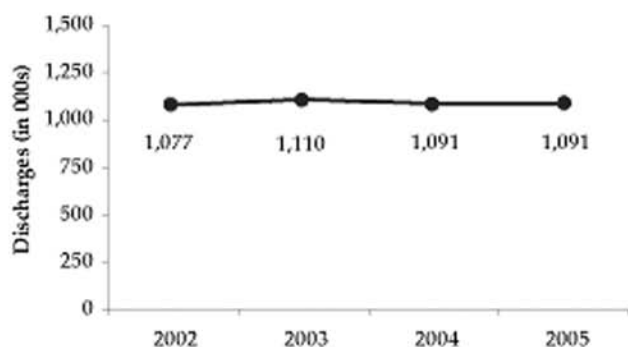
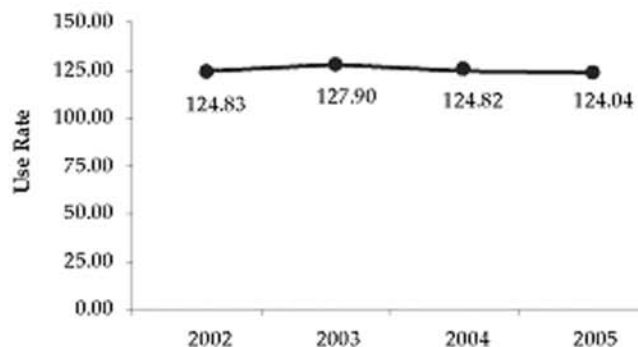
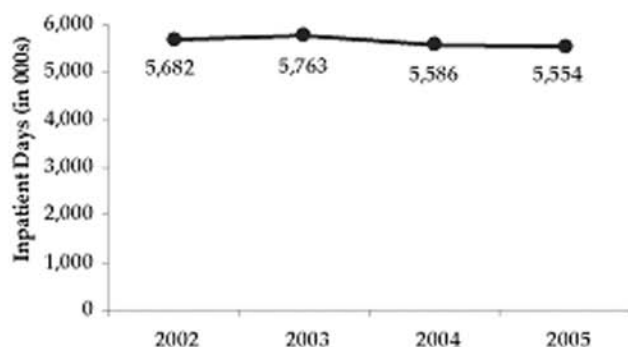
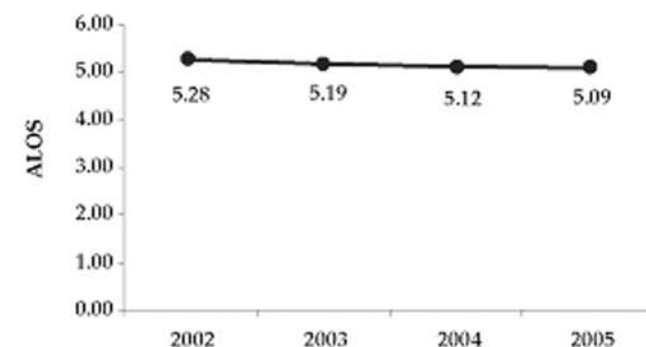
There is substantial variation in the 2005 and projected 2015 population by age group across the eight hospital market areas in New Jersey. In 2005, the Toms River and Atlantic City areas had the highest proportions of population in the 65 and over age group. By 2015, the 65 and over age group is projected to comprise 19 percent of the Toms River area's and 16 percent of the Atlantic City and Hackensack, Ridgewood and Paterson areas' total population.

B. Recent Trends in New Jersey Residents' Use of Inpatient Hospital Services

To gain an understanding of inpatient hospital utilization trends, the Commission's consultants analyzed UB-92 hospital discharge data from the Department of Health

and Senior Services from 2002 through 2005 for New Jersey residents hospitalized in New Jersey acute care hospitals at the statewide and hospital market area levels. At the statewide level, the figures below illustrate that between 2002 and 2005 (Figures 4.2-4.5):

- Discharges increased 1.3 percent.
- The use rate, i.e., discharges per 1,000 population, was relatively stable, declining a modest 0.6 percent.
- Inpatient days decreased 2.3 percent.
- The decrease in inpatient days was due to a 3.5 percent reduction in average length of stay (ALOS).

Figure 4.2:**New Jersey Residents' Discharges (2002-2005)****Figure 4.3:****New Jersey's Use Rate (Discharges per 1,000 population) (2002-2005)****Figure 4.4:****New Jersey Residents' Inpatient Days (2002-2005)****Figure 4.5:****New Jersey's ALOS (2002-2005)**

As Figures 4.6 and 4.7 illustrate, across hospital market areas there were significant variations in use rates and ALOS between 2002 and 2005:

- Changes in use rates ranged from an eight percent decrease in the Hackensack, Ridgewood and Paterson area, to a nearly seven percent increase in the Atlantic City area.
- ALOS decreased in most market areas, ranging from a drop of nearly nine percent in the Toms River area to one percent in the Camden area, while in the Hackensack, Ridgewood and Paterson and Trenton areas, ALOS increased two percent.

To gain a further understanding of these variations across hospital market areas, use rates and ALOS in 2005 were analyzed by hospital market area for selected

diagnosis-related grouping (DRGs), which are groupings of cases with clinically similar conditions. Variations in use rates across market areas are due to variations in the population's age composition, health and socioeconomic status, mix of services and local medical practice patterns. To remove the effect of age composition and mix of service variations across hospital market areas, we compared use rates and ALOS across market areas for 10 high volume DRGs for the 45 to 64 age group. We found that, even within the same age group, there was substantial variation in use rates and ALOS across the eight hospital market areas for these selected DRGs. This analysis supports the plan to perform the volume projections at the DRG and age group level within each market area. (See Appendix 4 for these data.)

Figure 4.6:
Use Rates (Discharges per 1,000 population) by Hospital Market Area (2002 – 2005)

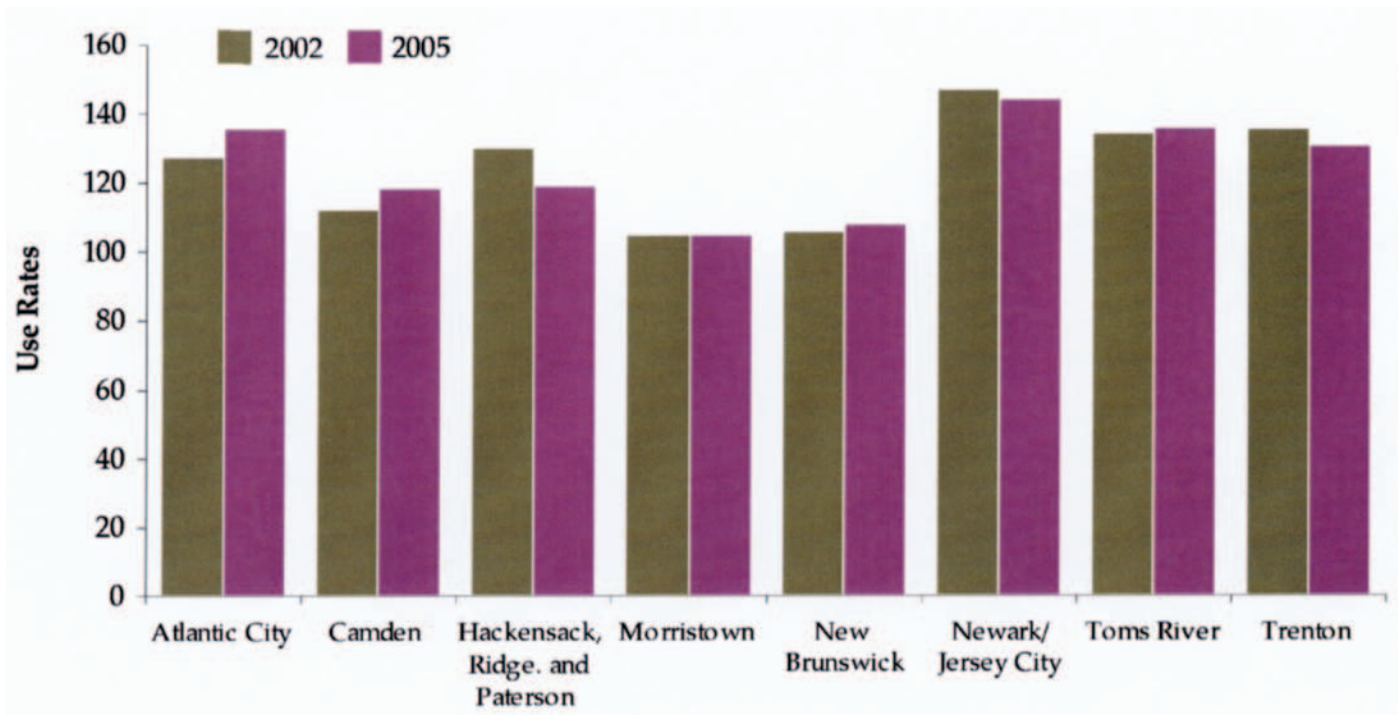
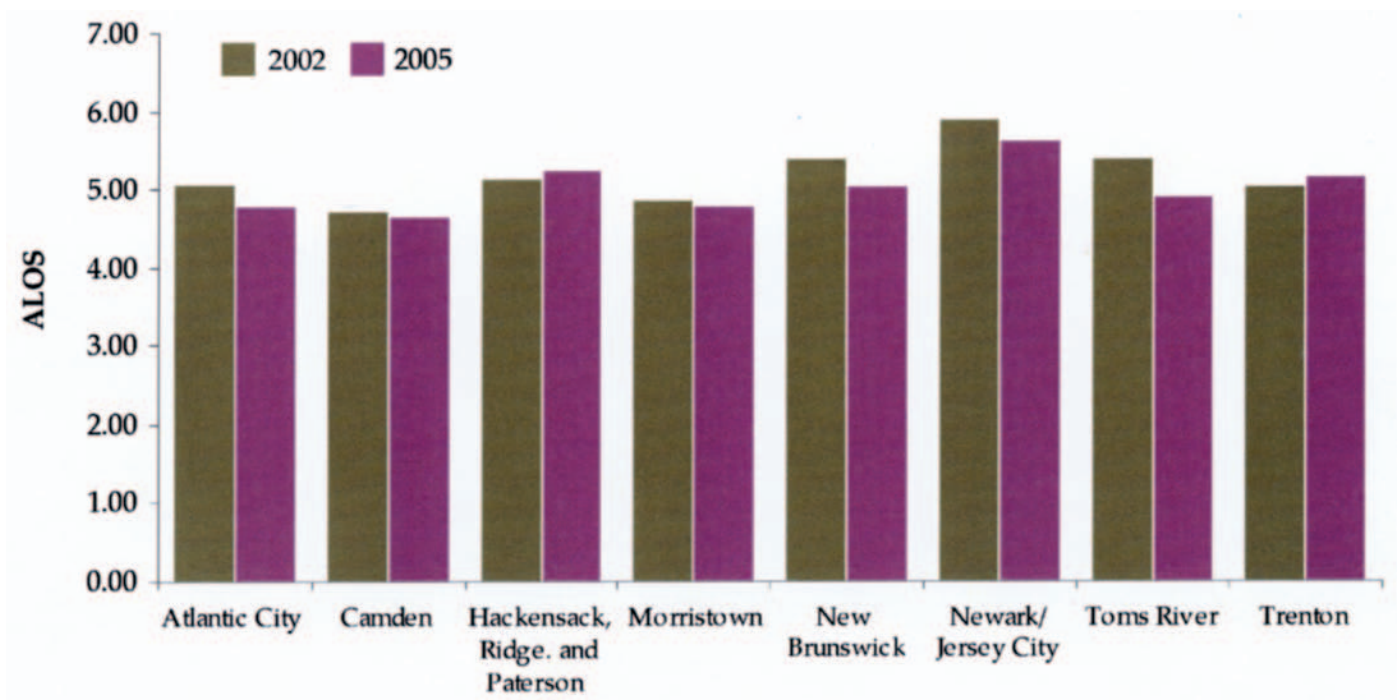


Figure 4.7:
ALOS by Hospital Market Area (2002 – 2005)



III. Results of Projected Demand for Inpatient Hospital Services

Figure 4.8 illustrates 2005 discharges compared to projected 2010 and 2015 discharges under the two projection scenarios. Under the baseline projection scenario, discharges are projected to increase in all hospital market areas by 2010 and 2015. Under the more likely adjusted baseline scenario, discharges are projected to increase in most hospital market areas by 2010 and 2015, but at lower rates than under the baseline scenario. The exceptions to this are in the Hackensack, Ridgewood and Paterson hospital market where, under the adjusted baseline scenario, discharges are projected to decrease through 2010 and 2015 and in the Newark/Jersey City market area where discharges under this scenario are projected to remain essentially constant.

Figure 4.9 illustrates the ALOS in 2005 and the projected ALOS for 2010 and 2015 under the two projection scenarios. Since the baseline projection scenario assumes a constant ALOS in 2005 level, there is little or no change in ALOS between 2005 and 2010 and 2015. Under adjusted baseline scenario, which continues the observed trend in

ALOS between 2002 and 2005 through 2008 and then holds ALOS constant thereafter, there are reductions in ALOS in most hospital market areas. The exceptions to this are in the Hackensack, Ridgewood and Paterson and Trenton market areas where, under the adjusted baseline scenario, ALOS increases very slightly between 2005 and 2010 and 2015. On a statewide basis, the ALOS in 2005 of 5.1 days increases to 5.2 under the baseline projections scenario and decreases to 4.9 under the adjusted baseline scenario.

Inpatient day projections are a function of projected discharge and projected ALOS. Figure 4.10 illustrates 2005 inpatient days and projected 2010 and 2015 inpatient days under the two projection scenarios. Under the baseline projection scenario, inpatient days are projected to increase in all hospital market areas through 2010 and 2015. Under the more likely adjusted baseline scenario, inpatient days are projected to increase in the majority of hospital market areas by 2010 and 2015, but at lower rates than under the baseline scenario. The exceptions to this are in the Hackensack, Ridgewood and Paterson and Newark/Jersey City market areas where under the adjusted baseline scenario, inpatient days are projected to decrease through 2010 and 2105.

Figure 4.8:
Discharges for New Jersey Residents by Hospital Market Area
(2005 and projected 2010 and 2015)

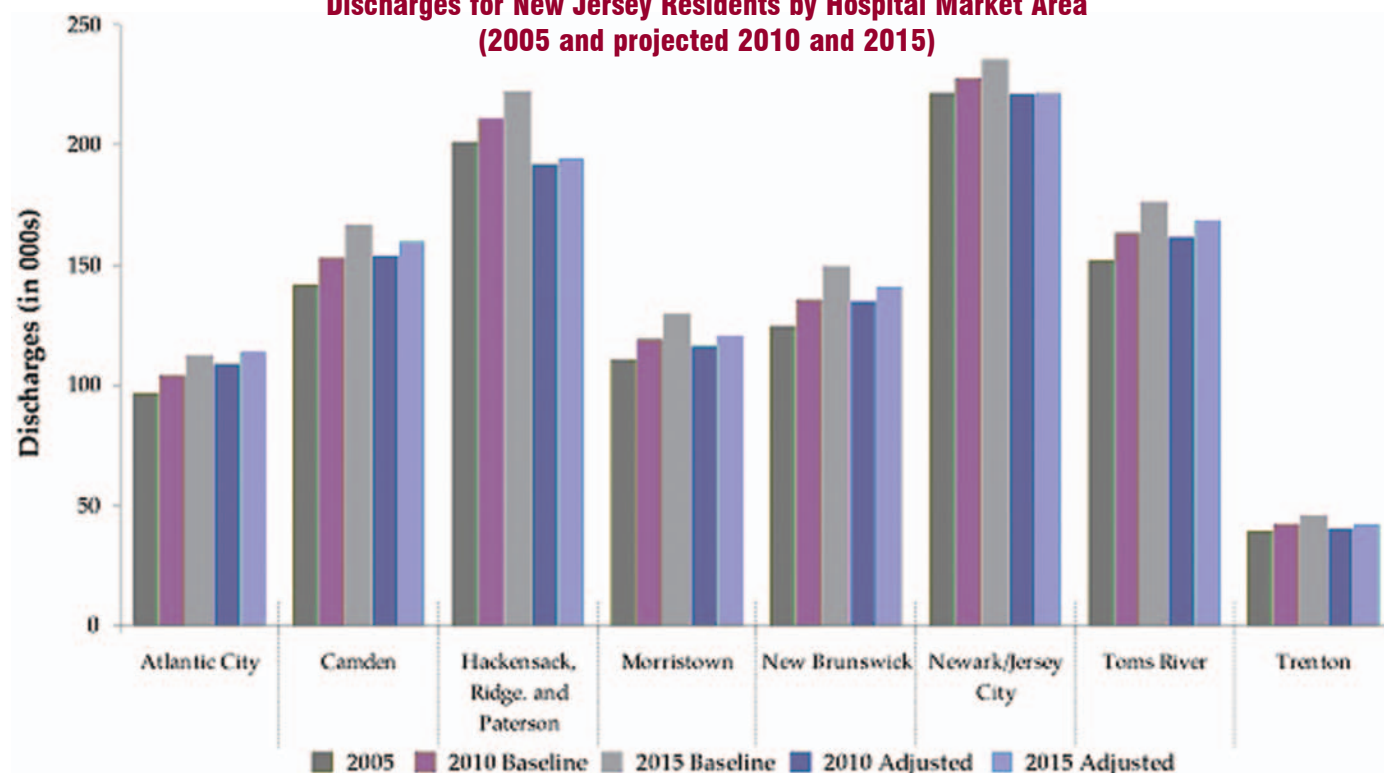


Figure 4.9:
Average Length of Stay for New Jersey Residents by Hospital Market Area
(2005 and projected 2010 and 2015)

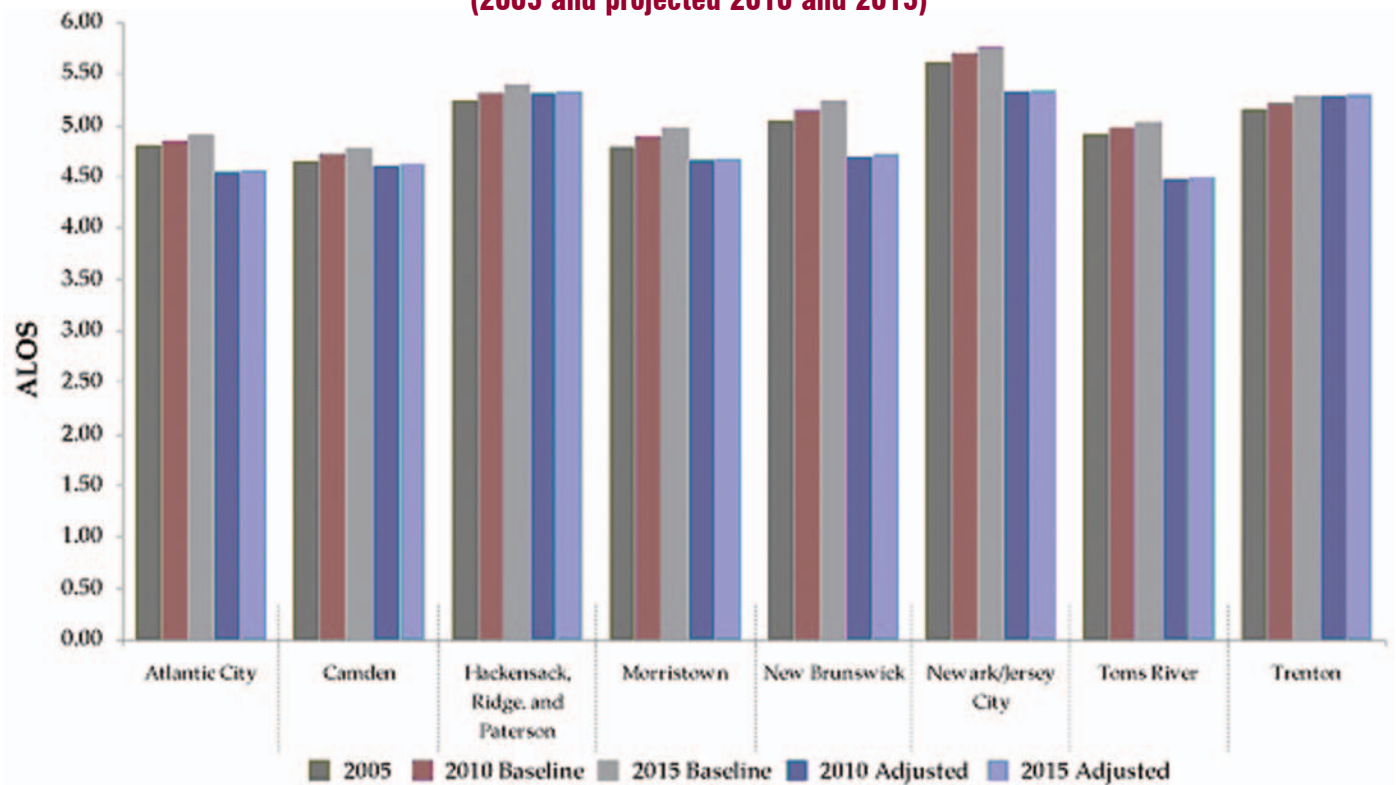
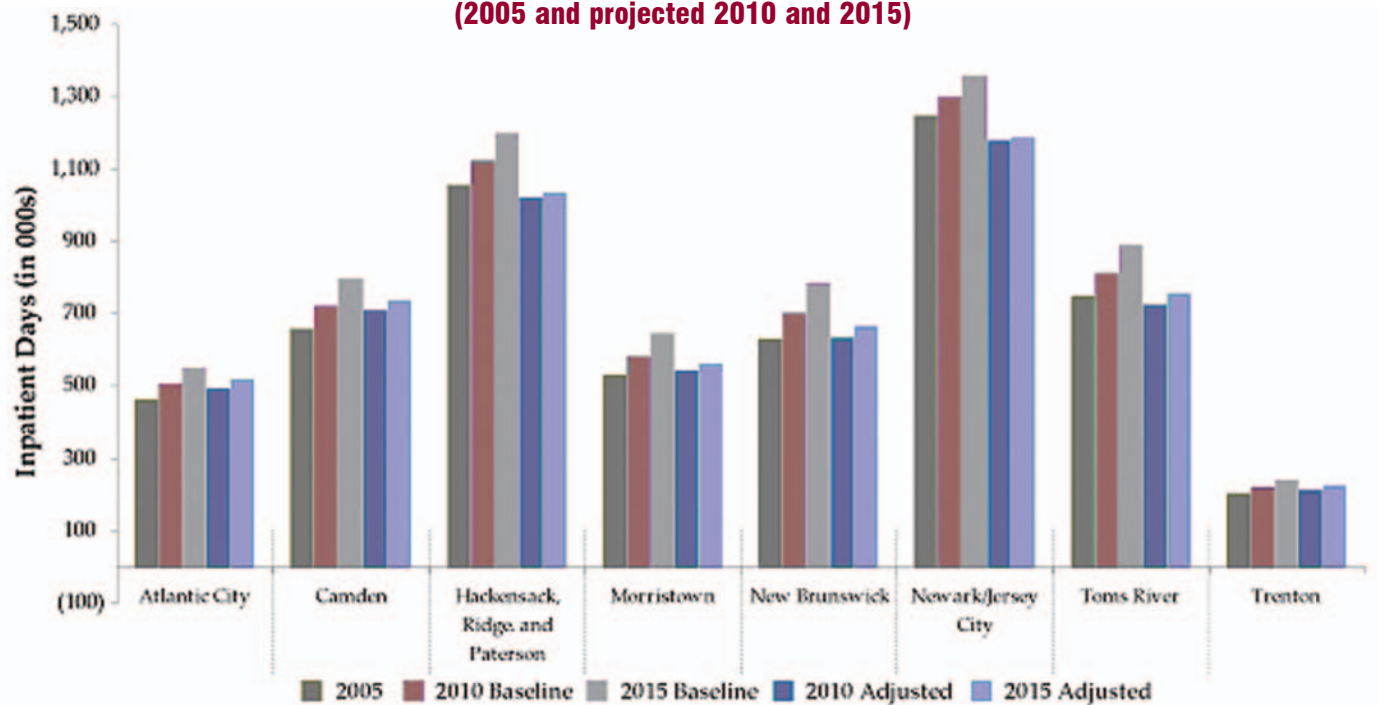


Figure 4.10:
Inpatient Days for New Jersey Residents by Hospital Market Area
(2005 and projected 2010 and 2015)

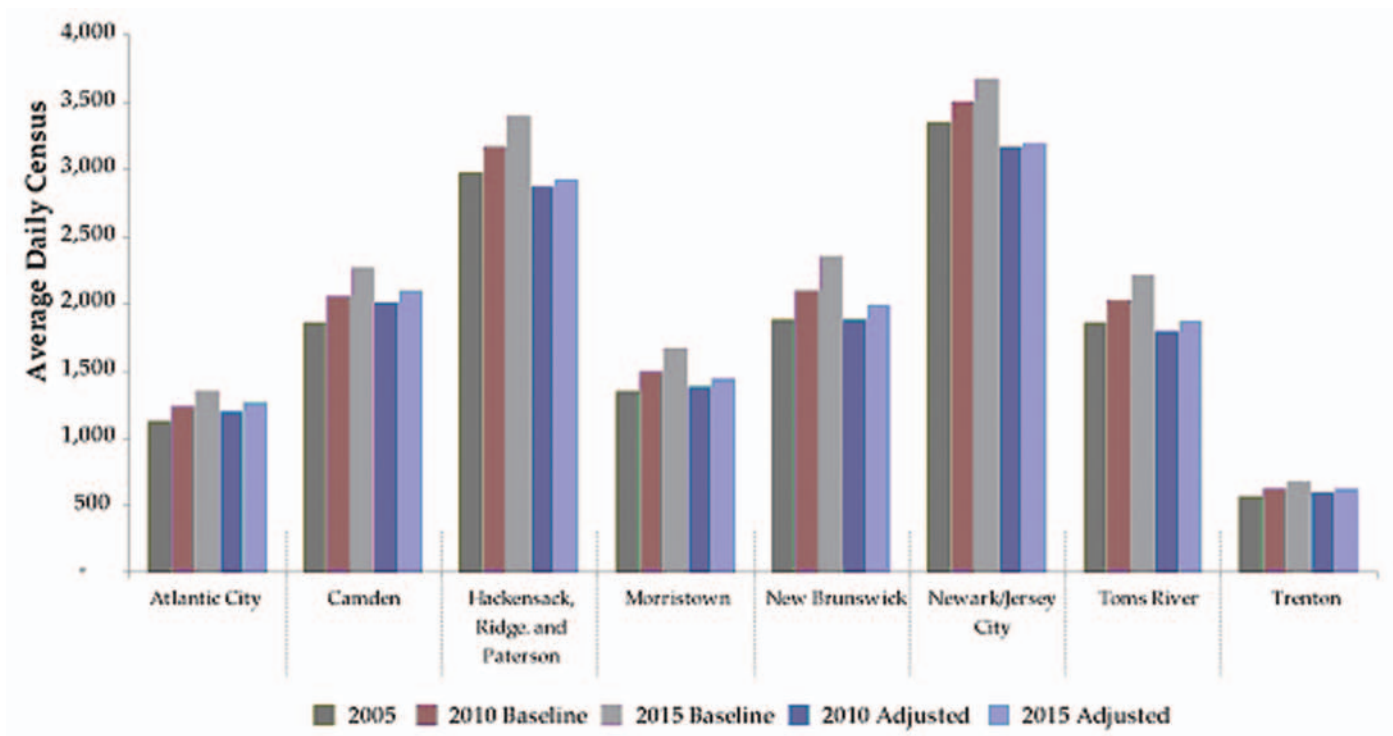


A. Number of Hospital Beds Needed to Meet Projected Demand

Two adjustments were made to the population-based projected inpatient days presented above to estimate the number of hospital beds needed to meet the projected demand. First, to account for inter-market migration by New Jersey residents across hospital market areas, the projected inpatient days for the population that reside in each hospital market area were converted to the market

area of hospitalization.²⁸ Secondly, to account for residents of other states who are hospitalized in New Jersey, it is assumed that their 2005 proportion of each market's total inpatient days for New Jersey residents would remain constant; hence, the projected days were increased accordingly. Figure 4.11 shows the average daily census,²⁹ after making these adjustments, for each hospital market area in 2005 and projected for 2010 and 2015 under the two projection scenarios.

Figure 4.11:
Average Daily Census for New Jersey Hospitals by Hospital Market Area
(2005 and projected 2010 and 2015)



²⁸ The population-based projected inpatient days by market area were converted to the market area where hospitals are located by multiplying them by the ratio of inpatient days for hospital located in each market area to inpatient days for patients who reside in each market area. For example, the ratio of inpatient days for hospitals located in the Camden market area to inpatient days in all New Jersey hospitals for residents of the Camden hospital market area is 1.05 based on 2005 UB-92 data. This means that there is net in-migration to hospitals in the Camden hospital market area by New Jersey

residents. The population-based projected inpatient days for the Camden hospital market area were multiplied by 1.05 to determine inpatient days for hospitals located in the Camden market area.

²⁹ Average daily census (ADC) is inpatient days divided by 365 days. For purposes of comparing 2005 and projected ADC with the number of maintained hospital beds, the inpatient days for normal newborns were excluded because the number of Level I nursery beds are not reported by hospitals on their B2 Reports.

A target occupancy rate of 83 percent was used to estimate the number of beds needed to meet the projected average daily census in 2010 and 2015, assuming efficient use of hospital capacity. Commission members agreed that 83 percent is a reasonable target occupancy rate for a mix of predominantly semi-private hospital rooms. By contrast, as Table 4.1 shows, the average occupancy

rate in 2006 varied across hospital market areas from a low of 59 percent in the Trenton area to a high of 80 percent in the New Brunswick area. The statewide average occupancy rate was 72 percent.³⁰

Table 4.2 shows the number of maintained beds, average daily census and occupancy rate for each individual hospital by hospital market area.

Table 4.1:
Total, Average and Median Number of Maintained Hospital Beds and Occupancy Rate by Hospital Market Area (2006)

Market Area where Hospitals are Located	Total Maintained Beds³¹	Average Hospital Bed Size³²	Median Hospital Bed Size	Average Occupancy Rate
Atlantic City	1,630	181	170	71%
Camden	2,599	236	214	72%
Hackensack, Ridgewood and Paterson	4,352	290	260	73%
Morristown	1,870	208	150	69%
New Brunswick	2,498	312	293	80%
Newark/Jersey City	4,475	280	256	73%
Toms River	2,745	343	316	66%
Trenton	995	249	240	59%
Entire State	21,164	265	248	72%

³⁰ Based on number of maintained Acute Care, Level II and Level III Nursery Beds and inpatient days reported by hospitals on the B2 Reports for 2006.

³¹ Includes number of Acute Care, Level II and Level III Nursery Beds.

³² Total maintained beds divided by number of hospitals.

Table 4.2:
Total Maintained Hospital Beds, Average Daily Census and Occupancy Rate by Hospital (2006)

Hospital / Hospital Market Area	Total Maintained Beds ³³	Average Daily Census ³⁴	Occupancy Rate
Atlantic City Hospital Market Area			
AtlantiCare Regional Medical Center, Inc.-Mainland Division	323	251	78%
South Jersey Healthcare Regional Medical Center	320	248	78%
Burdette Tomlin Memorial Hospital, Inc.	208	124	60%
Shore Memorial Hospital	208	163	78%
AtlantiCare Regional Medical Center, Inc.-City Division	170	120	71%
Southern Ocean County Hospital	124	99	80%
Memorial Hospital of Salem County	110	59	54%
South Jersey Hospital - Elmer	88	46	52%
William B. Kessler Memorial Hospital, Inc.	79	50	63%
Camden Hospital Market Area			
Cooper Hospital/University Medical Center	441	326	74%
Virtua-Memorial Hospital of Burlington County, Inc.	383	226	59%
Our Lady of Lourdes Medical Center	319	261	82%
Virtua - West Jersey Hospital Voorhees (East)	288	221	77%
Underwood - Memorial Hospital	229	174	76%
Lourdes Medical Center of Burlington County	214	127	59%
Virtua - West Jersey Hospital Marlton	198	136	69%
Kennedy Mem. Hospitals-Univ. M.C.-Washington Twp.	157	130	83%
Kennedy Mem. Hospitals-Univ. M.C.-Cherry Hill Div.	144	118	82%
Kennedy Mem. Hospitals-Univ. M.C.-Stratford Div.	131	90	69%
Virtua - West Jersey Hospital Berlin (South)	95	56	59%
Hackensack, Ridgewood & Paterson Hospital Market Area			
Hackensack University Medical Center	674	631	94%
St. Joseph's Hospital and Medical Center	527	362	69%
Valley Hospital	427	373	87%
Bergen Regional Medical Center	401	326	81%
Holy Name Hospital	307	218	71%

³³ Includes Acute Care, Level II and Level III Nursery Beds reported by hospitals on the B2 Reports for 2006.

³⁴ Total acute care, Level II and Level III patient days reported by hospitals on the B2 Reports for 2006 divided by 365 days.

Hospital / Hospital Market Area	Total Maintained Beds ³³	Average Daily Census ³⁴	Occupancy Rate
Englewood Hospital and Medical Center	293	222	76%
Pascack Valley Hospital	280	106	38%
Chilton Memorial Hospital	260	158	61%
PBI Regional Medical Center	245	125	51%
St. Mary Hoboken	216	120	56%
Palisades Medical Center of NY Presbyterian Healthcare System	183	150	82%
Barnert Hospital	171	97	57%
Meadowlands Hospital Medical Center	136	97	71%
St. Mary's Hospital (Passaic)	121	86	71%
St. Joseph's Wayne Hospital	111	102	92%
Morristown Hospital Market Area			
Morristown Memorial Hospital	532	431	81%
Overlook Hospital	375	263	70%
Saint Clare's Hospital / Denville Campus	242	160	66%
Muhlenberg Regional Medical Center	240	146	61%
Warren Hospital	150	90	60%
Newton Memorial Hospital	140	92	66%
Hackettstown Regional Medical Center	96	53	55%
Saint Clare's Hospital / Dover Campus	54	40	74%
Saint Clare's Hospital / Sussex	41	16	39%
New Brunswick Hospital Market Area			
Robert Wood Johnson University Hospital	584	531	91%
Saint Peter's University Hospital	421	328	78%
JFK Medical Center (Anthony M. Yelencsics Community Hospital)	343	293	85%
University Medical Center at Princeton	314	237	75%
Somerset Medical Center	271	240	89%
Raritan Bay Medical Center - Perth Amboy Division	264	158	60%
Hunterdon Medical Center	182	117	64%
Raritan Bay Medical Center - Old Bridge Division	119	100	84%
Newark/Jersey City Hospital Market Area			
Saint Barnabas Medical Center	641	451	70%

Hospital / Hospital Market Area	Total Maintained Beds ³³	Average Daily Census ³⁴	Occupancy Rate
Newark Beth Israel Medical Center	490	397	81%
UMDNJ - University Hospital	440	361	82%
Trinitas Hospital - Williamson Street Campus	347	273	79%
Jersey City Medical Center	316	253	80%
Clara Maass Medical Center	308	205	67%
Christ Hospital	278	212	76%
Bayonne Medical Center	261	142	54%
Robert Wood Johnson University Hospital at Rahway	251	106	42%
Saint Michael's Medical Center	223	176	79%
Mountainside Hospital	214	160	75%
East Orange General Hospital	202	160	79%
Columbus Hospital	175	116	66%
Union Hospital	142	94	66%
Saint James Hospital	104	81	78%
Greenville Hospital	83	63	76%
Toms River Hospital Market Area			
Jersey Shore University Medical Center	523	359	69%
Community Medical Center	454	363	80%
Riverview Medical Center	451	166	37%
Monmouth Medical Center	345	243	70%
Kimball Medical Center	287	191	67%
CentraState Medical Center	260	201	77%
Ocean Medical Center	257	179	70%
Bayshore Community Hospital	168	123	73%
Trenton Hospital Market Area			
Capital Health System at Mercer	350	143	41%
Capital Health System at Fuld	269	137	51%
Robert Wood Johnson University Hospital at Hamilton	211	209	99%
St. Francis Medical Center (Trenton)	165	98	59%

The estimated number of beds needed at the 83 percent occupancy level to meet the projected average daily census compared to the current (2006) bed supply is the bed need or surplus. As Figure 4.12 and Table 4.3 show, assuming an efficient use of the existing hospital capacity, i.e., an 83 percent occupancy rate, there is a

current surplus of beds in every hospital market area. A comparison of the current bed supply with the projected number of beds needed in 2010 and 2015 suggests that without a reduction in the bed supply, estimated bed surpluses will continue in many hospital market areas through 2010 and 2015.

Figure 4.12:
Bed Surplus Estimates by Market Area
(2005 and projected 2010 and 2015)

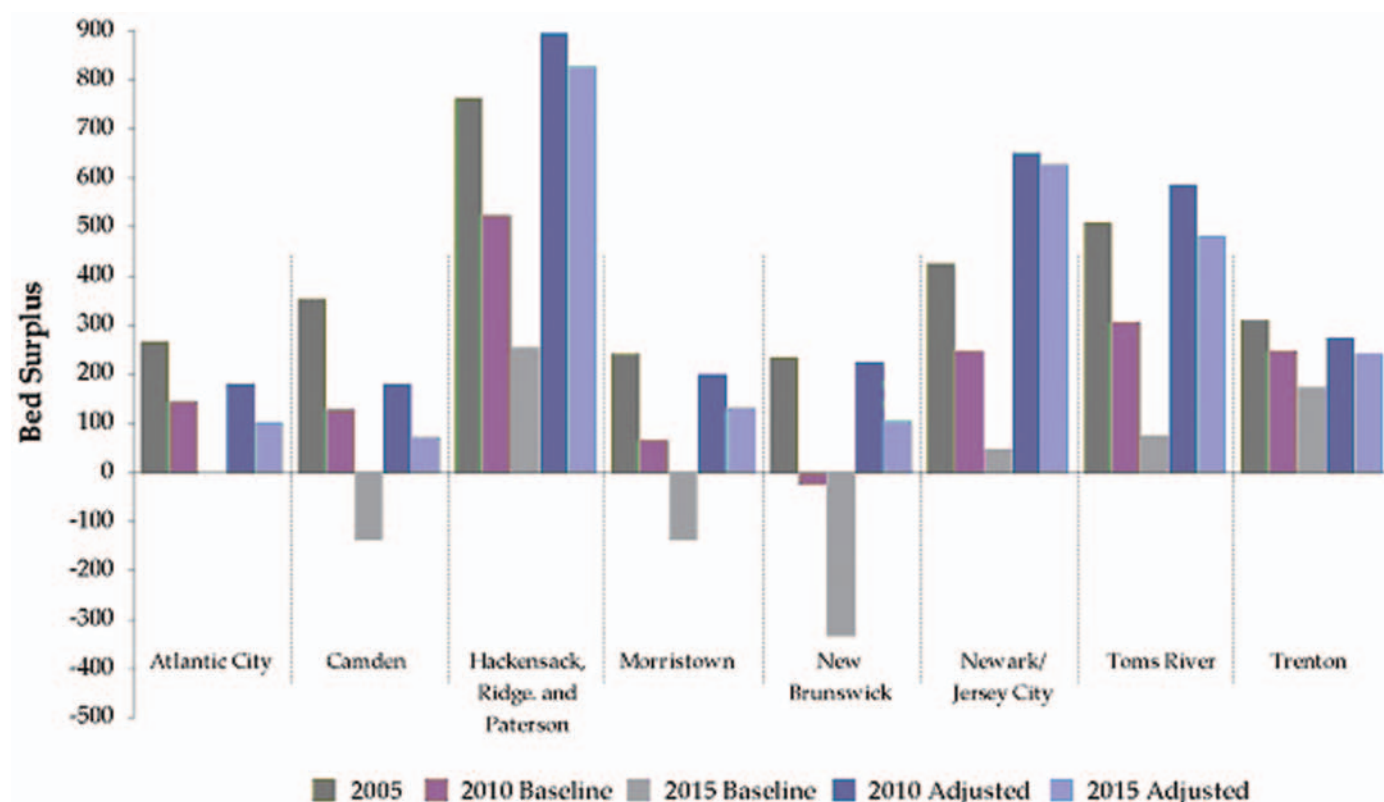


Table 4.3:
Bed Surplus Estimates by Hospital Market Area (2005 and projected 2010 and 2015)

Market Area where Hospitals are Located	2005 Estimated	2010 Baseline Projected	2015 Baseline Projected	2010 Adjusted Projected	2015 Adjusted Projected
Atlantic City	269	144	3	181	269
Camden	354	128	-137	180	354
Hackensack, Ridgewood and Paterson	765	527	254	895	765
Morristown	242	68	-138	199	242
New Brunswick	235	-25	-336	227	235
Newark/Jersey City	427	250	50	652	427
Toms River	510	308	79	586	510
Trenton	308	247	175	276	308

When a hospital market area's bed surplus estimate exceeds its average or median hospital bed size, it suggests that the area's demand for inpatient services could be satisfied without at least one of the existing hospitals. Table 4.4 shows the current and projected bed surplus estimates in relation to the average and median bed sizes by hospital market area. In every hospital market area, except New Brunswick, the current bed surplus estimates are greater than the average and median bed sizes. In the Hackensack, Ridgewood and Paterson hospital market area the current bed surplus is over twice the average and median hospital size (2.6 and 2.9, respectively), suggesting that current demand for

inpatient hospital services could be satisfied without at least one of this hospital market area's hospitals. In 2010, the estimated bed surplus under the adjusted projected scenario grows to over three times the current average and median bed size in the Hackensack, Ridgewood and Paterson hospital market area (3.1 and 3.4, respectively). Two other hospital market areas have significant estimated bed surpluses in 2010 – Newark/Jersey City, where the projected surplus is over twice its current average and median bed size (2.3 and 2.6, respectively) and Toms River area, where the projected surplus is nearly twice the size of the average and median number of beds in the area.

Table 4.4:
Current and Projected Bed Surplus Estimates Relative to Average Number of Beds per Hospital in Each Hospital Market Area

Market Area where Hospitals are Located	Ratio of Current Bed Surplus to Average Bed Size	Ratio of Current Bed Surplus to Median Bed Size	Ratio of 2010 Adjusted Projected Bed to Average Bed Size	Ratio of 2010 Adjusted Projected Bed Surplus to Median Bed Size
Atlantic City	1.5	1.6	1.0	1.1
Camden	1.5	1.7	0.8	0.8
Hackensack, Ridgewood and Paterson	2.6	2.9	3.1	3.4
Morristown	1.2	1.6	1.0	1.3
New Brunswick	0.8	0.8	0.7	0.8
Newark/Jersey City	1.5	1.7	2.3	2.6
Toms River	1.5	1.6	1.7	1.9
Trenton	1.2	1.3	1.1	1.2

B. Hospital Bed Surplus Estimates Under Alternative Average Length of Stay Assumptions

In New Jersey hospitals, as well as nationally, increasing proportions of total births are premature and a growing percentage of total deliveries are by cesarean section. The effect that continuation of these trends would have on projected inpatient days and estimated bed need was tested. For the obstetrics and newborn service lines, the 2005 use rates were not adjusted based on the trend between 2002 and 2005 because these services are a function of the female population's birth rate rather than changes in technology and practice patterns. However, between 2002 and 2005, the proportion of cesarean section deliveries and premature births increased in every hospital market area. Because cesarean section deliveries have a slightly longer average length of stay than vaginal deliveries and premature newborns have a significantly longer average length of stay than healthy newborns, the effect on projected days and bed need was calculated assuming these trends continue for three

years beyond 2005. The effect of this calculation is a slight reduction in the estimated bed surplus in 2010 and 2015, but it does not materially change the overall results of the estimated bed need analysis presented in Figure 4.12.

In addition, sensitivity testing was performed on the adjusted projection of inpatient days using a more aggressive (i.e., lower) average length of stay assumption. In response, the "Best New Jersey Practice" in average lengths of stay was identified and assumed this could be achieved across the entire state. At the DRG level, the hospital market area with the lowest average lengths of stay in 2005 was identified to calculate a "Best New Jersey Practices" average lengths of stay by service line. These average lengths of stay were applied to the projected discharges under the baseline and adjusted scenarios. The "Best New Jersey Practices" assumption reduced projected average lengths of stay to 4.4 days compared to the 4.9 and 5.2 days from our original baseline and adjusted projection scenarios and decreased projected inpatient days 10 to

15 percent, thereby resulting in significantly higher estimates of surplus beds.

However, the Commission concluded it was unrealistic to assume that all hospitals in New Jersey could achieve these “best practices” in average lengths of stay, because current variation in average lengths of stay are not solely due to variations in medical practice patterns that hospitals, in theory, could alter. Rather, the longer average lengths of stay in some of the market areas may be due to high proportion of low-income residents who have poor health status, lack stable relationships with primary and secondary care providers and social support networks. These factors contribute to longer lengths of stay because such “at risk” patients often must convalesce in the hospital rather than at home. These results reinforce the Commission’s belief that the original adjusted baseline scenario projections, which assume the continuation of each hospital market area’s recent trends in ALOS, are reasonable, albeit conservative.

IV. Conclusion

In conclusion, the analyses presented in this chapter indicate that there is currently an oversupply of hospital beds in every hospital market area in New Jersey, and the current oversupply is especially noticeable in the Hackensack, Ridgewood and Paterson area. Without a reduction in the supply of beds, the Hackensack, Ridgewood and Paterson area’s bed surplus is projected to grow through 2010, and by 2010, there will also be significant bed surpluses in the Newark/Jersey City and Toms River areas. These results suggest that projected demand for inpatient hospital services could be satisfied without at least one of each of these areas’ current hospitals. These findings are generally consistent with the essentiality and financial viability framework analysis discussed in Chapter 12, in that the two market areas of Newark/Jersey City, and Hackensack, Ridgewood and Paterson have the highest proportions of hospitals below the statewide average in terms financial viability.

Chapter 5: Assessing the Financial and Operational Condition of New Jersey Hospitals

Key Points

- **Many New Jersey hospitals are in poor financial condition relative to hospitals nationwide as measured by common financial indicators used by creditors.**
- **While not in acute financial distress, a large number of hospitals appear to be heading toward distress in the near future.**
- **A number of factors are common to hospitals in distress including location in the northeastern region of the state, high volume of publicly insured patients (i.e. Medicaid, Medicare, Charity Care), low volume of surgical cases, and small to medium size.**

At the request of the Commission, Navigant Consulting completed an analysis of the financial condition of the 80 general acute care hospitals that were open in New Jersey in 2005. The analysis included individual hospital and hospital system level financial information. The review focused on financial ratios that are indicators of profitability, liquidity and capital structure. In addition, the analysis compares the financial performance of New Jersey hospitals to hospitals nationwide and to benchmarks used by the major bond rating agencies. Based on this analysis, factors that are common to financially distressed hospitals are identified.

The Commission assessed the following seven financial indicators for each of the New Jersey hospitals:

- **Operating margin**
- **Total margin**
- **Days cash-on-hand**
- **Current ratio**
- **Debt service coverage**
- **Long-term debt to capitalization**
- **Average age of plant**

This chapter discusses the role of these financial indicators have in assessing the financial performance of organizations and provides information on these indicators for New Jersey hospitals. The Commission used three data sources to analyze the financial condition of New Jersey hospitals — Medicare Cost

Reports, Audited Financial Statements and Unaudited Financial Statements (2006 only). Appendix 5 describes in more detail each of the data sources and their relative strengths and weaknesses. In general, the Commission used Medicare Cost Report data to analyze long-term trends and for comparisons of New Jersey results to other states. Audited financial statements were used for hospital-specific assessments, for more detailed analysis of the range of values for each ratio and for comparisons to financial benchmarks available from the major rating agencies. Audited financial statements were used to provide a preliminary assessment of 2006 financial results. For several reasons — notably differences in classification of financial items and the number of hospitals reporting medians — financial indicators calculated from these different data sources will likely differ from one another.

I. The Financial Condition of New Jersey Hospitals

To assess the financial condition of New Jersey's hospitals, the Commission directed Navigant Consulting, to profile their performance on a series of standard financial indicators. In the following sections, these indicators are defined and explained with respect to their use in our financial assessment of New Jersey's hospitals. Finally, these financial measures are provided for hospitals in the state.

A. Operating Margin

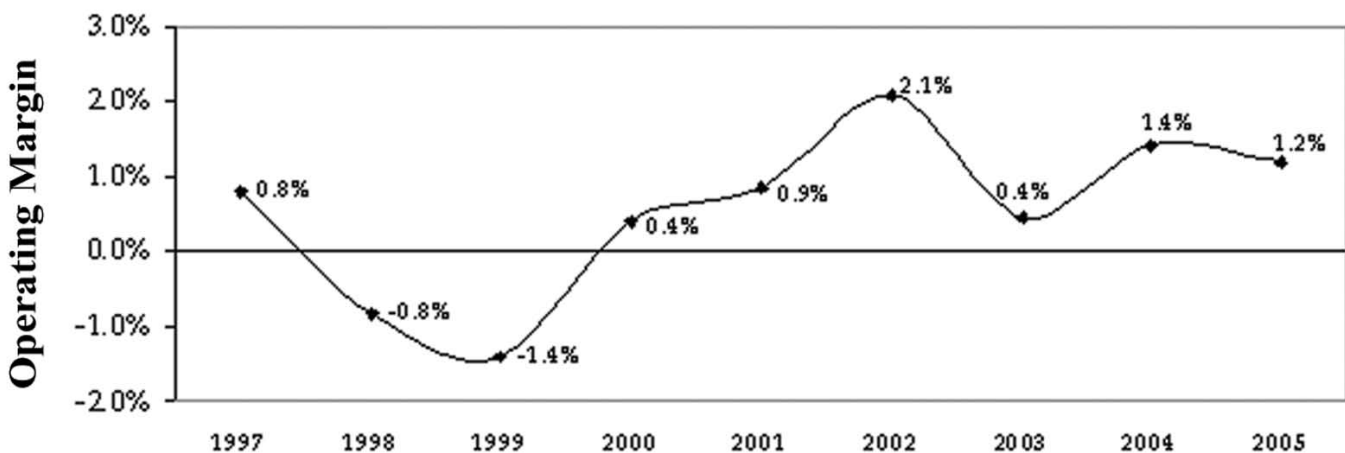
A hospital's operating margin is defined as income (or loss) from patient operations divided by net patient revenues (i.e., not patient revenues billed but patient revenues actually received or expected to be received by hospitals). This metric excludes non-operating items such as fundraising or gains or losses on the sale of assets. Thus, this metric measures a hospital's net income strictly from the core business of patient care. In the short-term, hospitals with negative operating margins may be able to bridge the shortfall with loans or by tapping cash reserves. These are, however, short-term solutions and a hospital experiencing sustained negative operating margins will likely be unable to meet its financial obligations over the long-term and faces the prospect of insolvency and bankruptcy.

Despite some differences in the calculation of operating margin in Medicare Cost Reports and audited financial statements (explained in Appendix 5), the operating margin trend obtained from Medicare Cost Reports is both valid and informative. As Figure 5.1 illustrates, the

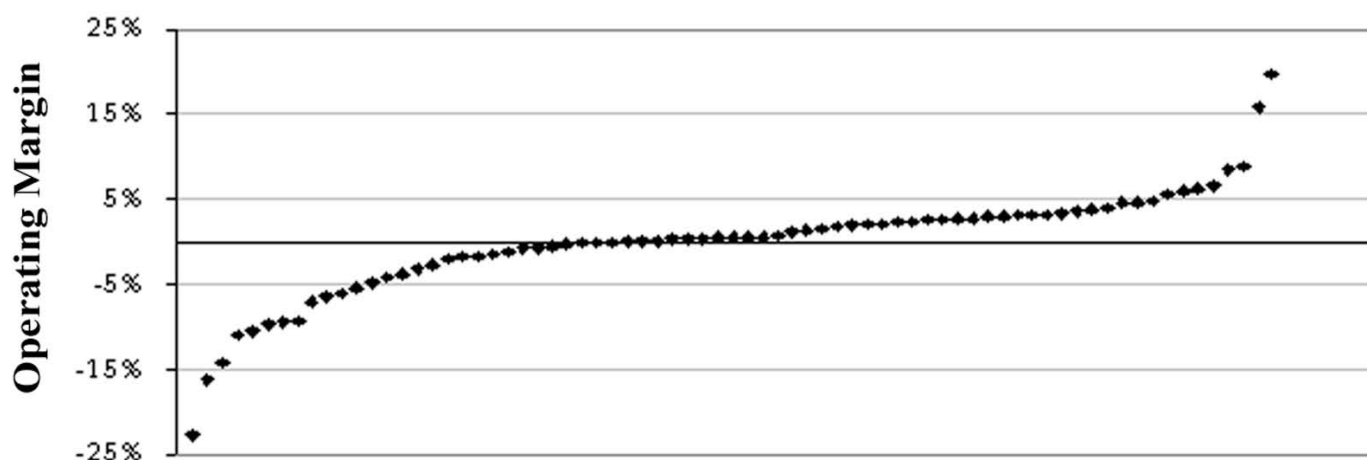
median³⁵ operating margin for New Jersey hospitals has ranged from a low of negative 1.4 percent in 1999 to a high of 2.1 in 2002. The trend since 2002 has been negative, with operating margins for New Jersey hospitals declining steadily since 2002. Audited data for 2006 show a median operating margin of positive .02 percent, indicating that approximately half of the State's hospitals lost money from operations.

However, a median, similar to an average, is only a measure of central tendency that obscures the dispersion of values around those central tendencies. Figure 5.2 shows the nature of the dispersion of the operating margin of New Jersey hospitals using 2005 audited financial statements. Each dot represents an individual hospital's operating margin. Operating margins ranged from negative 23 percent to nearly 20 percent, with the large majority of hospitals falling within the negative five percent to positive five percent range. By way of comparison, the average operating margin for acute care hospitals in the entire nation is approximately 3.3 percent.

Figure 5.1:
Trend in Median Operating Margins for New Jersey Hospitals (1997 – 2005)

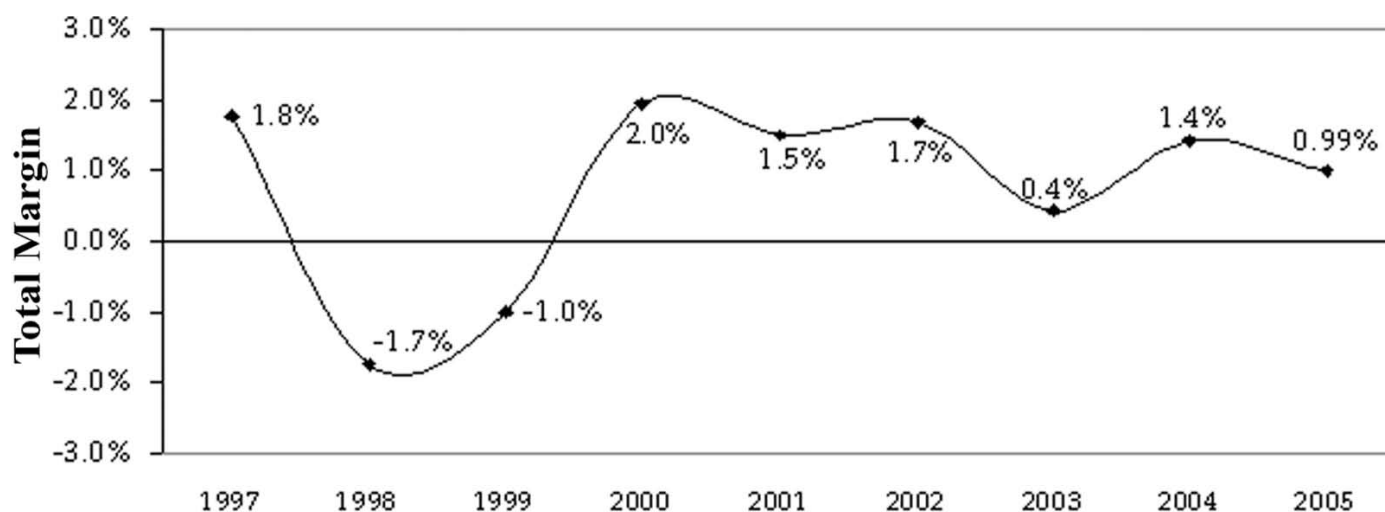


³⁵ The median of a distribution is a metric such that the values of the variable in question for half of the hospitals lie above the median and the metrics for half the hospitals below it. Unlike an average, its value is not distorted by large outlier values. For some purposes, the median describes a set of variables – here operating margins – more accurately.

Figure 5.2:**Distribution of New Jersey Hospitals' Operating Margins based on Audited Financial Statements (FY 2005)****B. Total Margin**

Total margin is defined as income (or losses) from all sources divided by net revenues. A positive total margin can, in the short-term, help offset operating losses or fund equipment and facility replacement. However, hospitals that continually rely on total margins to subsidize operating losses face difficult financial challenges and hospitals that fail to generate consistent positive total margins are unlikely to be able to meet their financial obligations in the long run.

According to Medicare Cost Report data from 1997 through 2005, the median total margin for New Jersey hospitals was at its lowest level in 1998 at negative 1.7 percent and peaked at 2 percent in 2000 (Figure 5.3). Since 2000, the median total margin for New Jersey hospitals has fluctuated between 0.4 percent and 1.7 percent, markedly below the national median. The median total margin for all acute care hospitals in the United States in 2005 was 3.6 percent.

Figure 5.3:**Trend in Median Total Margins for New Jersey Hospitals (1997 – 2005)**

Analysis of fiscal year (FY) 2005 audited financial statements showed hospital total margins in New Jersey ranged from negative 26 percent to nearly 20 percent with a median of 2.1 percent. Data for 2006, based on audited financial statements, shows a marked decline in the median total margin as it fell to 0.41 percent. Figure 5.4 illustrates the distribution of hospitals' total margins based on FY 2005 audited financial statements. The large majority of hospitals fall within the negative 1.0 percent to 8.0 percent range. Most importantly, more than two-thirds of New Jersey hospitals had total margins below the national median.

C. Days Cash-on-Hand

Days cash-on-hand is defined as cash and highly liquid assets (e.g., marketable securities or money-market funds) divided by the hospital's average daily cash

outflow to support operations; it excludes depreciation, which is a non-cash expense. In other words, days cash-on-hand measures a hospital's cash reserves in terms of the number of days the hospital could continue to meet daily operating expenses even if it were to receive no additional cash revenues. The lower the number, the more vulnerable a hospital is to disruptions in revenues (e.g., problems with reimbursement from third-party payers) or expenses (e.g., sharp increases in supply costs). A very low number may signal that the hospital may not be able to meet payroll.

As illustrated in Figure 5.5, median days of cash-on-hand for New Jersey hospitals, as calculated from Medicare Cost Reports, was relatively constant from 1997 to 2000, peaked in 2002 and subsequently declined to levels consistent with the figures recorded from 1997 through 2000.

Figure 5.4:

Distribution of New Jersey Hospitals' Total Margins based on Audited Financial Statements (FY 2005)

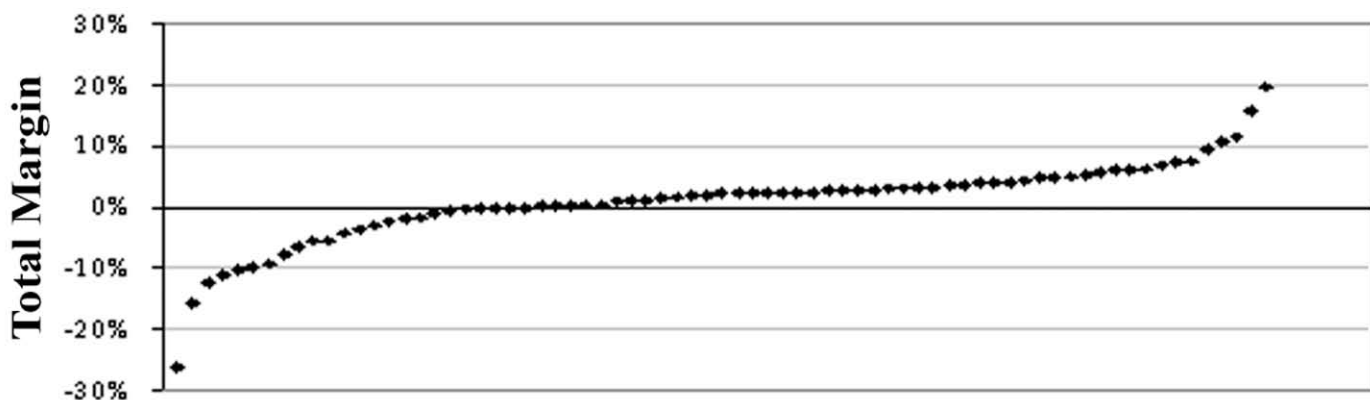
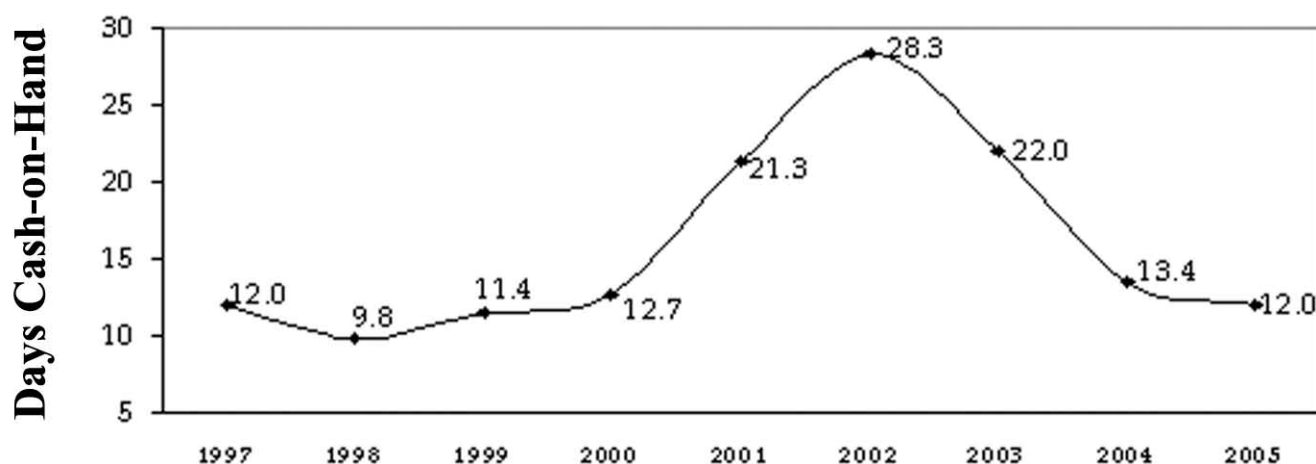


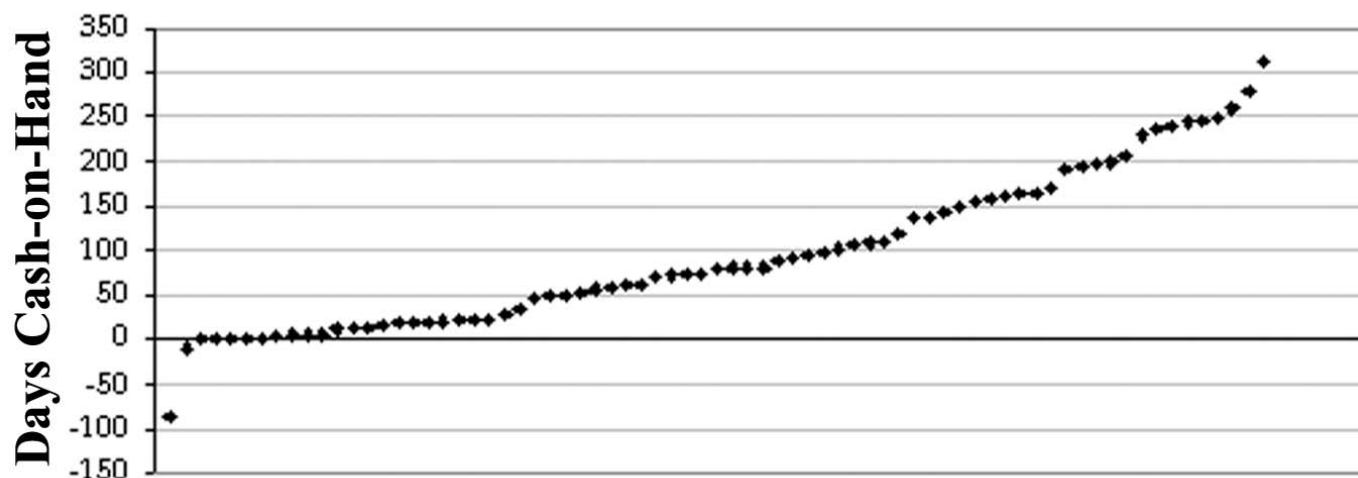
Figure 5.5:
Trend in Median Days Cash-On-Hand for New Jersey Hospitals (1997 – 2005)



However, as is explained further in Appendix 5, there are data limitations in Medicare Cost Reports that result in an understatement of hospitals' days cash-on-hand. Because of this limitation, Medicare Cost Reports were used to examine historical trends in the hospitals' days cash-on-hand indicator, but relied on hospitals' FY 2005 audited financial statement data that include board-designated funds to assess hospitals' more current days cash-on-hand positions. Figure 5.6 illustrates the distribution of hospitals' days cash-on-hand based on FY 2005 audited financial statements, which include board-

designated funds. In FY 2005, days cash on hand ranged from negative 87 (overdraft) to 311, with a median of 80 days. In 2005, the median days cash on hand, including board-designated funds that are available for immediate use if needed, for all hospitals in the nation was 160 days. Therefore, the median for New Jersey hospitals was half of the median for all hospitals in the nation. More importantly, approximately one-third of New Jersey hospitals had less than 50 days cash-on-hand in FY 2005. Audited data for 2006 show a further decline in median days cash-on-hand down to 69 days.

Figure 5.6:
Distribution of New Jersey Hospitals' Days Cash-On-Hand Based on Audited Financial Statements (FY 2005)



D. Current Ratio

The current ratio is defined as current assets divided by current liabilities, where “current” means assets likely to be converted into cash within a year or liabilities that have to be paid in cash within a year. The ratio indicates the ability of a hospital to meet its short-term obligations with cash or other assets that can quickly be converted to cash (e.g. patient accounts receivable). Lower values suggest potential problems in meeting payroll or making payments to vendors. Most often, a current ratio of two or higher is assumed to indicate that an organization is financially sound.

As illustrated in Figure 5.7, the median current ratio for New Jersey hospitals has declined steadily since 2001. Audited data for 2006 indicate continued decline, with the median current ratio falling to 1.26.

As Figure 5.8 illustrates, approximately three-fourths of New Jersey hospitals had current ratios below 2.0 in FY 2005. Liquidity problems are, therefore, systemic for the hospital industry in New Jersey and are likely affecting most of the State’s hospitals.

Figure 5.7:
Trend in Median Current Ratios for New Jersey Hospitals (1997 – 2005)

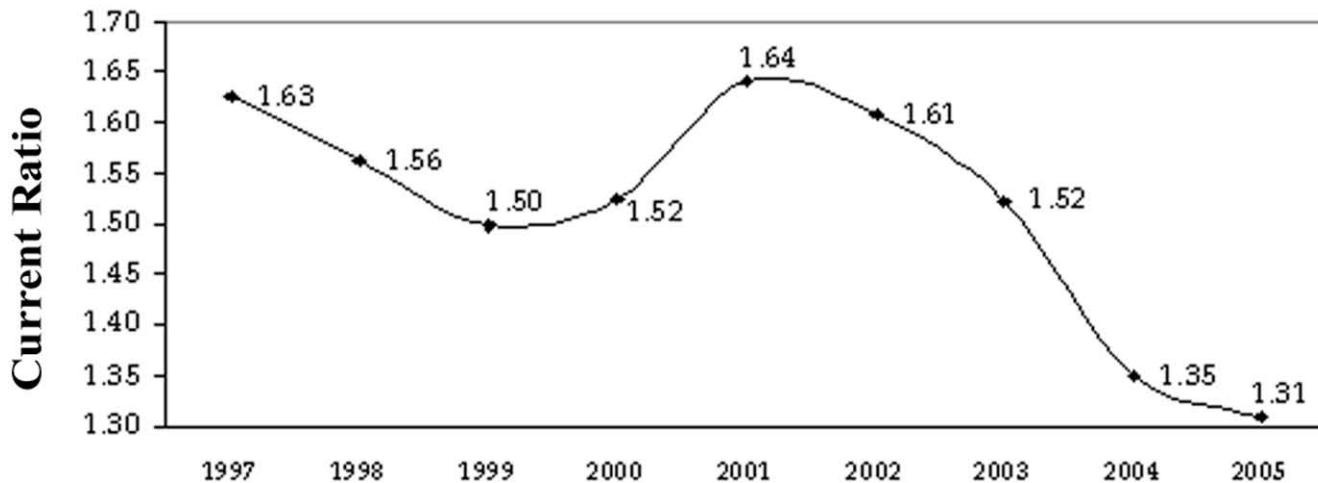
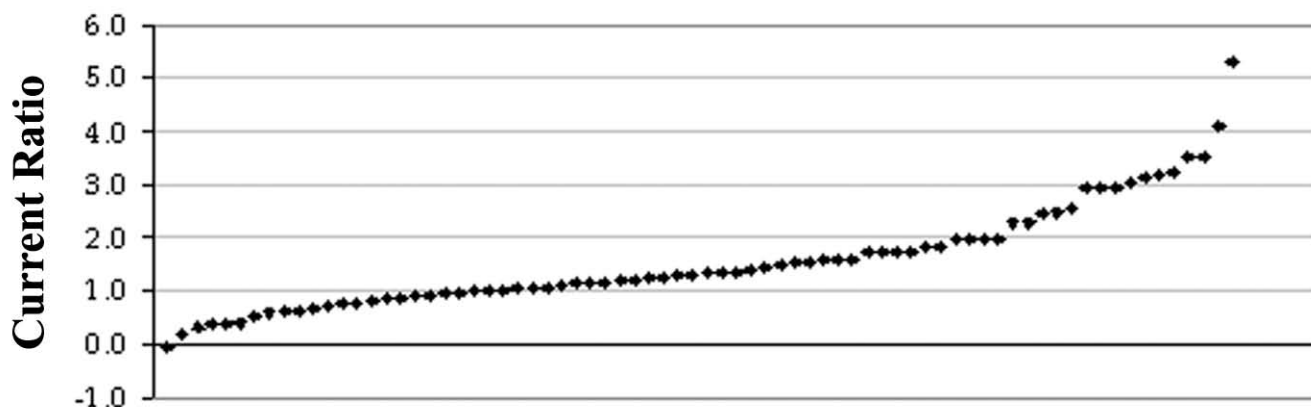


Figure 5.8:
Distribution of New Jersey Hospitals’ Current Ratios Based on Audited Financial Statements (FY 2005)



E. Debt Service Coverage

Debt service coverage is a widely used indicator that measures an organization's ability to cover its monthly debt payments – that is, interest and principal. The ratio is calculated by dividing the hospital's operating cash flow (net income plus depreciation and interest) by its annual debt service – the total of all interest and principal payments for the year. The higher a hospital's debt service coverage, the better its financial condition and ability to meet its debt requirements.

As Figure 5.9 illustrates, the median debt service coverage ratio for New Jersey hospitals was at its lowest point in 1998, then increased over the next three years and has stabilized since 2003. A stable debt service coverage ratio is normally the result of fairly low variation in operating income and low variation in the amount of debt. As discussed in the next section of this chapter, New Jersey hospitals have an exceptionally

high average age of plant, which suggests hospitals have incurred relatively less new debt in recent years. It is important to highlight that although New Jersey hospitals' debt service coverage has been stable in recent years, the State's debt service coverage ratio of 2.43 is substantially below the average of 3.98 for all hospitals in the United States.

Figure 5.10 illustrates the distribution of individual New Jersey hospitals' debt service coverage ratios based on FY 2005 audited financial statements. Values ranged from negative 3.5 to 14.4 with a median of 2.71. Particularly troubling is the number of hospitals with coverage ratios less than 1.0, an indication of potential problems in meeting debt service. Also, the median for 2006 based on audited financial statements shows further decline to 2.35.

Figure 5.9:
Trend in Median Debt Service Coverage for New Jersey Hospitals (1997 – 2005)

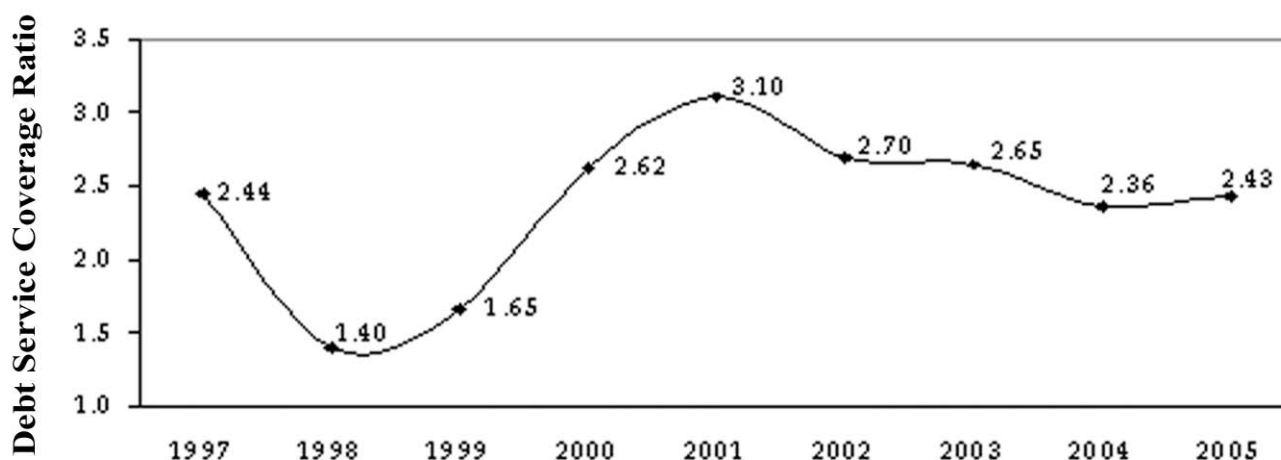
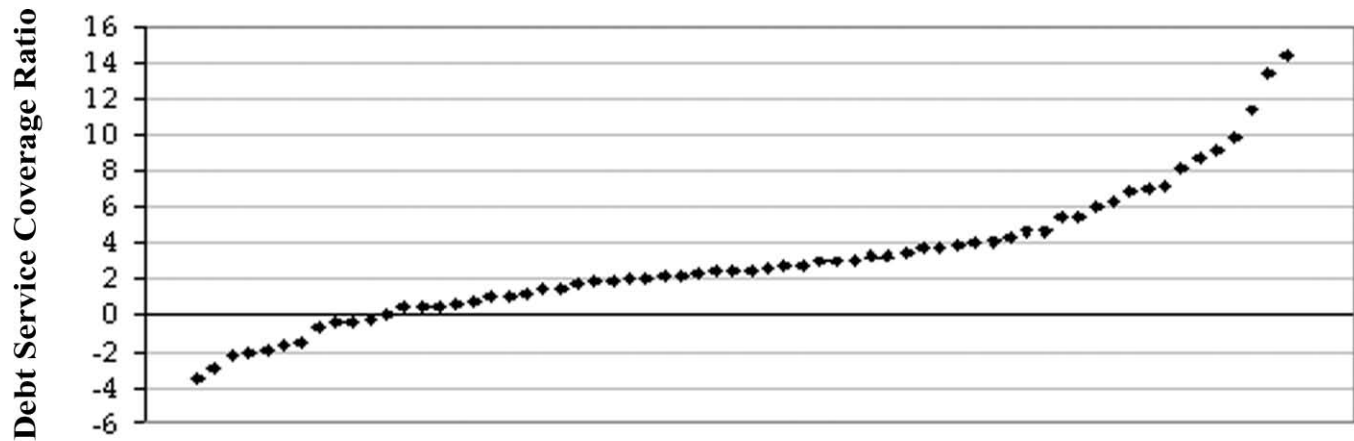


Figure 5.10:**Distribution of New Jersey Hospitals' Debt Service Coverage based on Audited Financial Statements (FY 2005)****F. Long-Term Debt to Capitalization**

A hospital's ratio of long-term debt to total capitalization measures its degree of financial leverage. One can think of it as the fraction of a hospital's total assets that has been financed with debt, rather than with the hospital's equity funds (endowments plus accumulated retained earnings). Other things being equal, the higher a hospital's debt-to-capitalization ratio, the larger the interest expense in the hospital's income statement and the larger the total debt-service in its cash flow statement. Therefore, this ratio is widely used by financial analysts to assess the degree to which a

hospital is leveraged and thus, may be unable to take on additional debt or the extent to which a hospital may have difficulty meeting its scheduled debt service payments.

Although New Jersey hospitals' median long-term debt to capitalization ratio has decreased since 2002 (as illustrated in Figure 5.11), the median long-term debt to capitalization ratio for New Jersey hospitals is substantially higher than the ratio for all hospitals in the United States (38.6 percent). This indicates that New Jersey hospitals are more highly leveraged and have less equity than other hospitals in the nation.

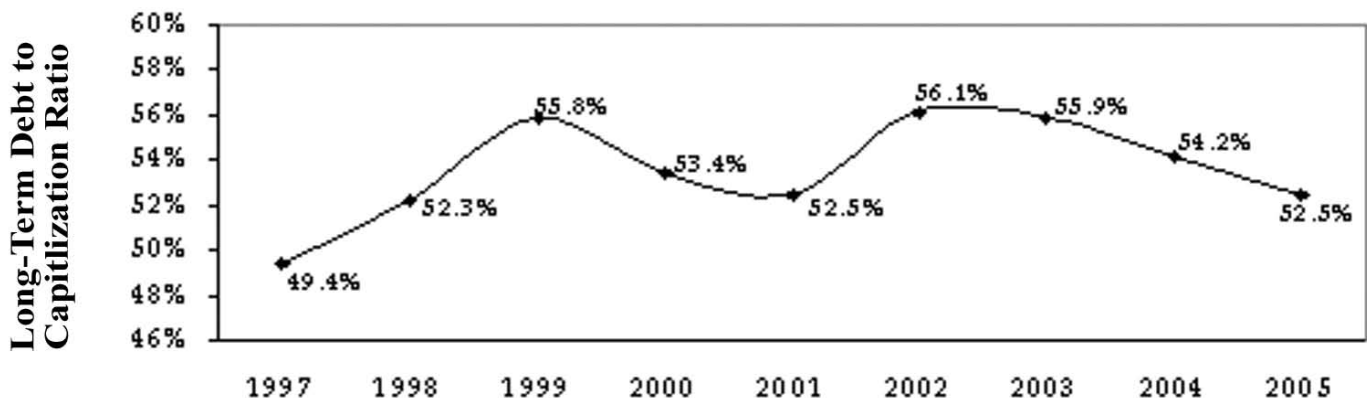
Figure 5.11:**Trend in Median Ratios of Long-Term Debt to Capitalization for New Jersey Hospitals (1997 – 2005)**

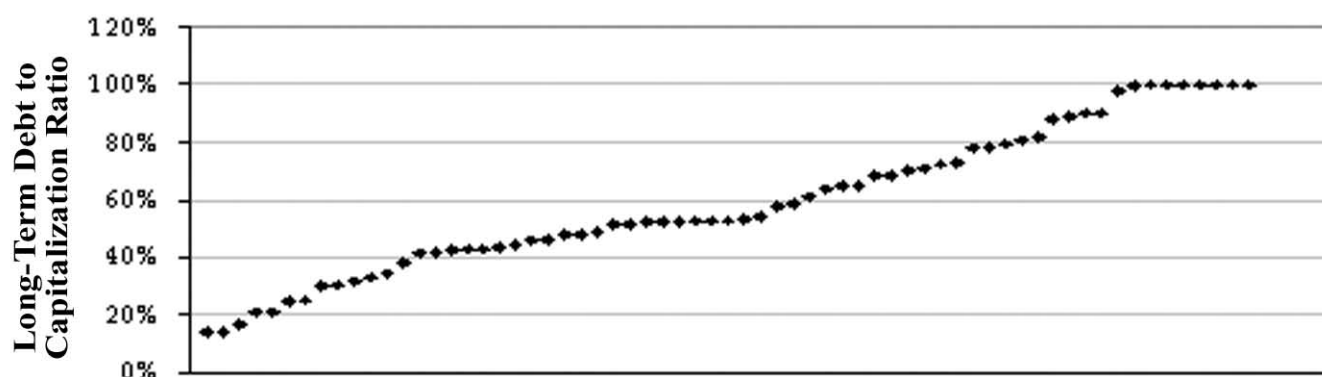
Figure 5.12 illustrates the distribution of individual hospitals' long-term debt to capitalization ratios based on their audited financial statements. These ratios ranged from 14 percent to 100 percent with a median of 46 percent. As shown in the figure, seven New Jersey hospitals have long-term debt to capitalization ratios of 100 percent, which means that their activities are entirely funded by debt. Audited data for 2006 indicate a decline in the median but this appears to be attributable to reclassification of debt at several hospitals rather than an actual improvement in fund balances or debt levels.

G. Average Age of Plant

In the eyes of economists and financial analysts, the average age of plant of an enterprise is a significant statistic for two reasons. First, higher average age of plant figures indicate that the facilities used by the organization are aging and are likely to require renovation and/or replacement. In addition, effective and efficient use of new technology often requires new capital outlays for structures and equipment.

The median value for New Jersey hospitals' average age of plant has increased nearly every year since 1997 as illustrated in Figure 5.13, and in FY 2005 was 13.4 years, which was more than 30 percent higher than the 10.2 median value for all hospitals in the nation in 2005.

Figure 5.12:
Distribution of Long-Term Debt to Capitalization for New Jersey Hospitals Based on Audited Financial Statements (FY 2005)*



*Note: The actual calculated long-term debt to capitalization ratio for seven hospitals was greater than 100 percent due to negative equity reported on their audited financial statements. Since 100 percent of an entity's capital is the maximum amount that can be financed via debt, these hospitals' long-term debt to capitalization ratio is capped at 100 percent.

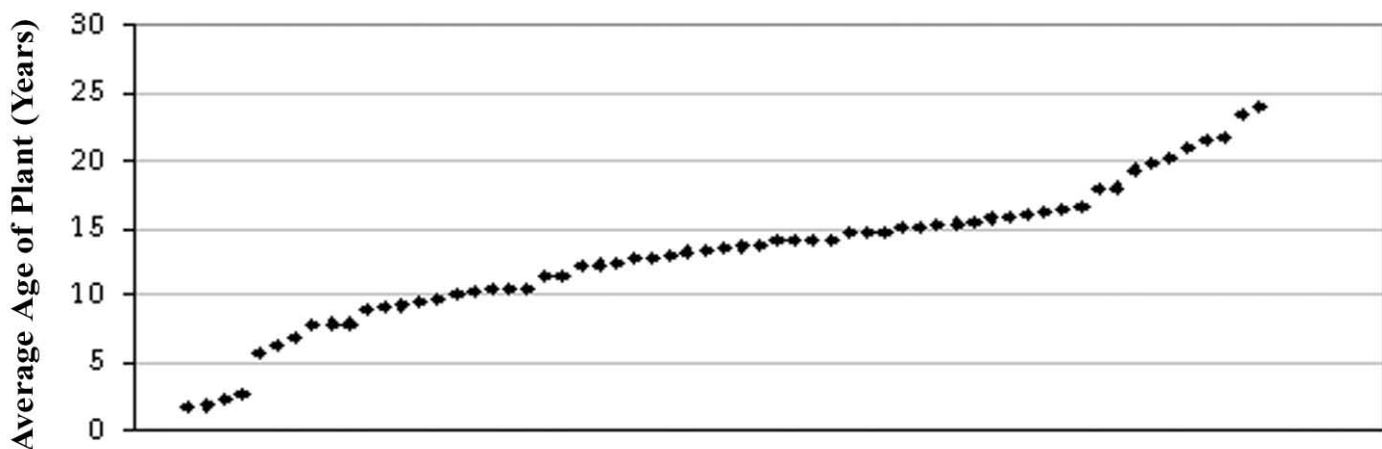
Figure 5.13:
Trend in Median Average Age of Plant for New Jersey Hospitals (1997 – 2005)



Data for individual hospitals calculated from audited financial statements (Figure 5.14) indicate that one-third of the State's hospitals had an average plant age of 15 years or older, and less than one-fourth had a plant age equal to or below the national median. This high average age of plant figures suggests that New Jersey hospitals will likely need to make significant capital investments to update, renovate, and replace old and

obsolete facilities. The ability of New Jersey hospitals to make these investments will be challenging, especially given the low margins (both operating and total), low debt service coverage ratios, and the high debt to capitalization ratios. The median average age of plant for New Jersey hospitals for 2006, calculated using audited financial statements, shows continued aging of the State's hospital infrastructure.

Figure 5.14:
Distribution of Average Age of Plant for New Jersey Hospitals Based on Audited Financial Statements (FY 2005)



II. How Hospitals Raise Capital

The vast majority of hospitals in New Jersey raise most of the funds needed for equipment, renovations, capital improvements and new facilities by borrowing from the proceeds of bonds or notes issued by the New Jersey Health Care Facilities Financing Authority (NJHCFFA). NJHCFFA is an independent State authority, in but not of the Department of Health and Senior Services. Since its creation by the New Jersey Legislature in 1972,³⁶ NJHCFFA has issued over \$14.3 billion in bonds for health care organizations, as that term is defined under its enabling statute.³⁷

Currently, the Authority has a total of over \$6.6 billion of bonds outstanding on behalf of nearly a hundred health care organizations. As of June 30, 2007, the total long term debt at New Jersey's 80 acute care hospitals was approximately \$5.2 billion. Seventy of the State's 80 acute care inpatient hospitals currently have debt outstanding through the Authority, which accounts for over \$4.3 billion of the Authority's bonds currently outstanding. Therefore, the Authority finances over 80% of the long term debt for New Jersey hospitals and about 88% of New Jersey hospitals currently have debt outstanding with the Authority. Other long term debt of these hospitals may include commercial loans from banks and capital leases with equipment manufacturers. Some hospitals also have operating leases which are not included in their calculation of long term debt.

The primary benefit of financing through a State or local financing authority is that not-for-profit, 501(c)(3) hospitals are able to receive the benefit of lower interest rates because the interest on the bonds issued on their behalf, in most cases, is exempt from Federal and State income tax. There are a few hospitals that typically do not issue bonds through the Authority. These hospitals fall into three groups: for-profit hospitals,

governmentally owned hospitals and hospitals in redevelopment zones.³⁸

In very simplified and generalized terms, in most cases, a hospital seeking to finance a health care project through the Authority enters into an agreement to pay an amount equal to the principal and interest on the bonds issued by the Authority plus fees and costs associated with the issuance of the bonds. The payments on the bonds are secured by that agreement. Neither the State of New Jersey nor the Authority is obligated to make any payments on the bonds except to the extent that the borrower makes its payments to the Authority under the agreement. There are some cases in which additional security or credit liquidity or enhancement are also pledged to satisfy payments on the bonds. These include bond insurance, letters of credit, mortgages and guarantees.

III. Comparison of Median Financial Indicators for New Jersey Hospitals and Other States and Credit Rating Agencies' Values

Similar analyses were completed for hospitals in the neighboring states of Connecticut, Maryland, New York, and Pennsylvania. With the exception of New York, hospitals in each of the comparison states had higher operating margins than New Jersey hospitals. Also, New Jersey hospitals had a more significant debt load, relative to the other states, again with the exception of New York. Lastly, New Jersey hospital facilities have the oldest plants relative to the comparison group of states. Table 5.1 on the following page presents these comparisons. In addition to the comparison states, median values for the United States are also presented.

³⁶ See N.J.S.A. 26:2I-1 *et seq.*, the Authority's enabling statute.

³⁷ "‘Health care organization’ means an organization located in this State which is authorized or permitted by law . . . to provide health care-related services, including, but not limited to, hospital, outpatient, public health, home health care, residential care, assisted living, hospice, health maintenance organization, blood bank, alcohol or drug abuse, half-way house, diagnostic, treatment, rehabilitation, extended care, skilled nursing care, nursing care, intermediate care, tuberculosis care, chronic disease care, maternity, mental health, boarding or sheltered care or day care, services provided by a physician in his office, or any other service offered in connection with health care services or by an entity affiliated with a health care

organization or an integrated delivery system." N.J.S.A. 26:2I-3.

³⁸ For-profit hospitals typically issue corporate bonds, use cash-on-hand or borrow through traditional commercial sources for their capital projects. As a separate State entity, the University of Medicine and Dentistry of New Jersey ("UMDNJ") typically issues bonds on its own behalf for capital projects at University Hospital. Bergen Regional Medical Center and Hoboken University Medical Center are owned by Bergen County and the City of Hoboken, respectively, and receive financing through local financing entities. Cooper Hospital University Medical Center in Camden is in a redevelopment zone and as such is typically financed through the Camden County Improvement Authority.

Table 5.1:
Comparison of Key Financial Indicators' Median Values –
Hospitals in New Jersey, Neighboring States and the United States (2005)

	Key Financial Indicators					
	Operating Margin	Total Margin	Days Cash on Hand	Debt Service Coverage	Long-Term Debt to Capitalization	Average Age of Plant
United States						
General Acute Care Hospitals	3.3%	3.6%	N/A	3.98	38.6%	10.2
New Jersey						
General Acute Care Hospitals	1.2%	1.0%	12.0	2.43	52.5%	13.4
Comparison States						
Connecticut	2.1%	1.6%	23.4	3.78	41.0%	10.8
Maryland	2.5%	3.1%	20.2	3.67	49.8%	6.2
New York	0.3%	1.2%	13.0	2.52	61.1%	11.3
Pennsylvania	2.6%	3.4%	10.6	3.23	44.8%	12.2
<i>Source: 2005 Medicare Cost Reports</i>						

It is also useful to compare the profitability, liquidity and financial structure indicators for New Jersey hospitals to the expectations that credit rating agencies have when they evaluate a hospital's credit worthiness. Median values for several financial indicators for different bond ratings calculated by Standard & Poor's, one of the major bond rating agencies, are compared to New Jersey hospitals' indicators in Table 5.2. The table clearly indicates that, for most of the ratios, New Jersey medians fall between the medians for BBB- hospitals (the lowest rating category above speculative grade) and

the medians for speculative grade ratings. To highlight one example, the median cash-on-hand for BBB-hospitals was 103 days compared to 80 days for New Jersey hospitals. Based on this indicator, the financial performance of a large majority of New Jersey hospitals does not meet the expectations for a typical BBB-hospital. A lower bond rating, especially a speculative grade rating, means that it will be more difficult for a hospital to obtain bond financing, and the financing that is obtained will be accompanied by higher interest rates.

Table 5.2:
Comparison of Key Financial Indicators – New Jersey Hospitals to Various Rating Levels (2005)

Financial Indicator	Stand-Alone Hospital Median Ratios by Rating Level ⁽¹⁾									New Jersey ⁽²⁾
	AA	AA-	A+	A	A-	BBB+	BBB	BBB-	Speculative Grade	
Operating Margin (%)	4.5	4.6	4.2	3.7	3.3	3.1	1.6	2.0	(0.4)	0.5
Total Margin (%)	9.5	8.8	6.8	6.1	5.4	4.6	3.4	3.3	0.8	2.1
Days Cash on Hand	401.0	262.0	202.0	204.0	180.0	154.0	110.0	103.0	46.0	80.0
Debt Service Coverage	5.6	5.8	4.8	4.1	3.8	3.4	2.7	2.4	1.9	2.7
Long-Term Debt to Capitalization (%)	24.7	32.3	31.5	36.4	34.4	37.5	44.1	41.8	55.1	46.1
Average Age of Plant (years)	8.4	8.7	8.7	9.2	9.6	9.5	9.2	10.0	13.1	11.9

Sources:
 (1) Standard & Poor's Rating Services, Public Finance: Stand-Alone Hospital Medians; July 2006
 (2) Data for New Jersey are based on audited financial statements
 * Note: All data are 2005 medians

To provide an additional perspective on New Jersey hospitals, the State's medians were compared to three specific bond rating levels: "A-", "BBB+", and "BBB-". Table 5.3 through 5.5 present these comparisons. As the

data in the tables show, New Jersey hospital medians are lower than the medians for all hospitals in the United States, even for BBB- rated bonds.

Table 5.3:
Comparison of Key Financial Indicators – New Jersey Hospitals to Median Values for BBB- Credit Ratings (2005)

	Key Financial Indicators for BBB- Credit Rating					
	Operating Margin	Total Margin	Days Cash on Hand	Debt Service Coverage	Long-Term Debt to Capitalization	Average Age of Plant
United States						
Standard & Poor's (Gen. Acute Hospitals) ⁽¹⁾	2.0%	3.3%	103.0	2.40	41.8%	10.0
Fitch Ratings (Not-for-Profit Hospitals) ⁽²⁾	1.9%	2.8%	112.0	2.20	48.2%	9.9
Moody's (Not-for-Profit Hospitals) ⁽³⁾	1.5%	2.5%	79.0	2.50	46.4%	10.3
New Jersey ⁽⁴⁾						
General Acute Care Hospitals	0.5%	2.1%	80.0	2.71	46.1%	11.9

Sources:
 (1) Data for the United States comes from *Standard & Poor's* and are based on FY 2005 audited financials. Values are medians.
 (2) Data for the United States comes from *Fitch Ratings* and are based on FY 2005 audited financials. Values are medians.
 (3) Data for the United States comes from *Moody's* and are based on FY 2005 audited financials. Values are medians.
 (4) Data for New Jersey are based on analysis of audited financial statements. Medians are used.

Table 5.4:**Comparison of Key Financial Indicators – New Jersey Hospitals to Median Values for BBB+ Credit Ratings (2005)**

Key Financial Indicators for <u>BBB+</u> Credit Rating						
	Operating Margin	Total Margin	Days Cash on Hand	Debt Service Coverage	Long-Term Debt to Capitalization	Average Age of Plant
United States						
Standard & Poor's (Gen. Acute Hospitals) ⁽¹⁾	3.1%	4.6%	154.0	3.40	37.5%	9.5
Fitch Ratings (Not-for-Profit Hospitals) ⁽²⁾	1.4%	4.0%	130.5	3.40	48.0%	10.0
Moody's (Not-for-Profit Hospitals) ⁽³⁾	2.3%	4.6%	116.1	3.70	45.9%	9.8
New Jersey ⁽⁴⁾						
General Acute Care Hospitals	0.5%	2.1%	80.0	2.71	46.1%	11.9

Sources:

(1) Data for the United States comes from *Standard & Poor's* and are based on FY 2005 audited financials. Values are medians.

(2) Data for the United States comes from *Fitch Ratings* and are based on FY 2005 audited financials. Values are medians.

(3) Data for the United States comes from *Moody's* and are based on FY 2005 audited financials. Values are medians.

(4) Data for New Jersey are based on analysis of audited financial statements. Medians are used

Table 5.5:**Comparison of Key Financial Indicators – New Jersey Hospitals to Median Values for A- Credit Ratings (2005)**

Key Financial Indicators for <u>A-</u> Credit Rating						
	Operating Margin	Total Margin	Days Cash on Hand	Debt Service Coverage	Long-Term Debt to Capitalization	Average Age of Plant
United States						
Standard & Poor's (Gen. Acute Hospitals) ⁽¹⁾	3.3%	5.4%	180.0	3.80	34.4%	9.6
Fitch Ratings (Not-for-Profit Hospitals) ⁽²⁾	3.0%	4.9%	162.0	3.70	43.0%	10.1
Moody's (Not-for-Profit Hospitals) ⁽³⁾	3.1%	5.3%	152.4	4.10	40.0%	9.7
New Jersey ⁽⁴⁾						
General Acute Care Hospitals	0.5%	2.1%	80.0	2.71	46.1%	11.9

Sources:

(1) Data for the United States comes from *Standard & Poor's* and are based on FY 2005 audited financials. Values are medians.

(2) Data for the United States comes from *Fitch Ratings* and are based on FY 2005 audited financials. Values are medians.

(3) Data for the United States comes from *Moody's* and are based on FY 2005 audited financials. Values are medians.

(4) Data for New Jersey are based on analysis of audited financial statements. Medians are used.

In the next section of this chapter, characteristics common to financially distressed New Jersey hospitals are discussed.

IV. Factors Common to Financially Distressed Hospitals

New Jersey hospitals, as a group, have had a poor financial performance in recent years, and a subset of hospitals has experienced significant financial distress. This section identifies factors common to financially distressed hospitals in New Jersey.

A. Factors that Can Affect Financial Performance

The Commission benefited from the expertise of consultants that have worked with hospitals across the United States. This collective experience has helped identify a number of factors that can affect financial performance. Among these factors are payer mix, indigent care load, staffing ratios, costs, and case mix. In some areas of the country, the location of a hospital can affect financial performance (although there is usually a correlation between location and payer mix—the less affluent an area is the more likely it is to have high levels of Medicaid and self-pay). Size can sometimes be a factor affecting financial performance, although this is not a consistent factor.

Although financially successful and financially unsuccessful hospitals often have a similar mix of

payers, the lower levels of payment by Medicaid and Medicare compared with private patients invariably affect hospitals with larger portions of government-funded patients. In addition, hospitals with poor financial performance are also likely to have larger numbers of uninsured patients.

Hospitals with less efficient operations, as demonstrated by higher full time equivalent (FTE) staff to bed ratios and higher costs per adjusted admission are also likely to be financially distressed. Hospitals that have a higher percentage of medical cases compared to surgical cases tend to be more financially challenged than those that have higher proportions of surgical cases.

B. Characteristics of New Jersey Hospitals Identified as Financially Distressed

To determine the factors that affect financial performance in New Jersey, this analysis focuses on a subset of 12 New Jersey hospitals that appear to be in the worst financial condition. These hospitals were identified based on financial performance indicators of profitability, liquidity and soundness of their capital financial structure (as measured by their operating margin, days cash on hand and long-term debt to capitalization ratios). All 12 of these hospitals have had negative operating margins for two or more consecutive years, have less than 20 days of cash on hand and long-term debt to capitalization ratios greater than 50 percent.

As Table 5.6 shows, most of the 12 hospitals in serious financial distress are located in the Newark/Jersey City market area.

Table 5.6:
Location of Hospitals in Serious Financial Distress

Hospital Market Area	Number of Hospitals in Serious Financial Distress
Newark/Jersey City	7
Hackensack, Ridgewood and Paterson	4
Atlantic City	1

As Table 5.7 shows, although there are both small and large hospitals in serious financial distress, compared with all hospitals in the State, a higher proportion of hospitals in serious financial distress are small.

Surgical volume is important to consider because margins on surgical cases are generally higher for all payers. As Table 5.8 shows, New Jersey hospitals in serious financial distress have lower proportions of surgical discharges compared with all hospitals in the State.

Table 5.7:
Bed Size Distribution: Hospitals in Serious Financial Distress versus All Hospitals

Number of Maintained Beds in 2006	Portion of Hospitals in Serious Financial Distress	Portion of All Hospitals
< 100	17%	9%
100 – 200	42%	26%
201 – 300	33%	31%
> 300	8%	34%

Table 5.8:
Inpatient Surgical Activity: Hospitals in Serious Financial Distress versus All Hospitals

2006 Surgical Discharges as a Percent of Total Discharges	Portion of Hospitals in Serious Financial Distress	Portion of All Hospitals
< 11%	-	1%
11 – 20%	67%	35%
21 – 30%	25%	45%
> 30%	8%	19%

Table 5.9:
Proportion of Government Programs and Uninsured Discharges: Hospitals in Serious Financial Distress versus All Hospitals

2006 Medicare, Medicaid and Uninsured Discharges as a Percent of Total Discharges	Portion of Hospitals in Serious Financial Distress	Portion of All Hospitals
< 50%	-	25%
51 – 60%	25%	26%
61 – 70%	42%	34%
71 – 80%	17%	11%
> 80%	16%	4%

As Table 5.9 shows, hospitals in serious financial distress have higher proportions of Medicare, Medicaid and uninsured discharges compared with all hospitals in the State.

While nationally, financially distressed hospitals typically exhibit higher costs and staffing ratios than well-performing hospitals, financially distressed hospitals in New Jersey appear to have responded to negative financial results by reducing staff and costs. As a result, some of the hospitals that are financially distressed do not have higher costs and staffing ratios. In addition, some of the more financially successful hospitals have higher costs and staffing ratios than hospitals that are financially distressed.

The characteristic that the vast majority of hospitals in serious financial distress share is location in the northeast portion of New Jersey. In terms of bed size, not all these hospitals are small, but it is noteworthy that all the small hospitals in the northeast portion of the State are in serious financial distress. It is clear that small hospitals with low rates of surgical discharges have significant challenges to their financial viability. When these characteristics are combined with a high proportion of Medicare, Medicaid and uninsured patients, the likelihood of experiencing serious financial distress is very high.

V. Conclusion

Based on the financial indicators analyzed in the first section of this chapter, it is evident that the financial condition of New Jersey hospitals is poor and has been deteriorating for the last several years. Currently, New Jersey hospitals are showing, on average, poor profitability, limited cash reserves and high levels of debt. Low margins and low levels of cash on hand threaten a hospital's ability to meet both short- and long-term debt obligations. Furthermore, New Jersey hospitals' capital structure is highly leveraged with a median long-term debt to capitalization ratio of 52.5 percent. When considered in their entirety, these factors significantly inhibit the ability of the State's hospitals to invest in their infrastructure, which has resulted in an exceptionally high average age of plant.

Additionally, the financial performance of New Jersey hospitals is worse than the average performance of its counterparts nationally, and it is not favorable when compared to financial benchmarks commonly used in the industry and by financial rating agencies that assess a hospital's credit worthiness. It is important to note, however, that there is a wide dispersion of values for these financial metrics across New Jersey hospitals. While some hospitals are considerably more distressed

than the averages or medians indicate, others are in very good financial condition, even by national standards.

Several characteristics appear to be common to financially distressed hospitals. Hospitals with a high

volume of publicly insured patients, low volume of surgical cases, or small to medium bed size are the most vulnerable based on current indicators. Geographic presence in the northeastern section of the state also is a key predictor of financial distress currently.

Section III:

Factors Affecting the Economics and Performance of New Jersey Hospitals

The previous section of the report provided a description of New Jersey's acute care hospital market including its relatively poor financial situation. In addition, it included the Commission's projections of a worsening oversupply of hospital beds in the State that will likely lead to greater financial distress of hospitals in the future. This section seeks to uncover additional causes of financial distress of New Jersey hospitals and provides the Commission's recommendations to mitigate these detrimental factors. In many cases, factors influencing hospitals' economic situation lie outside the direct control of institutional management and governance. However, all stakeholders share responsibility in addressing many of the factors outlined in this chapter including:

- Adequate reimbursement by public payers;
- Alignment of the hospital-physician relationship to improve efficiency and quality;
- Transparency of performance data for physicians and hospitals;
- Smart regulation that is evenly applied and minimizes perverse incentives;
- Effective and accountable hospital governance and management;
- An adequate ambulatory safety net that ensures people get the right care, in the right place, at the right time minimizing the inefficient use of hospital resources.

Chapter 6 provides New Jersey policymakers and the public with a primer on the economics of hospitals – this chapter is central to understanding the current challenges confronting hospitals across the state. The remaining chapters review the issues outlined above and provide a series of policy recommendations for the Governor, legislators, and health sector leaders.



Chapter 6: Hospital Economics 101

Key Points

- Many complex factors influence the economics of hospitals in peculiar ways resulting in strain on a given hospital's finances.
- The nature of the hospital-physician relationship allows doctors to exert significant influence over the use of resources – the lack of a traditional employer-employee relationship prevents the hospital from exercising effective managerial control.
- Most New Jersey hospitals are non-profit institutions – many of the boards of these respective institutions have not generally kept pace with changes in best practices for governance despite the increasing complexity and scope of health care institutions.
- The prices for hospital services vary widely by payer and operate with little to no transparency.
- Hospitals function as a financial hydraulic system – they continually attempt to shift costs from one payer to another or from one service line to another based on relative profitability. Underpayment by public payers, particularly Medicaid, leads to intense efforts to shift costs onto private payers.
- American health policy suffers from “half-hearted competition” and “half-hearted regulation” – the combination cannot be expected to produce a rational system.

To appreciate fully the problems that beset New Jersey's hospital sector – and of its health system in general – it will be helpful to explore briefly the peculiar economics of the hospital sector in the United States, to which New Jersey furnishes no exception.

It will be seen that most of the problems besetting the hospital sector are derivatives of these peculiar economics. They also make the problems faced by our hospital industry close to intractable, unless these peculiar economics undergo major changes. No other industrialized country has loaded quite this yoke on its health care sector nor has similar problems. They are unique features of American health care.

I. The Managerial Structure of the Hospital

Imagine an engineering firm, Apex, Inc. The firm's engineers are not employees of the firm, but self-employed entrepreneurs who can, free of charge to them, use Apex's laboratories and other facilities, along with draftsmen and other personnel, to develop the products these engineers sell on their own account.

The self-employed engineers are free to use Apex's facilities, to direct Apex's staff to perform work for them and to use in that task whatever of Apex's supplies and other resources the engineers see fit to have used. The engineers bill their clients for their own professional work. Apex bills these same clients separately for work or supplies or the use of Apex facilities that the engineers had requisitioned to perform their own professional work.

Imagine now that, in addition to being allowed to use Apex's facilities as a free workshop for their own products, the engineers also are allowed to establish their own engineering company – call it ACME PLC -- which employs its own support staff and procures its own supporting supplies. ACME PLC competes head on with Apex Inc. in the sale of engineering services.

Finally, imagine that the engineers are free to decide where they will have their own work supported: in their own facility, ACME PLC, or at their free workshop, ACME, Inc.

It is hard to imagine an industry that would be set up in this fashion – save, of course, America's hospital industry, which operates in precisely this fashion. A hospital's affiliated, self-employed physicians are the analogues of the entrepreneurial engineers described above. From a strictly economic perspective, self-employed physicians are business entrepreneurs. They can use the hospitals at which they have "privileges" as free workshops. Within fairly broad limits, they can direct the hospital's staff to perform whatever functions the physicians deem desirable and for which the staff is trained, using in the process whatever hospital-owned supplies or facilities the physicians wish to see used. In the process, they act as one of the hospital's major cost drivers, albeit without owing anyone any accountability for their use of the hospital's resources. If it is difficult for the reader to imagine how such an enterprise can be efficiently managed in society's best interest, the reader is perceptive.

The theory underlying the American model of physician-hospital affiliation appears to be that, by having physicians straddle both the ambulatory and inpatient sectors and follow their patients into the hospital and back into the ambulatory care sector, the overall quality of patient care is enhanced. That may well be so³⁹. In virtually all other industrialized nations, however, the work of physicians in the inpatient setting is performed by physicians who are fulltime employees of the hospital and thus fully under the hospital management's control. Through the hospital, these physicians can more easily be held accountable by management for their use of the hospital's resources, and also for the quality of their professional services.⁴⁰

The Wennberg Variations: The extraordinary autonomy that the American model of the physician-hospital relationship affords the individual, self-employed physician may be a major contributor to the enormous geographic variations in the per-capita use of health spending in general, and hospital resources in particular, that have been observed for some two decades now by physician and epidemiologist John Wennberg and his research associates at the Dartmouth Medical School and reported in their well-known Dartmouth Atlas⁴¹.

According to that research, per capita health spending for seemingly identical Medicare beneficiaries tend to vary across the United States by a factor of close to 3, without any commensurate, observable difference in the quality of health care processes, clinical outcomes or patient satisfaction⁴². Remarkably, one research study even suggested a negative correlation between health spending per capita and quality⁴³.

These so-called Wennberg variations are observable even within smaller regions, such as the State of New Jersey. Table 6.1 below, for example, exhibits the use of hospital resources in the care of Medicare patients during their last two years of life in a select number of hospitals in New Jersey. Differences in the characteristics of the beneficiaries' medical cases may play some role in explaining the observed differences in the use of hospital resources. However, the fact that the reported numbers represent *averages* for entire hospitals rather than individual patients limits that explanation. It can be doubted that, *on average*, all Medicare beneficiaries in their last two years at one New Jersey

³⁹ As models of integrated health care go, many health policy experts regard consider vertically integrated delivery systems such as the Kaiser Permanente health plan a superior approach.

⁴⁰ To be sure, the chiefs of departments in German hospitals, although employees of the hospital, do have the privilege of treating privately insured patients as if they were merely affiliated physicians. The number of patients so treated is quite small, however. Furthermore, the chiefs must actually pay the hospital a rental fee per patient day for patients they treat on a private basis in the hospital. And only the chiefs are permitted this privilege in the first place.

⁴¹ See <http://www.dartmouthatlas.org/> and http://www.dartmouthatlas.org/atlas/atlas_series.shtml.

⁴² See <http://www.annals.org/cgi/content/abstract/138/4/288>.

⁴³ Katherine Baicker and Amitabh Chandra, "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care," *Health Affairs* Web Exclusive, April 7, 2004

hospital truly required three times as much care than did all such beneficiaries at another hospital. In any event, the Dartmouth research team has long been persuaded that the bulk of these geographic differences in health care utilization are driven by differences in the practice style preferred by physicians and that these practice styles, in turn, are driven by either professional or economic considerations, or both.

Whatever the factors that drive the Wennberg Variations may be, however, they clearly stand as both an economic and a moral challenge to the physicians in areas with high health care utilization per capita to justify that

utilization on the grounds of differences in the characteristics of patients, in the quality of health care processes, in clinical outcomes, or in patient satisfaction. It is not only an economic but also a moral challenge, because the high cost of health care in the United States is driving more and more families of the middle- and lower-income groups out of health insurance and thus out of timely, appropriate health care. Furthermore, in case of illness, it visits financial distress on increasingly large numbers of uninsured American families, many of which have been reported to be driven into personal bankruptcy over unpaid medical bills⁴⁴.

Table 6.1:
Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries
(Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)

	Inpatient Reimbursements	Hospital Days	Reimbursements per Day	CMS Technical Quality Score
St. Michaels Medical Center	3.21	2.34	1.37	0.91
Kimball Medical Center	2.32	1.26	1.83	0.95
Raritan Bay medical Center	1.86	1.85	1.01	0.81
Christ Hospital	1.83	1.83	1	0.59
St. Mary's Hospital Hoboken	1.75	1.72	1.02	0.74
Beth Israel Hospital	1.58	1.86	0.85	0.83
Overlook Hospital	1.27	1.36	0.94	0.90
Medical Center at Princeton	1.17	1.26	0.93	0.94
Atlantic Medical Center	1.11	1.12	0.97	0.89

Source: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

⁴⁴ See, for example, David U. Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler "Illness And Injury As Contributors To Bankruptcy," *Health Affairs* Web Exclusive, February 2, 2005, available on website http://content.healthaffairs.org/cgi/search?ck=nck&andorexactfull-text=and&resourcetype=1&disp_type=&author1=Elizabeth+Warren&fulltext=&pubdate_year=&volume=&firstpage= .

So far the medical profession everywhere in the United States has not risen to this challenge and preferred largely to ignore the Wennberg Variations. Physicians argue that they are accountable only to their patients but should not be asked to worry in their work about the overall health care budgets of governments, health insurers or employers. A case can therefore be made that these large payers must take the lead in developing an information infrastructure that can hold physicians more fully accountable for the use of health care resources authorized by them. Since neither employers nor the private health insurance industry has stepped up to that task, a good case can be made for government to do so, on behalf of taxpayers who now shoulder roughly half of all health care spending in the United States.

Recommendation

As part of its work, the Commission had a presentation on software capable of tracking the order entries of every physician for every medical case by type of service or supply ordered in a hospital. The Commission recommends that the State, in cooperation with leaders of the hospital industry and the medical profession, explore the availability of such software from sundry sources and its adaptability to New Jersey hospitals, with the aim of enabling every hospital to track, for every physician affiliated with the hospital, the average cost per well-identified inpatient case by severity-adjusted DRG (it being understood that exceptions must be made for so-called non-standard “outlier” cases.) If such an information infrastructure is feasible, all New Jersey hospitals should be required to use it, and financial assistance of hospitals by the State should be made contingent on the submission of such information to the State.

Affiliated Physicians as the Hospital’s Competitors:

As noted above, a hospital’s affiliated physicians can establish competing imaging centers, ambulatory surgery centers and, in many parts of the country, surgical specialty hospitals. These competing facilities may be only a stone’s throw away from the hospital that grants their physician owners the privilege of using the hospital as a free workshop.

In principle, there is much to be said for subjecting each and every provider of health care to competition, and ambulatory care centers and physician-owned specialty hospitals do so as far as hospitals are concerned. If properly and fairly structured, such competition can keep all providers of health care on their toes in their quest to deliver high quality, customer-friendly and price-competitive health care. The leaders of ambulatory care and imaging centers, and of specialty hospitals, make the case that this is precisely what they are doing. They argue that their services are more customer-friendly than is the delivery of similar, hospital-based services and that, moreover, they charge less for their services than hospitals charge for the same services.

Table 6.2 supports that contention. The table shows the average payment in 2007, averaged over all commercial insurance products (i.e., excluding Medicare Advantage and Medicaid), one large New Jersey health insurer made to physicians and facilities for hospital- and ASC-based colonoscopies. Although the insurer pays physicians in the ASC setting more for the procedure than is paid physicians in the hospital setting, the savings on payments for the facility are such that the total cost of the procedure to the insurer is considerably lower for ASC-based than for hospital-based colonoscopies. This overall price differential gives insurers a strong incentive to favor ASCs over hospitals in the performance of the procedure, an incentive that could be mitigated if hospitals priced colonoscopies more competitively.

As is shown in Table 6.3, there is considerable variance around the averages presented in Table 6.2. The high facility payment and the wide range of hospital payments is particularly remarkable. These variances about the averages inevitably open a generalization based on averages to counter-arguments with appeal to

particular anecdotes – e.g., that Hospital A's total payment are lower than ASC X's total payments. But the general thrust of the assertion based on Table 6.2 nevertheless appears valid, namely, that on average ASCs tend to be cheaper in the delivery of colonoscopies.

Table 6.2:
A Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers

Insurer's Average Payment	In-Network
Physician component	\$194
Hospital facility payment	\$1,516
Insurer's total payment for hospital-based colonoscopy	\$1,710
Physician component	\$393
Ambulatory Surgery Center payment	\$612
Insurer's total payment for ASC-based colonoscopy	\$1,005

Notes:

- * Colonoscopy procedure codes used in this study are 45378 - 45392 & 45355
- * Cost per procedure is calculated based as the weighted average mean
- * Incurred claims date between 1/1/07 and 10/31/07 for all product lines.
- * Physician reimbursements at the Hospital is reduced by the site of service reduction.

Table 6.3:
Large New Jersey Insurer's Payment for Colonoscopies Performed in Hospitals and Ambulatory Surgical Centers – Minimum Cost Per Procedure versus Maximum Cost Per Procedure

Cost per Colonoscopy	In-Network Minimum to Maximum Range
Physician	\$178 to \$431
Hospital	\$716 to \$3,717
ASC	\$443 to \$1,395

For their part, however, hospital executives complain that, given the autonomy they enjoy, hospital-affiliated physician owners of ambulatory care centers tend to allow physicians to direct relatively less problematic and more profitable patients to their own establishments and relatively more problematic and less profitable patients to the hospitals with whom they are affiliated. The higher payments to physicians in the ASC setting provide physicians with additional incentives to refer patients to ASCs. Of course, those are precisely the economic signals one should expect under the rationale of a market-based health system, if these higher payments to physicians in the ASC setting yield the insurer (and the insured) overall savings on colonoscopies and similar procedures.

Furthermore, argue hospital leaders, the ambulatory care centers are not subjected to nearly the same rigorous regulations imposed on hospitals. Finally, they argue that this arrangement allows physicians over time to siphon off from the hospitals' services – with relatively higher profit margins – what hospitals would otherwise use to finance the uncompensated or underpaid healthcare they are required to deliver to uninsured or Medicaid patients (a requirement not imposed on ambulatory care centers).

In principle, a hospital could, of course, use economic credentialing to combat the growth of competition from ambulatory care centers. Under economic credentialing, physicians known to use hospital resources excessively or to divert profitable patients to their own ambulatory care centers would be denied hospital privileges. In practice, the admissions decisions of affiliated physicians are the main source of a hospital's revenue, which makes controlling the economic behavior of affiliated physicians a highly delicate issue. Furthermore, such economic credentialing would be bound to be challenged in court.

The time and resources available to the Commission did not permit it to delve into this complex issue in the depth it warrants. Some recommendations on it will be offered in other chapters. They pertain mainly to some regulatory measures, including quality assurance. A lingering and unresolved question is whether the presence of ambulatory care centers as competitors of hospitals saves society money overall and, if so, how much. A related question is whether the services

provided by ambulatory-care centers are of the same quality, including patient safety, than those delivered in a hospital setting. Answers to both questions require a major research study in its own right.

In any event – and this is an important point – were it not for the inadequately compensated services hospitals routinely perform (and in many instances are mandated to perform), the entire issue of competition from ambulatory care centers would not be one of the Commission's concerns in the first place. One could simply accept it as a manifestation of disruptive medical and organizational technologies.

II. The Ownership and Governance of Hospitals

As in most other countries, the bulk of American hospitals are either private not-for-profit institutions or government-owned institutions, e.g., municipal hospitals. Only about 14% of the nations close to 6,000 hospitals are investor-owned, for-profit hospitals, and only about 12% of all beds are in those hospitals. In New Jersey, that percentage is much smaller.

Formally, not-for-profit hospitals are owned by their Trustees who are thought to represent the “community,” where the “community” could be secular, civic, or a religious order. Unlike the boards of for-profit hospitals, who are elected by shareholders, however, the “community” does not elect the board members of not-for-profit hospitals. Instead these boards are “self-perpetuating” in the sense that the boards appoint their own new members, often at the behest of the hospital's chief executive.

In principle, the managers of not-for-profit hospitals owe their owners financial accountability for the resources entrusted to them. That accountability is rendered to the Trustees at their regular board meetings. Unlike for-profit hospitals, which routinely post their annual financial reports and submissions to the U.S. Securities and Exchange Commission (SEC) on their websites, most not-for-profit hospitals do not post analogous documents (e.g., Form 990 submitted to the Internal Revenue Service) on their websites. The public at large, therefore, has little insight into the finances and

economics of the not-for-profit hospitals in their communities.

There appears to be no reason why in this regard not-for-profit hospitals should be spared the full, public disclosure now mandatory for their for-profit counterparts through the Sarbanes-Oxley strictures. In chapter 10 of this report, the Commission explores the issue of governance in some depth and makes a number of recommendations on mandatory disclosures by non-profit hospitals, including the posting on the hospital's website of the financial reports and Form 990 filings for the prior three years.

As a rule, the Trustees serving on the boards of not-for-profit hospitals are not compensated for their services, which require considerable financial sophistication and much time, if the trustees are to conscientiously fulfill their fiduciary obligations. By contrast, members of the board of for-profit hospitals are typically well-compensated for their services. The lack of compensation for trustees of not-for-profit institutions raises the question why presumably busy and savvy individuals serve on these boards. In many instances they do so because they are also allowed to have business relationships with their institutions. Such conflicts of interest are frowned upon in the for-profit sector.

The question arises as to which arrangement serves the community better: (A) not compensating trustees but allowing them to have economic conflicts of interest or (B) compensating the trustees for their services but interdicting conflicts of interest (or making them highly visible to the community). More on this issue will be said further on, in the chapter on Governance (see Chapter 10).

III. The Cost Structure of Hospitals

Students in economics learn that every economic enterprise has fixed, variable and incremental (or "marginal") costs.

Fixed, Variable and Incremental Costs: *Fixed costs* do not vary at all with the volume of goods or services produced by the enterprise in a given period. They include buildings and equipment, once in place, the salaries of upper and middle management, and the many other costs that must be incurred whether or not there is any productive activity in a period.

Variable costs do vary systematically with the volume of output. One thinks here of the labor directly involved in producing the goods or services, the energy, raw materials and other supplies used up in production and directly identifiable with units of production, and so on.

By *incremental* (marginal) costs, economists have in mind the extra cost that would be incurred to produce one more unit of output.

In the case of a hospital, we can think about it as follows:

- On any given day, with some fully staffed but empty beds available, most of the hospital's costs are fixed. The added incremental cost of admitting one more patient therefore is very low. They consist solely of the food eaten by the patient, the supplies used in treating her or him, the cost of washing the linen and other items used by that patient, and so on. Economists call this the short run. In the *short run*, even most labor costs in a hospital are fixed.
- The breakdown between fixed and variable costs is different when a hospital considers whether or not to staff licensed beds that are empty and not yet staffed. It might decide to do so to admit a slightly elevated patient flow day in day out. Economists would call this the intermediate run. Here the *intermediate-run incremental cost* per new patient (the total new cost from staffing the beds, plus the cost of occupancy if these beds are filled, all averaged over the added, more or less permanent new patient flow) would be higher than the *short-run incremental costs*, because now the cost of added labor and yet other added items must be considered variable.

- At the extreme, at the blueprint stage, before a hospital is being built, all costs are, of course, variable. Economists call this the long run. In the long run, there are no fixed costs.

The Arbitrariness of “Fully Allocated” Unit Costs:

When an enterprise seeks to calculate the full unit cost of particular units of output, it should be able to determine reasonably well the costs of inputs whose use vary directly with the volume of production. The problem is how to assign the enterprises fixed overhead costs that, by definition, do not vary with the volume of output to each unit of output to obtain what is known as “fully allocated unit costs.”

To accomplish that task, cost accountants use a variety of different methods – e.g., direct cost allocations, step-down allocations, or reciprocal allocations – that have the appearance of scientific exactness, but, in the end, all of them are inherently arbitrary. This arbitrariness of overhead allocation, for example, offers a hospital cost-accountant considerable leeway in allocating fixed overhead costs to particular service lines and thence to particular units of service. A good example is the cost of non-emergent care procured at the emergency departments of hospitals.

In principle, the actual incremental cost borne by the hospital for a non-emergent visit to its emergency room should be quite low when that emergency room is not fully preoccupied by emergencies at the time.⁴⁵ Emergency rooms do, after all, have the ability to shift non-emergent cases to such time periods. Yet the prices hospitals charge for the non-emergent use of emergency departments tend to be extraordinarily high, with the rationale that the cost of such care is extraordinarily high. It typically is not. Rather, the high mark-ups on non-emergent uses of the emergency room are then justified on the basis of arbitrarily high, fully allocated costs with the thought that the demand for emergency room care tends to be price insensitive, as surely it is for true emergencies.

A hospital’s emergency department is not different from a community’s fire department and it should be financed analogously. All members of the community derive peace of mind from knowing that a hospital emergency department is nearby in case of a true emergency. The community should pay for that piece of mind with an annual budget to cover the full cost of the emergency department, including enough slack, whether or not it is fully used for emergencies. Any use of the facility in non-emergency downtimes for non-emergent care should then be priced closer to incremental costs. Providing such care in downtimes at those low prices would be highly efficient from a strictly social perspective. That this pricing policy is rarely ever used reflects tradition and practicality, rather than sound economic reasoning.

With these somewhat pedantic preliminaries, we can now consider the relationship between a hospital’s cost structure and pricing policies.

Cost Structure, Product Pricing and Solvency: In a price-competitive product market, the cost structure of enterprises has important implications on pricing of services as well as upon solvency over the long run. At issue here is the so-called “operating leverage” of the enterprise, that is, the relationship between its fixed and incremental costs (also called “marginal costs”) in any given period of time. It is distinct from the firm’s “financial leverage,” which refers to the fraction of total assets that are financed with debt. As far as their effect on the volatility of the firm’s annual net income is concerned, these two forms of leverage amplify one another.

Hotels and airlines, for example, have very high operating leverage. In an airline, the incremental (marginal) cost per passenger on any given day on any given plane with empty seats is virtually zero. It explains why, under fierce price competition and in the short run, most airlines are willing to take on added passengers at virtually any price above zero. A similar policy is used in the hotel industry. The argument is that in the short run, with fixed capacity paid for, any price above zero is pure gravy, so to speak, which means that it is a contribution to the recovery of the airline’s fixed overhead costs (or, the airlines hopes, to profits). This pricing principle applies to all enterprises with high operating leverage and tends to be applied by them unless it is prohibited by

⁴⁵ See, for example, Robert M. Williams, “The Cost of Visits to Emergency Departments,” *The New England Journal of Medicine* (March 7, 1996) 334(10): 642-46; available at the website http://content.nejm.org/cgi/content/abstract/334/10/642?ijkey=f4ae7574a2547465389e85f65013d4b6a2a7c3c1&keytype2=tf_ipsecsha

regulation, or if customers can resell the product, in which case arbitrage would drive the industry toward a single-price regime.

Because airplanes can easily be leased and added to the fleet, however, even the *intermediate* incremental costs of added passengers in an airline tend to be low relative to the airline's fixed costs, which consist of the cost of maintaining hubs at various locations, headquarters, booking systems, repair facilities, and so on. In the *intermediate* run, airlines will add to their fleet only if those avoidable costs are more than covered by the prospect of added revenue, but they may still price their services below fully allocated variable and fixed costs per trip, leaving some fixed costs unrecovered.

All of which can explain why, under the fierce, cut-throat competition typical of the airline industry, they struggle to earn a profit even with planes crammed full of passengers. The airlines try to solve their problem through various co-marketing schemes – really attempts to gain monopolistic power -- and also through judicious price discrimination (the airlines prefer to call it “value pricing”) under which the same trip is sold to different customers at vastly different prices, and customers are not allowed to resell airline tickets to others.

It is worthwhile to dwell a bit on the airline industry, because its cost structure resembles in some respects that of the hospital industry in which price discrimination is rampant as well, and in which fixed-cost recovery can be problematic in markets that are over-bedded or subject to effective price competition from payers. This observation leads us directly to a consideration of pricing policies in the American hospital industry, but before doing so, it may be helpful to add a word in passing on the “cost” of charitable and otherwise uncompensated health care rendered by hospitals.

The Cost of Uncompensated Care: The preceding analysis of hospital costs also bears on the calculation of the costs hospitals incur for health care for which they are not directly compensated. There tends to be much confusion on this point, particularly because many observers do not have an intimate knowledge of *cost accounting* and *financial accounting*.

To illustrate, when hospitals proudly boast in the media that they have separated this or that pair of Siamese twins free of charge, and “at a cost of several million dollars,” the laity is made to believe that the “several million dollars” represents true costs that the hospital had to absorb, that is, for which it had to write checks. In fact, those amounts almost always represent merely the hospital's total *charges*, at charge-master levels. A hospital's “charge master,” to be described more fully further on, is merely a set of list prices that the hospital would have billed for that care to a very wealthy individual, but normally would never have collected from ordinary, self-paying or insured patients. For many hospitals, charge-master list prices for particular items can be multiples anywhere from 2 to 6 times their actual cost to the hospital. It follows that hospital bills issued at full charges tell one nothing whatsoever of hospital costs.

In the audited annual financial reports of for-profit hospitals – and probably of most not-for-profit hospitals as well – the cost of outright charity care, for which no bill was issued, is not identified as such and merely scattered among sundry line items such as “personnel,” “supplies,” etc. Estimates of uncollected accounts receivables (also called “bad debt expense”), on the other hand, are reported as the differences between the charges originally billed to patients and what is expected actually to be collected from them. Because it is based on charges, that measure, too, tells one nothing at all about the true cost of the underlying care. A more appropriate name for this expense item on the hospital's income statement would be “*charges that no reasonable person would expect ever to collect – and should never have been billed in the first place – minus what is likely to be collected with considerable effort at collection.*” The magnitude of that item varies with (a) the height of the “charges” billed to patients and (b) the collection effort made to collect these charges. For the world of for-profit hospitals, the metric has caused enormous confusion among financial analysts and in the financial press.

But even if one is interested only in the *true cost* to the hospital of providing care on an uncompensated basis, matters are not simple. At least three distinct cost measures suggest themselves:

1. **Fully allocated costs**, that is the average cost of the care patients received, including all variable and all allocated fixed overhead costs;
2. **Intermediate-run incremental costs**, assuming there will always be a steady flow of patients receiving care on an charitable basis or otherwise “uncompensated” basis;
3. **Short run incremental costs** for the occasional, specifically identified patient receiving care.

If hospitals were paid by particular patients anything more than short-run incremental costs, they would not actually lose money on those patients (unless these patients occupied beds that could otherwise have been filled with a patient paying more), but would not earn much of a contribution to overhead and profits.

Much the same can be said for situations in which payments exceed intermediate incremental costs for a steady flow of patients paying less than full costs.

In the long run, however, hospitals can remain solvent only if they are paid fully allocated costs for every patient, or if some patients pay sufficiently more than the fully allocated cost of their care to cover the shortfall of payments from fully allocated costs of other patients.

IV. The Prices Paid Hospitals for their Services

In a broadcast in October 1939, in an entirely different context, Sir Winston Churchill famously remarked: “I cannot forecast to you the action of Russia. It is a riddle, wrapped in a mystery, inside an enigma.”

Churchill undoubtedly would say the same, were he alive and asked to describe how American hospitals bill and ultimately are paid for their services.⁴⁶ It almost defies description.

A. The Variation of Prices across Hospitals and Payers

Table 6.4 below presents the payments one larger health insurer makes to a select number of hospitals for four standard medical cases treated on an inpatient basis.

Table 6.4:
Payments by a N.J. Insurer to Various Hospitals for Four Standards Services, 2007⁴⁷

	Normal Delivery ¹	CABG ²	Appendectomy ³	Hip Replacement ⁴
Hospital A	\$2,178	\$26,342	\$2,708	\$3,330
Hospital B	\$2,787	\$32,127	\$2,852	\$3,444
Hospital C	\$2,906	\$34,277	\$3,320	\$4,200
Hospital D	\$3,187	\$36,792	\$3,412	\$4,230
Hospital E	\$3,276	\$37,019	\$3,524	\$5,028
Hospital F	\$3,629	\$45,343	\$4,230	\$5,787

¹ Mother only, case rate.

² Coronary Bypass with Cardiac Catheterization (DRG 547), tertiary hospitals only.

³ Surgical per diem (DRG 167) with average length of stay of 2 days

⁴ Surgical per diem for Total Hip replacement, average length of stay 3 days.

⁴⁶ For a taste, readers are invited to consult Uwe E. Reinhardt, “The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy,” *Health Affairs* 25(1) January/February, 2006: 57-69.

⁴⁷ Rates represent managed care insurance policies.

The payment rates for the same service vary among the selected New Jersey hospitals by a factor of almost two. This variation of payment rates by the same insurer to different hospitals exists over the entire range of services rendered by hospitals. Furthermore, a given hospital will be paid quite different amounts for the same services by different private insurers, by Medicaid, by Medicare and by the uninsured, self-paying patients. There really does not exist one price for a given hospital service in New Jersey – not for a given insurer, nor for a given hospital.

This variation of hospital prices for given hospitals and for given insurers is even wider in other parts of the United States. Table 6.5, for example, shows payment rates by one large California insurer to different hospitals in California. Once again, a given California hospital will receive substantially different amounts from different payers for the same standard service.

Few citizens understand what drives these enormous variations in hospital prices. Indeed, it would be an amusing exercise to ask anyone serving on the board of a hospital to describe how that hospital bills customers for its services.

To understand why even a well-managed hospital can be pushed to bankruptcy under this payment system, and also to develop some healthy skepticism on the much touted idea of “consumer-driven health care” that would have patients shop among competing hospitals for cost-effective health care, it may be well to describe this payment system in a bit more detail.

B. The Hospital’s Charge Master

Every hospital maintains what is called in the trade a “charge master.” This is a very extensive and excruciatingly detailed list of prices that are merely “list prices,” which few payers actually pay. In California, where hospitals must make their charge masters publicly available under the law, that list of prices extends to close to 20,000 distinct services and supply-items. Figure 6.1 below shows a tiny excerpt from the model charge master for hospitals published on a website of the State of California.

Table 6.5:
Payments by One California Insurer to Various Hospitals, 2007 (Wage Adjusted)

	Appendectomy¹	CABG²
Hospital A	\$1,800	\$33,000
Hospital B	\$2,900	\$54,600
Hospital C	\$4,700	\$64,500
Hospital D	\$9,500	\$72,300
Hospital E	\$13,700	\$99,800

¹ Cost per case (DRG 167)

² Coronary Bypass with Cardiac Catheterization (DRG 107); tertiary hospitals only.

Figure 6.1:
Excerpt from California's Master Charge Master for Hospitals, 2005

3043442	CATH MARIORRAN	510.00
3043445	CATH MRI SINGLE	1,642.00
3043446	CATH MRI DUAL	2,181.00
3043448	CATH PERITONEAL TENCHOFF	396.00
3043449	CATH PORTA CATH ARTERIAL	2,842.00
3043450	CATH PORTA CATH INTRO 9FR	198.00
3043451	CATH PORTA CATH PERIT	1,878.00
3043452	CATH PORTA CATH TITANIUM	2,875.00
3043453	CATH PORTA CATH VENOUS A	2,842.00
3043454	CATH PORTA CATH VENOUS B	1,416.00
3043455	CATH ROUND 6FR	76.00
3043456	CATH TPN	99.00
3043459	CLIP APPLIER	420.00
3043462	CLIP WECK	180.00

Each hospital maintains and updates its own charge master when and as it sees fit. The charge masters of different hospitals are not strictly comparable, because they may not follow a common nomenclature and because specific items may be updated by hospitals at different intervals. As William McGowan, CFO of University of California Davis Health System, a 30-year veteran of hospital financing, was quoted in *The Wall*

Street Journal of December 27, 2004 on this practice: "There is no method to this madness. As we went through the years, we had these cockamamie formulas. We multiplied our costs to set our charges."

Not surprisingly, the price for a particular item in these charge masters can vary enormously among hospitals, as is shown in Figure 6.2 for California.

Figure 6.2:
List Pries for Various Services in California Hospitals, 2005

How Much Is That Chest X-Ray?							
A new California law allows patients to look up the retail prices of many goods and services at hospitals. A survey of several hospital price lists shows dramatic differences in price.							
	SCRIPPS MEMORIAL LA JOLLA, San Diego	SUTTER GENERAL, Sacramento	UC DAVIS, Sacramento	SAN FRANCISCO GENERAL, San Francisco	DOCTORS, Modesto	CEDARS-SINAI, Los Angeles	WEST HILLS HOSPITAL, West Hills
Chest X-ray (two views, basic)	\$120.90	\$790	\$451.50	\$120	\$1,519	\$412.90	\$396.77
Complete blood count	\$47	\$234	\$166	\$50	\$547.30	\$165.80	\$172.42
Comprehensive metabolic panel	\$196.60	\$743	\$451**	\$97	\$1,732.95	\$576	\$387.18
CT-scan, head/brain (without contrast)	\$881.90	\$2,807	\$2,868	\$950	\$6,599	\$4,037.61	\$2,474.95
Percocet* (or Oxycodone hydrochloride and acetaminophen) one tablet, 5-325 mg	\$11.44	\$26.79	\$15	\$6.68	\$35.50	\$6.50	\$27.86
Tylenol* (or acetaminophen) one tablet, 325 mg	\$7.06	No charge	\$1	\$5.50	No charge	12 cents	\$3.28
*Hospitals carry either generic version, brand name, or both. **Represents the added total of 14 tests that make up the comprehensive metabolic panel Sources: Scripps Memorial La Jolla; Sutter General; UC Davis Health System; San Francisco General; Doctors Medical Center, Cedars-Sinai Health System; West Hills Hospital and Medical Center							

Source: Lucette Lagnado, "California Hospitals Open Books, Showing Huge Price Differences," *The Wall Street Journal*, December 27, 2004: A1.

As already noted, however, only a few payers still pay hospitals their full list prices. They include worker's compensation insurers, motor vehicle insurers or small insurance carriers with little bargaining power vis a vis hospitals. They also may include self-paying patients with little market clout. Among the latter may be well-to-do patients or uninsured Americans not poor enough to qualify for outright charity care. Many of these uninsured Americans struggle to pay these highly inflated hospital charges. As *Business Week* reported in its issue of December 3, 2007, to add insult to injury these patients may find their huge hospital bills factored to finance companies that charge them very high interest rates (between 10% to 30% per year) on unpaid balances and use harsh collection techniques. It is one of the dark corners of the American hospital system.⁴⁸ How commonly the uninsured in New Jersey are billed these inflated charges and what collection techniques are practiced by New Jersey hospitals are not well known, but they ought to be routinely monitored by state government.

Although charge masters are price lists, and most enterprises in the rest of the economy post at least their price lists electronically, as a general rule hospitals do not release their price list to the public, either in print or electronically on their websites. Hospitals may justify this opaqueness on the ground that so few patients actually are billed at charges. Even so, because at least some patients may be exposed to these prices and they form the basis for price discounts offered to payers, the Commission offers in Chapter 10 of this report the following recommendation reproduced below.

Recommendation

All New Jersey hospitals should be required to post their charge masters on their websites, along with their sliding scales of prices for uninsured New Jersey residents.

⁴⁸ Brian Grow and Robert Berner, "Fresh Pain for the Uninsured," *Business Week*, December 3rd, 2007. See http://www.businessweek.com/bwdaily/dnflash/content/nov2007/db20071120_397008.htm?chan=top+news_top+news+index_top+story.

C. Different Bases for Hospital Payments

As noted, the prices in a hospital's charge master are not actually relevant to all patients, because fee-for-service payment is only one of several alternative bases on which hospitals are paid. The most commonly used bases for hospital pricing are the following:

- *Fee-for-service (FFS)*, either at 100% of the charge master prices or at various discounts off the charge master (up to 40% to 50%), for literally thousands of distinct services or supplies;
- *Payments per day (per diem)* of an inpatient stay, often tiered by the average complexity of cases (e.g., a different per diem for cardiac cases than for other medical cases or for gynecology);
- *Prospective payment per medical case* (e.g., the Diagnosis Related Groupings (DRG) of distinct cases developed and used nationwide by Medicare since 1983, and first tried in New Jersey during the 1970s);
- *Retrospective full-cost reimbursement*, even for per-diem- or per-case payments in cases of unusual complexity;
- *Bundles of services* rendered patients in hospital outpatient settings, classified according to the Ambulatory Payment Classification (APC) system developed by Medicare.

Thus, every hospital must cope with a Byzantine mélange of different bases and different payment rates per base on which they are paid for a given service by various payers, and for different insurance products for any given commercial insurer (e.g., Horizon Blue Cross Blue Shield of New Jersey's HMO, Preferred Provider (PPO), Point of Service (POS) and so on).

Private Insurers: It is worth emphasizing that every private insurance carrier negotiates discounts off the charge master and the per-diem or case-based rates for its various insurance products separately with each hospital or hospital system in the relevant market area, which helps explain the large variation in actual hospital payments for particular services or cases across hospitals and insurance carriers. Insurers with relatively larger shares of a hospital's patients usually arrive at

lower payment rates with that hospital than can smaller insurers with lower market shares. Negotiating these myriad deals is a highly labor-intensive and administratively expensive process.

Medicare: From the Medicare program hospitals receive case-based payments that are set nationwide, with some local adjustment for differences in labor and other costs. For inpatient care these payments are based on the diagnostically-related-grouping (DRG) method, which was first applied in practice in the State of New Jersey on an experimental basis and, from 1983-86, was introduced by Medicare nationwide. For outpatient hospital services Medicare now pays hospitals on a case-based method, the Ambulatory Payment Classification (APC) groupings.

Medicaid: Finally, the traditional, state-administered Medicaid program pays hospitals on a DRG basis as well, although these are not at the same monetary level as Medicare's DRGs. When Medicaid contracts with commercial Medicaid Managed Care companies on a flat annual capitation per insured, these companies typically pay hospitals on the basis of negotiated per diems, although other payment methods may be employed as well.

D. Varying Profit Margins by Service

Although, as noted, every hospital receives a great variety of different payments for a given service or medical case, on average the payments hospitals receive embody vastly different profit margins, which is true even of the case-based prices (DRG rates) paid by Medicare. Some service lines maintained by hospitals are known to be money losers, especially when they are heavily used by uninsured patients. Other service lines – e.g., cardiac surgery, orthopedic surgery, some procedural lines such as imaging or colonoscopies – tend to be highly profitable. As noted elsewhere in this report, for example, hospitals without surgery as a service line are much more likely to be in financial distress than are full-service hospitals.

The traditional posture on these variations of profit margins had been that they mattered little as long as the profits from the profitable product lines could be used by hospitals to subsidize money-losing services. This

system of hidden cross subsidies, however, becomes unraveled when physicians are allowed to invest in and establish competing enterprises in the more profitable product lines, thereby siphoning off the hidden cross subsidies with which hospitals had traditionally covered their money losing activities, including mandated charity, otherwise uncompensated care or potentially money losing services.

There is something awry in an ostensible “market system” in which some enterprises are saddled by government with unfunded mandates while their competitors are not so encumbered. How would the hotel industry operate if some hotels were mandated by government to house the homeless free of charge while competing hotels are not so encumbered? It is a problem in the hospital industry that New Jersey and, indeed, the entire United States, has yet to solve satisfactorily.

E. Lack of Transparency of Hospital Prices

With the exception of the payment rates made by government payers, the prices paid to hospitals by the various private insurance carriers are closely held trade secrets. A hospital’s pricing policies therefore lack any transparency whatsoever. Very few sectors in the economy enjoy a similar lack of transparency of the prices they charge or of the cost they incur.

Many health policy analysts and political candidates now talk bravely of so-called “Consumer Directed Health Care” (CDHC) by which they mean health insurance policies with annual deductibles or coinsurance of up to \$10,500 per family, coupled with tax-favored health savings accounts (HSAs). The theory is that, faced with these high out-of-pocket expenditures for their own health care, prospective patients will shop around carefully for cost-effective health care.

An irony is that none of these proponents of consumer-shopping in health care appear ever to have given a thought to how a hospital’s prices are to be revealed to these putatively prudent shoppers for health care. Given the current chaos and the secrecy surround hospital pricing, so-called CDHC in effect envisages the analogue of blindfolded individuals pushed into department stores there to shop prudently. The lack of transparency in hospital pricing makes a mockery of the very term “consumer directed.”

F. Is Price Discrimination Worth its Complexity?

It may be noted in passing that no other country pays its hospitals in the utterly confusing manner now passively accepted by Americans, nor does any hospital in any other country employ anywhere near the large number of billing clerks employed and paid by American hospitals, not even to speak of the ever growing industry of expensive consulting firms specializing in helping physicians and hospitals bill for their services. And even with these large and costly billing staffs and consultants, the U.S. approach is possible only with the help of large computer systems, which help hospitals and other providers of health care cope with the confusion but, at the same time, also enable ever more billing complexity being heaped upon the providers of health care.

It is a payment system in which the payments received by hospitals have never, so far, reflected either the cost of services or their quality, but merely the relative market moxy of hospitals and of payers. Small wonder, then, that individual uninsured patients often are charged the highest prices. As Michael E. Porter and Elizabeth Olmsted Teisberg, both well-known business school professors, sagely observe in their *Redefining Health Care*,

“The current system has resulted in pervasive price discrimination, in which different patients pay widely different charges for the same treatment, with no economic justification in terms of cost. The administrative cost of dealing with multiple prices adds cost with no value benefit. The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages that individual system participants can gain from it.”⁴⁹

In making their recommendation, Porter and Teisberg are thinking of a futuristic health system that will have decomposed the current U.S. health system into a myriad of distinct mini-enterprises, each arrayed around one definable type of medical episode of finite duration or around treating one particular chronic disease. The idea then is that each of these mini-enterprises would be free to quote one lump-sum fee for the entire episode (or,

⁴⁹ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care*, Harvard Business School Press, 2006: 65-66.

presumably, per year for chronic conditions) and charge that fee to all payers. This vision, however, is highly utopian and may never become reality except for a few well defined conditions for which services can easily be bundled by episode. In the meantime, one would need to think about all-payer systems applied to the existing U.S. health system. Here two prototypical all-payer systems suggest themselves:

1. **A Price-Competitive, Hospital-Specific All-payer System:**

All New Jersey hospitals could be mandated to adopt a common Relative Value Scale (RVS), based on DRG case payments as a basis for inpatient care and APC payments for ambulatory care. Each hospital would be free to set its own monetary conversion factor to the base units in the common RVS to convert it into a hospital specific fee schedule that would be applied to all payers without payer-specific discounts (except uninsured New Jersey residents, who would never be charged more than the all-payer rates but might receive sliding-scale discounts based on ability to pay). Unless specific waivers were granted, Medicare and Medicaid patients presumably would remain outside this hospital-specific all-payer system. All hospitals would have to post their monetary conversion factor on their websites and also reveal it to patients telephonically or in person upon request. To make price competition among hospitals most effective, insurance carriers could adopt various stratagems to steer their insured to lower-priced hospitals. One approach, for example, would be to adopt the analogy of reference pricing for prescription drugs, that is, reimburse patients more or less fully for lower-priced hospitals in a market area and force them to pay out-of-pocket the full difference between that “reference reimbursement price” and what the hospital actually charges.⁵⁰

2. **A Statewide All-Payer System:** An alternative would be a public-utility model, perhaps through reverting to the statewide rate-setting facilitated by Congress in 1972 in Section 222 of the Social Security Amendment and introduced during the 1970s and early 1980s in many states, including

New Jersey, only to be abandoned in one state after the other during the 1980s, after President Reagan was elected in 1980 and initiated his “pro-competitive” strategy. Today only Maryland still operates such a system. Under that approach, the Governor’s office would establish a Health Services Cost Review Commission that would set DRG- or ACP-based hospital prices based on detailed cost analyses. All hospitals would charge these prices to all payers – certainly all private payers – once again with the exception of uninsured New Jersey residents who might be offered sliding scale discounts on the basis of ability to pay.⁵¹

It may be noted in passing that in oral testimony before the Commissioners representatives of the hospital industry hearkened back with evident nostalgia to the “good old days,” when the state’s hospitals were subject to rate regulation, although neither they nor anyone else coming before the Commission formally advocated reverting to that system.

Clearly, any move away from the present, highly price-discriminatory system of hospital pricing toward a more uniform all-payer system would be a major health reform. Such a move should be made only after careful study of the full implications of the move for the cost-effectiveness and quality of health care in New Jersey and for the financial condition of hospitals. Probably for that reason, the Governor’s Executive Order 39 establishing this Commission did not include a review of this highly complex issue in the Commission’s purview. Although the Commission took cognizance of this facet of health care and comments on its implications for the financial conditions of New Jersey hospitals throughout its report, for purposes of this study it considered the matter as something akin to a state of nature – like New Jersey’s climate – and therefore offers no formal recommendation on it. Unlike New Jersey’s climate, however, the manner in which New Jersey hospitals are paid is a facet that New Jersey’s government could change, if it so chooses.

⁵⁰ For more detail, see Uwe E. Reinhardt, “The Pricing Of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy,” *Health Affairs*, January/February 2006; 25(1): 57-69.

⁵¹ In Maryland, that rate setting commission has a budget of less than \$ 5million and employs a staff of 28 economists, accountants, statisticians and computer programmers. It is not a huge outlay relative to the State’s total hospital revenues of about \$10 billion. See http://www.ans.gov.br/portal/upload/biblioteca/sem_int_8_1400_RobertMurray_Health_Care_Regulation.pps#639.5, Overview of Maryland Health Regulatory Agencies.

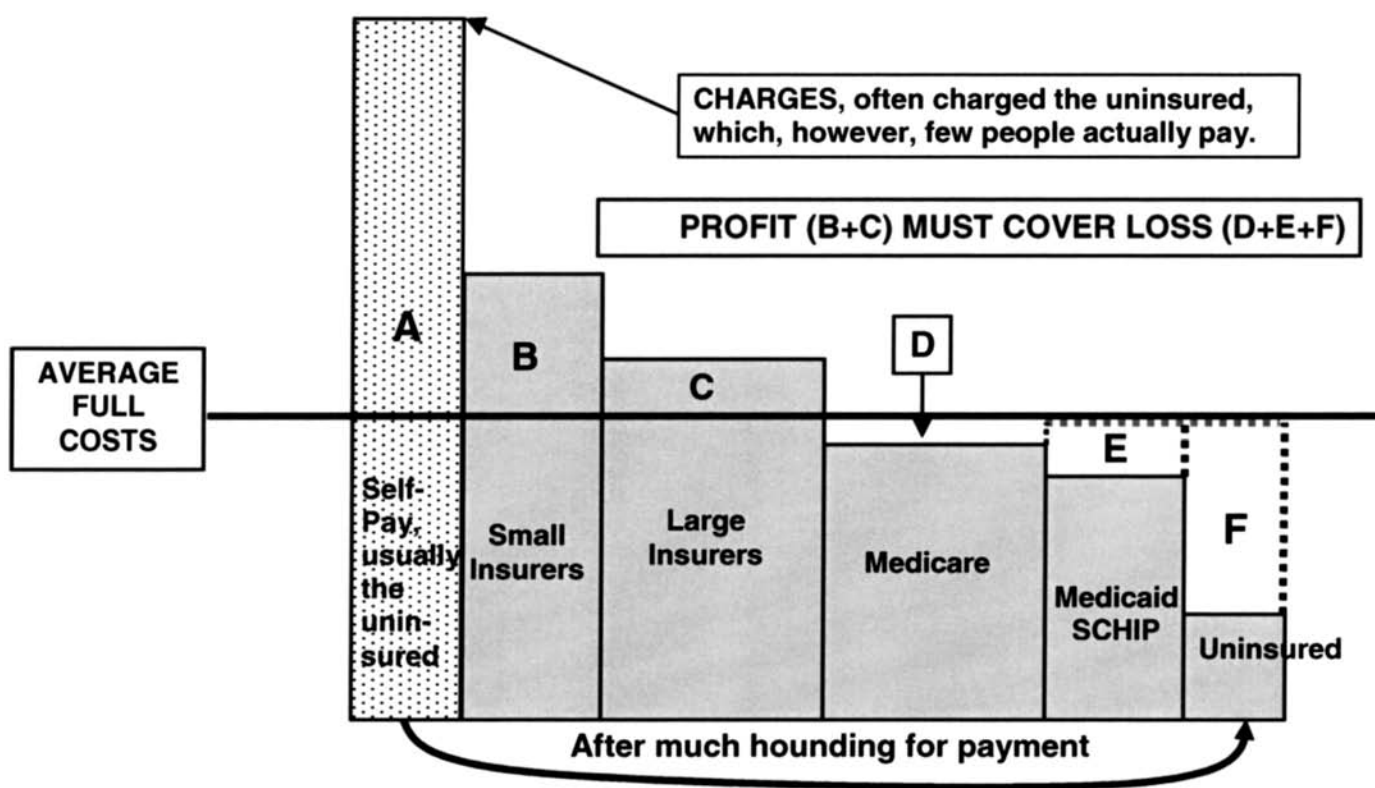
V. How Large is the “Medicaid Shortfall”?

The price discrimination rampant in American health care in effect turns every hospital into the analogue of a hydraulic financial system, such as that sketched out in Figure 6.3 below. Under that system, some payers pay sizeable mark-ups over full costs for the services used by their insured. Government, on the other hand, often chooses to pay less than full cost. The uninsured, although initially charged the highest prices by hospitals, in the end pay much less than the full cost of their services. The system requires the managers of hospitals to recover the payment shortfalls forced on them by the uninsured, by Medicare and by Medicaid, and from other payers who are willing to pay positive mark-ups over the cost of their insured’s services, or who are unable to resist high mark-ups.

By imposing on hospitals at the same time the mandate to provide health care to many critically ill, uninsured patients who cannot pay for these services with their own resources, government effectively requires hospitals to act as *catastrophic insurers of last resort* for the uninsured and then to search for paying customers from whom the cost of that care can be recovered through higher mark-ups over costs. That task is made ever more difficult when government itself elects to pay the hospital less than full cost for services rendered to publicly-insured patients.

In many parts of the country hospitals have, by and large, been able to make this system work, although in so doing they inadvertently have enabled politicians to perpetuate this unseemly approach to hospital financing.⁵² In New Jersey, the approach now threatens to push more and more hospitals to the brink of bankruptcy and closure.

Figure 6.3:
The U.S. Hospital as a Hydraulic Fiscal System

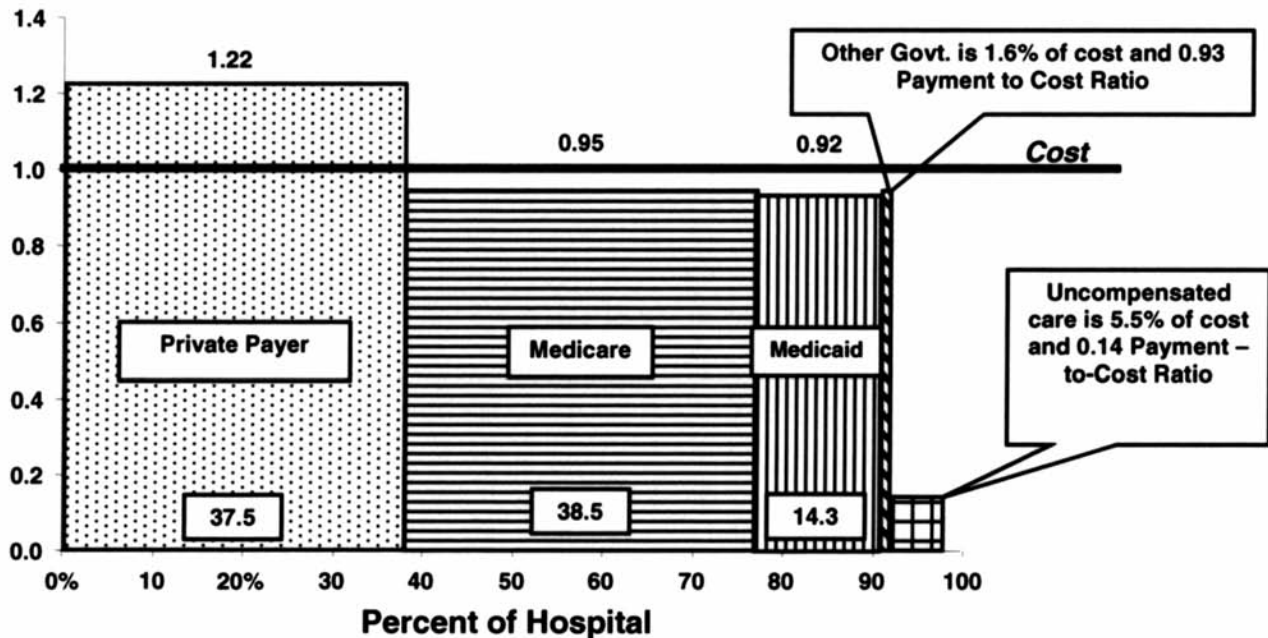


Source: Adapted from a design by Larry Lewin.

⁵² Reinhardt, U.E. “U.S. health care stands Adam Smith on his head.” *British Medical Journal* (November 17, 2007): vol. 335:1020.

Figure 6.4:
The Cost-Shift as a Payment Hydraulic – U.S. Averages, 2004

Payment-to-Cost Ratio



Source: Al Dobson, Joan DaVanzo, Namrata Sen, The Lewin Group, analysis of data presented in the American Hospital Association/ Lewin Group Trendwatch Chartbook 2005.

Figure 6.4 illustrates the hydraulic cost-shift described above with real numbers from the year 2005, albeit for the United States acute-care hospital sector as a whole. The Medicaid shortfall in 2004 was 8% for the nation as a whole.

Does New Jersey's Medicaid program underpay hospitals and, if so, by how much? Unfortunately, the answer is more complicated than may appear at first blush.

In its previously cited report, *New Jersey Acute Care Hospitals Financial Status* (October 3, 2006), the consulting firm Accenture reports that the 2004 Medicaid payment to cost ratio in New Jersey was only about 0.73, up from 0.70 in 2002. In conversations with the Commission, representatives of New Jersey's Medicaid program generally agreed with this finding that DRG payments cover approximately 70% of inpatient hospital costs.

However, the question is more complicated when one considers other payments made to hospitals (other than DRG-based reimbursements). First, outpatient hospital services are reimbursed at cost minus a 5.8% reduction for a majority of services. When inpatient and outpatient rates are combined, Medicaid covers approximately 75-80% of costs.⁵³ Second, thirty-eight New Jersey hospitals receive supplemental payments totaling \$263 million for Graduate Medical Education (\$60M) and for providing certain services to low-income populations through the Hospital Relief Subsidy Fund (HRSF - \$203M). These payments are described in more detail in Chapter 7. When these supplemental payments are added to the nominal payments, some New Jersey hospitals are actually receiving payments and subsidies that approximate the full cost of care. Hospitals that do not qualify for these supplemental funds typically receive considerably less than costs.

⁵³ In February 2007, payment for outpatient mental health services for adults was converted to a fixed fee schedule and are no longer paid at cost.

So, does New Jersey's Medicaid program underpay hospitals? The answer is yes and no and varies by hospital but, as a group, the State does pay hospitals less than it costs to care for Medicaid patients. The magnitude of the shortfall varies by hospital.

The Commission, however, is not certain that the "costs" against which shortfalls are measured are necessarily the cost that would be experienced in a highly efficient hospital. They are the costs reported by hospitals, which may or may not reflect full efficiency. The Commission, therefore, makes the following recommendation:

Recommendation

The Commission recommends that the State should commission a major study by outside expert consultants of the efficiency of all New Jersey hospitals relative to recognized national and regional benchmarks. Such a study should put in place a process of continuous

monitoring of the relative efficiency of all New Jersey hospitals. The results from this monitoring process should be available to the public. Robust data on the relative efficiency of New Jersey hospitals are essential to a yearly hospital-by-hospital assessment of shortfalls in Medicaid payments relative not to actually reported costs, but to efficient costs.

While on the topic of the Medicaid shortfall for hospitals, it may be noted in passing that, according to the Henry J. Kaiser Family Foundation, payment ratios for New Jersey physicians are even lower than those for hospitals, as is shown below. In fact, both in relation to Medicare rates for physicians and in relation to the overall U.S. average for Medicaid rates paid to physicians, New Jersey's overall Medicaid payment rates for physicians now ranks at the very bottom of the nation – a remarkable ranking for one of the richest states in the U.S.

Table 6.6:
New Jersey Medicaid Physician Payment Rates Relative to the Nation, 2003

Clinical Service	NJ Payment Rate as Percentage of National Average
All Services	56%
Primary Care	61%
Obstetric Care	41%
Other Services	65%

Source: www.statehealthfacts.org

Table 6.7:
Physician Medicaid Payment Rates as a Percentage of Medicare Rates, 2003

Clinical Service	Physician Medicaid Reimbursement Rates as a Percentage of Medicare Rates	
	NJ	US
All Services	35%	69%
Primary Care	34%	62%
Obstetric Care	31%	84%
Other Services	43%	73%

Source: www.statehealthfacts.org

Economists teach their students that relative prices signal relative social valuations. New Jersey State legislators must be aware that when they offer to pay, say, a New Jersey pediatrician only \$30 per visit by a poor child covered by Medicaid, while commercial insurers pay \$100 or more for the identical service, physicians are being signaled by these legislators that the physicians' professional work is much less socially valuable if applied to a poor child as it is when applied to a better-off child.

That New Jersey's physicians, and American physicians in general, clearly understand this signal flashed to them by legislators on behalf of the citizenry can be inferred from the fact that so many of them simply refuse to treat Medicaid patients altogether. In this regard, however, the Commission was encouraged by the addition of \$5 million (\$20 million once annualized and matched with federal dollars) to increase Medicaid reimbursement rates for services to children in Governor Corzine's 2008 budget initiative. In Chapter 11 the Commission recommends that payment rates for physicians for Medicaid patients and other state-funded health care services be set at 75% or more of current Medicare rates.

VI. Half-Hearted Markets and Half-Hearted Regulation

A final point to be made in connection with hospital economics is that, when it comes to their health care system, Americans suffer from severe *cognitive dissonance*, a mental condition in which two conflicting thoughts or theories are held at the same time.

On the one hand, Americans are deeply suspicious of their governments and, in particular, of government interference in the private sector. The mantra is that private markets invariably are more efficient and, in general, that government legislators and bureaucrats cannot "walk and chew gum at the same time," as a famous *dictum* goes. On the other hand, however, Americans are also unwilling to accept the harsh verdicts of the market in health care and many other sectors.

Whatever private markets can achieve, they cannot by themselves achieve "fairness." Instead, markets are giant bazaars in which resources flow primarily to those bidders who have the most money to bid. Furthermore, private competitive markets are bazaars in which the quick-witted and better-informed are allowed to exploit the less smart and less well-informed. In this regard, the finance sector is a perfect example of such a bazaar, as legions of desperate homeowners who assumed subprime mortgages that they did not understand and legions of investors who bought derivatives backed by those mortgages that they did not understand either are learning at this time, while others reaped huge windfall gains at the expense of the losers.

New Jersey's health system is a predictable expression of this *cognitive dissonance*.

Citizens pay lip service to the power of markets and price competition. But then they wring their hands in astonishment and despair when hospitals favored by patients with the ability to pay thrive while hospitals with a largely poor clientele, many uninsured and Medicaid patients, for whom reimbursement rates are below full costs, are pushed to the brink of bankruptcy.

Citizens also hold physicians, hospitals and providers of health care to the idea that "all men are created equal" and, therefore, all patients should be treated by the

providers of health care on an egalitarian basis. However, through their legislative representatives, those same citizens pay the providers of health care substantially less for Medicaid patients than they pay for their own families, wringing their hands in disapproval when physicians refuse to treat Medicaid patients altogether.

Hospitals already in place favor health planning through the Certificate of Need (CON) program, which effectively bestows monopoly power on providers protected by it. However, they would look askance at the price regulation that should naturally come with CON. Stuart Altman, Brandeis economist and one of the more astute observers of the American health system, has

aptly described American health policy as “half-hearted competition and half-hearted regulation.” It applies to New Jersey’s health system in force.

Such an amalgam of mutually contradictory theories cannot be expected to produce a “rational” health system. It seems designed to confuse and anger everyone, which can explain why in so many cross-national opinion surveys American respondents rate their nation’s health system much less favorably than do other nationals theirs, in spite of the abundance of resources Americans heap on their health system and the system’s undeniable clinical excellence in so many instances⁵⁴.

⁵⁴ See, for example, Robert J. Blendon, Minah Kim, and John M. Benson, “The Public Versus The World Health Organization On Health System Performance,” *Health Affairs*, May/June 2001; 20(3): 10-20.



Chapter 7: State Funding for New Jersey Hospitals

Key Points

- **Medicaid and Disproportionate Share Payments (DSH) will combine to provide hospitals with nearly \$3 billion in annual payments in State fiscal year 2008 (62% Medicaid service payments, 38% additional subsidies).**
- **New Jersey's ability to tap additional federal funding is limited. The State can only do so by committing additional State funds. Complex federal regulations limit the flexibility of states to consolidate funding streams.**
- **Certain subsidy funds (Hospital Relief Subsidy Fund and Graduate Medical Education fund) should be consolidated into the Medicaid payment rates to ensure optimal distribution and to facilitate appropriate annual increases in funding levels.**
- **A small portion of current subsidies from the Hospital Relief Subsidy Fund should be shifted to the Hospital Relief Subsidy Fund for Mental Health to address shortages of acute and intermediate care mental health beds for community-dwelling individuals.**
- **An ongoing study of the efficiency of all New Jersey hospitals should be commissioned to guide the development of Charity Care and Medicaid payment reforms that would reward efficiency. In addition, the State should move toward a Charity Care payment methodology that is either an insurance or institutional grant model as opposed to the current mixed approach.**

The previous chapter examined the basic economics underlying the hospital market in New Jersey and elsewhere. It highlighted the fact that public payers are generally reimbursing providers at lower rates than private payers and in some cases far below the cost of providing care. This problem is not unique to New Jersey but appears to be more pronounced here with respect to payment levels. This leads to intense efforts on the part of hospitals to shift costs on to other payers.

Public funds flowing to hospitals on behalf of the State represent a complex relationship between New Jersey and the federal government. In nearly all cases, extensive regulatory requirements exist that provide fairly strict regulations on how funding can be distributed. While it is tempting to weigh policy options that could simplify the distribution of public funds,

some changes would threaten the current level of federal matching funds for such programs.

This chapter examines the various sources of public funding for hospitals from the State of New Jersey and makes recommendations intended to improve the returns on investment of those funds.

I. Medicaid Hospital Payments

The Medicaid Program, which consists of 50 distinct state-level programs,⁵⁵ comprises the bulk of states' funding for hospital services. In accordance with broad federal guidelines, each state develops its own administrative structure for its Medicaid program;

⁵⁵ There are six additional Medicaid Programs in the District of Columbia, Puerto Rico, and each United States territory.

establishes its own eligibility criteria; determines the type, amount, duration and scope of covered services and sets provider payment rates. States share the funding for their Medicaid expenditures with the federal government. Under this shared funding arrangement, the federal government matches state expenditures according to a formula based on each state's per capita income, whereby lower income states have higher federal matching rates. In federal fiscal year (FFY) 2008, the federal government's share can range from 50 percent to approximately 76 percent of a state's total Medicaid spending.⁵⁶ Because of New Jersey's relatively high per capita income, its Medicaid federal match rate is equal to the minimum 50 percent.

The State Children's Health Insurance Program (SCHIP) is designed to provide low-cost health insurance coverage to uninsured children who are not eligible for Medicaid

and cannot afford to purchase private coverage. Within broad federal guidelines, each State determines the design of its SCHIP plan, eligibility groups, benefit packages, payment levels for coverage and administrative and operating procedures. New Jersey's SCHIP, known as NJ FamilyCare, is combined with its Medicaid program. The federal government and states share in the funding of SCHIP, but the amount of federal funding is capped at an allotted amount nationwide and by state. States receive an enhanced federal matching rate under the SCHIP, based on their Medicaid matching rate.⁵⁷ For FFY 2007, the SCHIP enhanced rate ranged from 65 percent to approximately 83 percent. New Jersey's SCHIP enhanced rate is 65 percent.

Table 7.1 shows New Jersey's estimated Medicaid (including NJ FamilyCare) payments in 2008 to acute care hospitals, followed by a description and discussion of each type of payment.

Table 7.1:

Estimated Payments to Acute Care Hospitals under New Jersey Medicaid and DSH Programs (SFY 2008)

Type of Payment	Amount (in 000s) ⁵⁸
Medicaid	
Service Payments for Fee-For- Service	\$970,400
Service Payments by Medicaid HMOs	888,900
Graduate Medical Education (GME) Payments	60,000
Supplemental Payments - Hospital Relief Subsidy Payments	183,000
Supplemental Payments – Mental Health Subsidy Payments	20,000
Disproportionate Share Hospital (DSH)	
Charity Care Subsidy Payments	\$715,000
State Agency other than Division of Medical Assistance and Health Services (DMAHS) Contract Payments	153,900
Total Medicaid and DSH Payments to Acute Care Hospitals	\$2,991,200

⁵⁶ National Conference of State Legislatures, "HHS Release FY 2008 FMAP Figures." Available online: <http://www.ncsl.org/statefed/health/FY08FMAP.htm>.

⁵⁷ Legislation passed by Congress to reauthorize SCHIP and increase its funding was vetoed by President Bush on October 3, 2007 because it provided more funding and included higher family income eligibility limits than his proposal. As a temporary measure until compromise

reauthorization legislation is enacted, Congress has passed a continuing resolution that extends current funding levels, but the levels are not sufficient to allow states to maintain coverage for current enrollment.

⁵⁸ **Source:** Expenditure estimates and budget appropriations provided by Division of Medical Assistance and Health Services.

A. Service Payments

For Medicaid recipients in the fee-for-service delivery system, New Jersey's Medicaid Program pays for most inpatient hospital services under a diagnosis-related groupings (DRG) system. The DRG system is designed to group together cases with clinically similar conditions that require similar amounts of hospital resources. New Jersey, like some other states, uses a DRG grouper developed for all patients, not just Medicare patients. New Jersey uses hospital-specific base rates derived from cost reports, with many adjustments, to reflect geographic variation in wages and variations in capital structure. For outpatient services, New Jersey Medicaid pays hospitals on a cost basis less a 5.8 percent discount. The Division of Medical Assistance and Health Services (DMAHS), the agency that administers New Jersey's Medicaid Program, estimates that in State Fiscal Year (SFY) 2008 its service payments to acute care hospitals for fee-for-service Medicaid recipients will total \$970.4 million, as shown in Table 7.1.

For Medicaid recipients enrolled in managed care, New Jersey's Medicaid Program pays HMOs capitation amounts intended to cover all the health care services their enrollees need. HMOs contract with hospitals in their networks and negotiate payment rates for services the hospitals provide to their Medicaid members. Medicaid HMOs generally pay contracting hospitals per diem or per case rates, depending on the services. All 80 acute care hospitals in New Jersey contract with at least one Medicaid HMO. If a Medicaid HMO member receives services at a hospital that is not in his or her HMO's network, the HMO must pay the hospital that provides the out-of-network care the Medicaid fee-for-service rate. Medicaid HMOs pay for outpatient hospital services based on individually negotiated contracts with each hospital. DMAHS estimates that Medicaid HMOs' payments to acute care hospitals for Medicaid managed care enrollees will total \$888.9 million in SFY 2008, as shown in Table 7.1.

B. Graduate Medical Education

Teaching hospitals have long been a critical part of healthcare delivery, often serving as safety-net hospitals and providing uncompensated care for the most vulnerable populations. Because of their education and research missions, teaching hospitals typically offer the

newest and most advanced services and equipment and more highly specialized services. They also care for a higher proportion of severely ill patients who require a greater amount of resources.

The federal government supports medical education through two kinds of Medicare payments – Direct Graduate Medical Education and Indirect Medical Education. Direct Graduate Medical Education payments compensate teaching hospitals for some of the costs directly related to the graduate training of physicians, including stipends and fringe benefits of residents; salaries and fringe benefits of faculty who supervise the residents; other direct costs and allocated institutional overhead costs. Indirect medical education payments to hospitals are, as stated in a 1983 House Ways and Means Committee report as part of the legislation that enacted the Medicare DRG payment system, “only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals.” These factors may include teaching hospitals' typical location in low-income inner city areas, where patients often have more co-morbid conditions and fewer social support networks, both of which can make them costly to treat; teaching hospitals' breadth of specialized services and programs; as well as the additional costs associated with the residents' learning process.⁵⁹

Like many other states, New Jersey Medicaid also makes GME payments to qualifying teaching hospitals.⁶⁰ To qualify for a Medicaid GME payment, a hospital must have Medicaid fee-for-service inpatient days at or above the statewide median. The purpose of this qualifying test is to target GME payments to the teaching hospitals with high Medicaid utilization. Medicaid distributes GME payments among the qualifying hospitals based on hospitals' number of full-time-equivalent residents and their Medicaid fee-for-service inpatient days. Currently 20 hospitals qualify to

⁵⁹ The Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the Medicaid Program, issued proposed regulations that would deny states federal match for Medicaid GME payments to hospitals. Congress acted to prevent CMS from finalizing or implementing these proposed regulations until May 25, 2008.

⁶⁰ See Henderson, T. Medicaid Direct and Indirect Graduate Medical Education Payments: A 50 State Survey 2006. Association of American Medical Colleges. This survey found that 47 states provide GME funding in their Medicaid programs but did not quantify the amount.

receive Medicaid GME payments. For SFY 2008, the amount of funds allocated for Medicaid GME payments increased to \$60 million from the \$20 million level in many previous years.

C. Medicaid Supplemental Payments

Many states have Medicaid supplemental payment programs for hospitals. These payments are often referred to as upper payment limit (UPL) payments because they provide increased payments to hospitals up to the maximum limit federal regulations allow. The federal government has set the UPL as the amount that the Medicare Program would pay, and, currently, the UPL is an aggregate payment limit for three groups of hospitals – state-owned public, other public and private hospitals.⁶¹

Hospital eligibility criteria for these supplemental payment programs vary by state, but all the programs are similar in their intent to target Medicaid payments for particular hospitals in addition to the regular per DRG, per diem, etc. patient service-related payments. New Jersey has one such Medicaid supplemental payment program – the Hospital Relief Subsidy Fund.⁶²

New Jersey's Hospital Relief Subsidy Fund targets Medicaid supplemental payments for hospitals that provide high volumes of care in seven categories of services that are highly utilized by Medicaid and uninsured patients. To qualify to receive payments from this fund, hospitals must have Medicaid patient days at or above the statewide median, and total cases at or above the statewide median in at least one of the following seven service areas: AIDS as a primary diagnosis, AIDS as a secondary diagnosis, neonatal care, mental health, substance abuse, substance abuse for pregnant women and tuberculosis. In SFY 2008, 32 hospitals qualify to share \$183 million in payments from this fund. DMAHS distributes these payments monthly among the qualifying hospitals based on their share of cases in the special service categories.

⁶¹ On May 29, 2007, the Centers for Medicare and Medicaid Services published a final rule that makes the UPL for providers operated by units of government an individual facility limit rather than a group limit if the state uses intergovernmental transfers from these facilities or their certified public expenditures for purposes of claiming federal matching funds. Congress implemented a one-year moratorium on implementation of these rules.

⁶² New Jersey Medicaid previously counted this program as a DSH payment.

D. Disproportionate Share Hospital Payments/Charity Care Subsidy Program

The Medicaid disproportionate share hospital (DSH) payment program is the largest source of federal funding for hospital care for uninsured patients, and, similar to other Medicaid expenditures, state governments share in this funding. The Medicaid DSH payment program requires that states take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs.⁶³ There are two minimum federal criteria for hospitals to qualify for the DSH program: at least one percent of a hospital's total inpatient days must be attributable to Medicaid patients, and the hospital must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid.⁶⁴ Federal law requires that states make DSH payments to DSH-eligible hospitals that meet the federal statutory mandatory eligibility criteria of having a Medicaid inpatient utilization rate that is one standard deviation above the statewide average, or a low-income utilization rate (i.e., Medicaid and charity care) of 25 percent or higher. Some states limit DSH payments to only those hospitals that meet one of these two mandatory criteria, while other states, including New Jersey, have criteria that are more expansive and make DSH payments to virtually all hospitals.

The Medicaid DSH program began in 1981, and initially, the federal government placed no limits on the amount of DSH payments for which states could receive federal matching funds. However, in 1991, the federal government capped states' federal share of DSH payments – known as federal DSH allotments – at each state's DSH expenditure level in 1991. Thus, states that made use of Medicaid DSH funding in the early years of the program have higher DSH allotments than states that did not. New Jersey is an example of such a state; its current federal Medicaid DSH allotment of \$606.4 million is the fifth highest in the nation.⁶⁵ In 1998, the federal government began cutting states' DSH

⁶³ Social Security Act 1902(a)(13)(A)(iv)

⁶⁴ This requirement does not apply to a hospital that did not offer non-emergency obstetric services as of December 21, 1987 or to a hospital that predominantly serves individuals under 18 years of age.

⁶⁵ Kaiser Family Foundation. New Jersey: Federal Medicaid DSH Allotments, FY 2007. <http://www.statehealthfacts.org/cgi-in/healthfacts.cgi?action=profile&area=New+Jersey&category=Medicaid+%26+CHIP&subcategory=Medicaid+Spending&topic=Federal+DSH+Allotments%2c+FY2007>

allotments, but the Medicare Modernization Act of 2003 restored states' allotments for 2004 with a 16 percent increase over 2003 levels. Most states' DSH allotments remain at the 2004 level until at least 2010, at which point they will increase annually by the rate of change in the Consumer Price Index.

The federal government also limits the amount of Medicaid DSH payments an individual hospital can receive. This hospital-specific DSH limit specifies that no hospital can receive Medicaid and DSH payments in excess of its total cost for caring for Medicaid recipients and uninsured patients.

The federal government is increasing its scrutiny of states' Medicaid DSH payments and, as required by the Medicare Modernization Act of 2003, the Centers for Medicare and Medicaid Services, the federal agency responsible for the Medicaid Program, issued proposed regulations in 2005 that specify new reporting and auditing requirements for hospital-reported information that states use to make DSH payments hospitals. CMS has not yet published final regulations on these DSH reporting and auditing requirements, but the regulations as proposed have significant implications for hospitals and states. For example, states must have independent audits to verify the accuracy of the hospital-reported data they use to make DSH payments. The audits must also verify that states collect and maintain appropriate documentation for calculating hospitals' costs in caring for uninsured patients and payments hospitals receive on behalf of uninsured patients.

As noted earlier, New Jersey's federal Medicaid DSH allotment of \$606.4 million, or \$1.2 billion in combined federal and state shares, is among the highest in the nation. New Jersey's Hospital Relief Subsidy Fund for Mental Health represents a small portion of DSH funds - \$20 million. It targets hospitals that provide short-term inpatient mental health services and inpatient children's crisis intervention services. The purpose of this fund is to support the State's efforts to move patients out of state mental health institutions, by encouraging community-based acute care hospitals to provide inpatient mental health services. In SFY 2008, 24 hospitals qualify to share \$20 million in payments from this fund. Medicaid distributes these funds quarterly among qualifying hospitals based on their number of short-term inpatient mental health beds and inpatient children's crisis intervention beds.

New Jersey's charity care subsidies to acute care hospitals comprise a large part of the State's Medicaid DSH payments. To be eligible for charity care in New Jersey, patients must have no or limited health insurance coverage, be ineligible for Medicaid or SCHIP, have limited assets excluding their primary residence and automobile or spend down below the asset limit to become eligible. Patients who meet these eligibility criteria pay a portion of their hospital bills based on their income; the portion of hospital bills patients are responsible for paying ranges from none for those with incomes below 200 percent of the Federal Poverty Level (FPL) to 80 percent for those with incomes between 270 and 300 percent of the FPL.

Under New Jersey's charity care program, hospitals apply for charity care by submitting claims for uninsured patients to the Medicaid fiscal agent and, in so doing, certify that these patients have sufficiently documented their eligibility for the program. The Medicaid fiscal agent "prices" the charity care claims at the Medicaid fee-for-service inpatient and outpatient rates, and the sum of all a hospital's charity care claims for the year "priced" in this way is its total amount of charity care for the year. The State uses this charity care information and follows a statutory formula in distributing charity care subsidy payments to hospitals.⁶⁶ New Jersey also counts payments to acute care hospitals by State agencies other than DMAHS of \$153.9 million in SFY 2008 as DSH payments and claims federal match on them. In addition, New Jersey, like most other states, also counts some expenditures for its state-owned psychiatric hospitals as DSH payments and claims federal match on these expenditures⁶⁷.

For SFY 2008, the New Jersey Legislature increased funding for the charity care subsidy payments to \$715 million from \$583.4 million, and eliminated discretionary hospital assistance grants that had been given to hospitals in the prior years. As a result of the increase in funding for charity care subsidy payments for SFY 2008, the DMAHS estimates its DSH payments to hospitals, when combined with the other State

⁶⁶ An Overview of Charity Care in New Jersey – Past, Present and Future. Forums Institute for Public Policy. September 29, 2004.

⁶⁷ The federal government limits states' Medicaid DSH expenditures for institutions for mental diseases and other mental health facilities to 33 percent of states' total federal DSH allotment.

expenditures claimed as DSH, will exceed New Jersey's \$1.2 billion total DSH allotment. Thus, the State will have to fund some of the increased charity care subsidy payments with 100 percent state dollars.

The Charity Care program, like Medicaid, pays hospitals less than the full cost of care. The program is thus another example where state government pays less than full costs – hospitals and other payers are expected to make up the difference. If the State were to fully fund Charity Care to cover 100% of costs, an additional \$500 million above and beyond the approximately \$1 billion already spent on charity care would be needed to support the program. Instead, New Jersey, like other states, continues to rely on the good will and professional and legal obligations of hospitals and doctors to make up the difference and provide such care. Private payers offset the shortfall in part by paying a rate above costs as was highlighted in the previous chapter discussing the financial hydraulic system common to most hospitals.

II. Policy Options to Optimize Public Funding for Hospitals

Public funding for health care has two important goals. First, it should provide adequate financing to ensure equitable access to health care for all people. Second, public funds should support health care institutions (i.e. hospitals) that serve a high fraction of individuals from vulnerable populations (i.e. “essential” hospitals). The current public financing system for health care in New Jersey falls short on both goals. Medicaid payments are woefully inadequate such that access is compromised, particularly for physician services. And while the State provides important charity care payments to hospitals, it has not settled on whether it is an insurance program for low-income patients or a grant program for safety net hospitals. The mixed features of the program seem to have interfered with a rational disbursement of funds that would maximize gains toward either goal.

A. Consolidation of Public Funding into a Single Stream

Some have suggested that New Jersey Medicaid combine its various payments to hospitals to simplify the funding. However, federal regulations restrict the ability of states to combine Medicaid, DSH and SCHIP funds into a single unencumbered federal funding

stream. While it is possible to combine all Medicaid payments under a single distribution methodology, doing so could limit the State's flexibility to target higher payment to safety net hospitals that are especially integral to the State's Medicaid program and to teaching hospitals. In addition, as discussed below, Medicaid DSH funds that New Jersey uses for its charity care subsidy payments are designed to compensate hospitals for the care they provide to uninsured patients and are subject to specific federal limits. For this reason, these funds must be accounted for separately from other Medicaid payments. An exception to this is the “block grant” mechanism under an 1115 federal waiver of the Medicaid Program's rules that enables states to combine Medicaid, DSH and SCHIP funds into a single unencumbered federal funding stream.⁶⁸ Florida and Massachusetts have recently implemented 1115 waiver block grants programs. Block grants provide states with greater flexibility in how to use Medicaid, SCHIP and DSH funds. However, these block grants are not a means to increase federal funding because, as a condition of approval of the grant, the federal government requires a state to agree to a cap on its federal funding.

B. Medicaid Coverage Expansion

In addition, the federal government is taking steps to restrict the ability of states to cover additional uninsured populations through special Medicaid and SCHIP waiver programs as previously allowed.⁶⁹ For example, the Deficit Reduction Act prohibited states from using SCHIP funds to cover childless adults, which had previously been allowed through a special Medicaid and SCHIP “HIFA” waiver program. Many states have expanded coverage recently to the uninsured by expanding public coverage to higher income levels, and

⁶⁸ Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. (http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp)

⁶⁹ Some states have used SCHIP funds to cover parents of children enrolled in SCHIP and pregnant women and on a limited basis, childless adults. New Jersey's SCHIP, NJ FamilyCare, covers certain parents of enrolled children and pregnant women.

many other states are looking to do the same. However, this may be a limited option for New Jersey, given the already relatively generous nature of the State's public programs. New Jersey's SCHIP, NJ FamilyCare, has the highest family income limit in the nation, up to 350 percent of the FPL. The Bush Administration released new guidance in August that require states to demonstrate that they have enrolled at least 95 percent of children in the State below 200 percent of the FPL who are eligible for Medicaid or SCHIP before they will be able to expand SCHIP for children and families beyond 250 percent of the FPL. The federal government is also threatening to withhold federal funding for existing expansion programs beyond 200 percent FPL, and most states including New Jersey, have not achieved the 95 percent level. States are generally reluctant to expand Medicaid coverage through non-waiver programs (i.e., a State Plan Amendment) as this approach entails an open-ended financial commitment to the new "entitlement" population(s). However, this remains an option available to New Jersey if the State were willing to devote new funding to expanding coverage for the uninsured.

C. Partial Consolidation of Funds into Medicaid Direct Payments

While there is some appeal to consolidating funding into a single stream, the numerous regulatory issues described above would have a negative financial impact on the State. However, there are several more limited opportunities to streamline funding. Two good candidates for consolidation into Medicaid direct payments are the Hospital Relief Subsidy Fund (HRSF) and Graduate Medical Education (GME) payments. HRSF is a supplemental Medicaid payment to hospitals based on the volume of care for a range of conditions common among Medicaid and uninsured patients. GME payments are allocated to hospitals with residency training programs. Both of these programs implicitly and explicitly target hospitals with large numbers of Medicaid patients. Consolidation ensures that hospitals are subsidized in a fair and rational way that is directly linked to Medicaid volume rather than relying on fragmented sources based on different payment formulas. In addition, consolidation would ensure that funding grows each year commensurate with annual cost increases rather than remaining frozen at current appropriations levels.

Recommendation:

The Commission recommends consolidation of the Hospital Relief Subsidy Fund (with the exception noted below) and Graduate Medical Education funds into Medicaid direct payments.

D. Shifting Funds to Support Mental Health

A landmark Supreme Court case in 1999 ruled that the Americans with Disabilities Act may require states to provide community-based rather than institutional placements for individuals with disabilities.⁷⁰ New Jersey's Department of Human Services has responded by steadily moving more institutional patients back into the community. This new model of care requires an infrastructure to handle short-term emergencies through the provision of acute care hospital beds.⁷¹ The Hospital Relief Subsidy Fund for Mental Health (HRSF-MH) provides financial incentives to maintain such beds. The Commission heard from numerous sources that there are current shortages of these beds and that emergency rooms are now facing increased numbers of visits related to mental health issues. The current funding level for HRSF-MH is \$20 million – this funding is shared across the system and diminishes in per bed value as the total number of beds increases.

Recommendation

The Commission recommends shifting some funds from the Hospital Relief Subsidy Fund to the Hospital Relief Subsidy Fund for Mental Health to ensure existing beds are maintained and to provide financial incentives for the addition of new beds to address current shortages.

The Commission believes that a \$5 million transfer of funds from the HRSF to increase the HRSF-MH fund from \$20 to \$25 million is an appropriate amount to achieve the stated goal of enhancing the capacity for acute and immediate care mental health beds.

⁷⁰ Olmstead vs. L.C. (98-539) 527 U.S. (581) 1999 – See Cornell University Law School Legal Information Institute – available at <http://www.law.cornell.edu/supct/html/98-536.ZS.html> (accessed December 13, 2007)

⁷¹ Short-term care facility (STCF) and Children's Crisis Intervention Services (CCIS) beds

E. Should Efficiency and Profitability be Factored into Charity Care Payments?

Based on input from the Subcommittee on Reimbursements and Payers, the Commission identified a range of issues relevant to discussion of the current methodology for distributing charity care subsidies:

- 1) Subsidies do not consider efficiency and in some cases reward inefficient hospitals.
- 2) Subsidies do not consider profitability and in some cases subsidies are going to hospitals that do not need them to remain financially viable.
- 3) Lags in data collection and hold harmless provisions prevent the subsidies from truly following the patients and transform the charity care payments into quasi-grants.
- 4) The documentation requirements encourage hospitals to spend money on documenting charity care rather than pursuing collection procedures or public insurance enrollment.
- 5) Hospitals often have to use a portion of their subsidies to pay for physician services for charity care patients.
- 6) Charity care payments lack any type of care management program that would optimize health outcomes or the cost effectiveness of care.

There are two competing theories as to how the State should disburse Charity Care funds. First, the funds could be structured as an insurance program to cover hospital care for the uninsured. Funds would directly follow patients and be distributed in the same manner in which patients are distributed across hospitals in New Jersey. Second, the funds could be distributed as grants to the most “needy” hospitals caring for a disproportionately high number of patients from vulnerable populations and experiencing financial challenges. In this case, funds would be concentrated on a smaller number of hospitals that would generally be characterized as essential and in financial distress. New Jersey has generally pursued a mixed strategy that looks somewhat like insurance and somewhat like grants with some of the shortcomings identified above. Choosing a particular strategy would go a long way toward making the distribution of funds more objective and rational.

The Commission was unable to come to resolution as to which of the two strategies is better for New Jersey. On one hand, a fiscally constrained governmental environment combined with a substantial number of essential hospitals experiencing financial distress calls for more a focused strategy for disbursing funds. On the other hand, concentrating funds on a limited number of hospitals may penalize some hospitals that are more efficient and thus more profitable.

In weighing these options, it is important to consider the various reasons why one hospital might be more profitable than another. First, the hospital may be efficiently run with physicians practicing cost-effective medicine. Second, the hospital may be located in a relatively affluent area with a case mix consisting primarily of well insured or well paying patients. Third, the hospital may have greater bargaining power and thus able to obtain higher payment rates from private insurers. Efficiency is but one cause for better profitability; the others are external to the hospital and have little to do with the effectiveness of management.

Recommendations:

The State should further examine and resolve the issue of whether the Charity Care program should be based on an insurance model, under which State subsidies for charity care would travel with the patient regardless of what hospital the patient used, or on an institutional grant model under which State subsidies would not travel with the patient but be concentrated on essential hospitals in financial distress.

The State should develop a payment system for Medicaid and Charity Care that includes incentives for efficiency and high quality health care.

III. Conclusion

State funds supplemented by federal matching funds provide an important revenue source for New Jersey's hospitals. Current funding levels are generally inadequate as Medicaid underpays many hospitals for services provided, forcing the shifting of costs on to other payers. The Commission entertained proposals to consolidate funding sources into a single stream; however, the ability to do so is limited by current federal regulations. However, the Commission identified several opportunities to merge funds directly into Medicaid payment rates (i.e. GME payments, Hospital Relief Subsidy Fund). Such changes would ensure that funding increases annually commensurate with changes in health spending. It would also ensure that funding

flows to hospitals in a more equitable fashion based on need given that Medicaid burden is highly correlated with requirements for financial support. In addition, the Commission also put forth a recommendation for a modest shift of subsidies to support the capacity of acute care mental health beds – an area of great need. Finally, the Commission strongly urges the State to conduct an efficiency study of New Jersey hospitals that would help guide reform of the Charity Care and Medicaid payment system to reward efficiency. In addition, the State is urged to further examine the design of the Charity Care system and resolve whether an insurance or institutional grant model is preferred public policy.



Chapter 8: The Relationship of Hospitals and Physicians

Key Points

- **Hospitals and physicians do not operate on a common or compatible set of practice-oriented and financial concerns with respect to the medical management of patients and the provision of in-patient services. Provider payment models for acute hospital care should be developed and piloted that better align incentives for physicians and hospitals.**
- **Ambulatory care facilities have created new economic challenges for hospitals. These centers, generally owned in part by physicians, do not have the same regulatory requirements as hospitals. Regulations should be evenly applied across all facilities with respect to reporting of cost and quality data.**
- **Physicians face little accountability for consumption of hospital resources. Validated performance measures are needed to begin a program of public reporting to increase quality and cost-effectiveness of care.**
- **Hospital costs are generally unknown to providers and patients. Increased transparency of hospital acute care costs and utilization data is needed to enable more cost-effective care.**
- **There are many opportunities to improve efficiency and quality of inpatient hospital care. Hospitals should seek to expand more services to extended hours, explore the use of practice extenders, and implement alternative physician staffing models to facilitate more efficient, high quality care.**
- **There are no financial incentives to coordinate care or insure patients have access to continued care once they leave the hospital. Guidelines and financial incentives need to be developed and implemented to improve care coordination across the full continuum of care.**

The complex nature of hospital-physician relations in the US health care system has profound consequences on the economics and management of hospitals. Although growing in popularity, physicians generally are not salaried employees of hospitals. Rather, independent physicians have “privileges” at a given hospital that entitles them to provide medical services within the respective facility. In exchange for these privileges, physicians are often expected to provide certain service on behalf of the hospital (e.g. hospital committees, on-call ER availability). In turn, hospitals are dependent on these physicians as a referral base for patient volume. This arrangement in the US health care

system is a long-standing tradition that has only recently shown signs of changing with the rise of hospitalist physicians. It is a peculiar economic relationship because physicians benefit financially from the use of hospitals but do not bear direct responsibility for the fiscal health of these institutions.

The Commission examined factors related to the relationships of physicians and acute care hospitals that affect the performance of hospitals including issues such as differences in financial incentives for clinical services for physicians and hospitals, the availability of physician services in hospitals, competition from free-standing

facilities, transparency of cost and quality data, and the general coordination of care across the clinical continuum. There was a range of issues that arose in the Commission's discussion that affect the interaction of hospitals and physicians that were beyond the scope of its work including but not limited to regionalization of health care resources, medical liability reform, and alternative strategies for the delivery of acute care services.

The Commission has adopted a number of recommendations aimed at improving elements of the relationship among New Jersey's acute care hospitals and their physicians to improve the financial condition of essential hospitals. While many of these recommendations will require the agreement and collaboration of different stakeholders and may take considerable time and energy to implement, the governors, trustees and senior management of each acute care institution bear direct and ultimate responsibility for the fortunes of facilities under their collective direction and control.

I. Misalignment of Hospital and Physician Financial Incentives

Physicians and hospitals do not share the same financial incentives and concerns when patients are hospitalized for inpatient services. Hospitals generally face strong utilization controls in the form of prospective payment (i.e. DRGs – bundled payment determined by diagnosis and severity) or utilization review tied to per diem payments (negotiated daily rate which can be downgraded if deemed unnecessary). Physicians on the other hand face an entirely different set of financial incentives for inpatient services for the same hospital stay. Physicians are generally paid on a fee for service basis for inpatient services and face fewer utilization controls. Although a payer could decide to downgrade a hospitalization as medically unnecessary, a physician can continue to be paid for daily services while the hospital is likely to be paid far below cost.

Admission and discharge decisions are generally made by physicians and not under the immediate control of the hospital. In addition, physicians have the primary role in determining what resources are utilized within the hospital through the ordering of diagnostic tests, consulting other physicians, or moving patients to

different levels of care (i.e. ICU). Yet the hospital is financially liable for many of these decisions and currently has few tools at its disposal to address over-utilization of resources by physicians. The Commission heard a presentation from a consultant where costs for similar risk patients with a similar diagnosis varied by a magnitude of five depending on the physician caring for the patient within a given hospital. The fact that physicians are generally not employees of the hospital and the hospital itself is dependent on these very physicians for referrals makes it difficult for a hospital to exercise effective managerial control over these issues.

Misaligned incentives are not limited simply to excess utilization driven by physician clinical decision-making in the absence of financial liability. New Jersey physicians receive some of the lowest reimbursement rates in the nation for treating Medicaid patients, while hospitals are paid at considerably higher rates. Such a misalignment of incentives is regarded as a key reason for lack of physician availability in hospitals serving a large proportion of Medicaid patients.

Closer alignment of hospital and physician financial incentives for hospital care holds significant potential for improving the cost effectiveness and rationality of health care resource utilization. There are several strategies that may be employed to help achieve such a goal including goal-based incentives, reimbursement systems for physicians based on severity-adjusted Diagnosis-Related Groups (DRGs) or Relative Value Units (RVUs), or other means of sharing gains in productivity and cost-savings. Detailed study and evaluation of plans and strategies for improving alignment of payers⁷², hospital and physician financial incentives would be a key step to remedying poorly aligned incentives.

Better alignment of financial and practice incentives among hospital systems, physicians and payers will help close service gaps, promote common goals, and encourage more cost-effective practices. The absence of a coherent framework of incentives for providing and compensating cost-effective medicine and care is at the root of the problem. However, any such initiative must

⁷² "Payers" as used here refers to public and private third party payers, and excludes self-insured individuals or co-payees.

take measures to avoid the risk that, as physicians and hospitals payments are more closely aligned, patients' interests are not unduly constrained. For example, patients who, for medical reasons, should receive extended or more intensive care may be faced with increased or more complex barriers. Safeguards including procedural checks, rights to second opinions, and a swift and straightforward route of review and appeal are essential to assure fairness and protection of patient rights as the economic interests of physicians, hospitals and payers are brought into alignment.

Alignment-oriented payment schemes that provide physicians appropriate incentives for cost-efficient case management through case-rates or severity-adjusted payments but that do not unduly impose penalties for unavoidable or unintended consequences should be thoroughly examined. This is an area requiring careful study of alternatives and demonstration projects before widespread implementation can confidently be recommended. The following considerations are important components of future efforts to better align incentives among physicians and hospitals for cost-effective care:

- Educate and incent physicians to practice cost-effective medicine, reward physicians based on system cost savings, and eliminate or reduce incentives to over utilize resources and continue defensive medicine tactics.
- Rationalize the appropriate use of consultants and consulting practices through physician and medical student education.
- Align financial incentives and liability exposure for hospitals and physicians to improve physician accountability for appropriate use of hospital resources.
- Establish uniform hospital and physician payment criteria for all payers (public and private sector.)
- Avoid payment systems that improperly incent hospitals, physicians or payers to withhold, curtail, or deny medically necessary care.

⁷³ Ambulatory surgery facilities, as defined by NJAC 8:43A-1.3, are commonly referred to as ambulatory surgery centers (ASCs). The term ASC is used to refer to such facilities throughout the report.

⁷⁴ NJAC 8:43A-1.3 "Ambulatory care facility" means a health care facility or a distinct part of a health care facility in which preventive, diagnostic, and treatment services are provided to persons who come to the facility to receive services and depart from the facility on the same day. Ambulatory surgery centers are a type of ambulatory care facility.

Recommendation:

The State should encourage or support the development of new provider payment models for acute hospital care that better align financial incentives for physicians and hospitals.

1. Funding for new incentives required to implement such a system must come from savings generated within the present scope of payments and reimbursements.
2. Safeguards must be built-in to protect patient rights for all medically necessary care and provide percentage-based payment for out of network services.
3. Payer fee schedules should be transparent through complete and public disclosure.
4. A carefully designed, geographically limited and closely monitored pilot or demonstration project would be a prudent first step.

II. Proliferation of Ambulatory Care Facilities

In recent years, the nation has witnessed high growth rates in the number of free-standing ambulatory care facilities such as ambulatory surgery centers (ASCs).^{73,74} These centers, often owned in part by physicians, provide services that do not require overnight stays in the hospital. Among ASCs, ophthalmology and gastroenterology surgical procedures are the most common procedures.⁷⁵ In recent years, hospitals have expressed concerns that freestanding ambulatory care facilities, particularly surgery facilities, are eroding hospital's fiscal health by attracting highly profitable services away from hospital outpatient departments. Research corroborates hospitals' concerns – one study of surgical procedures found that for each additional ASC per 100,000 people, hospital outpatient surgical volume decreases by 4.3 percent.⁷⁶ A study of Horizon Blue

⁷⁵ Among Medicare beneficiaries nationwide, ophthalmology and gastroenterology surgical procedures account for more than two-thirds of all ASC services provided. [Source: MedPAC; available online: http://www.medpac.gov/publications/congressional_reports/Jun04DataBookSec8.pdf]

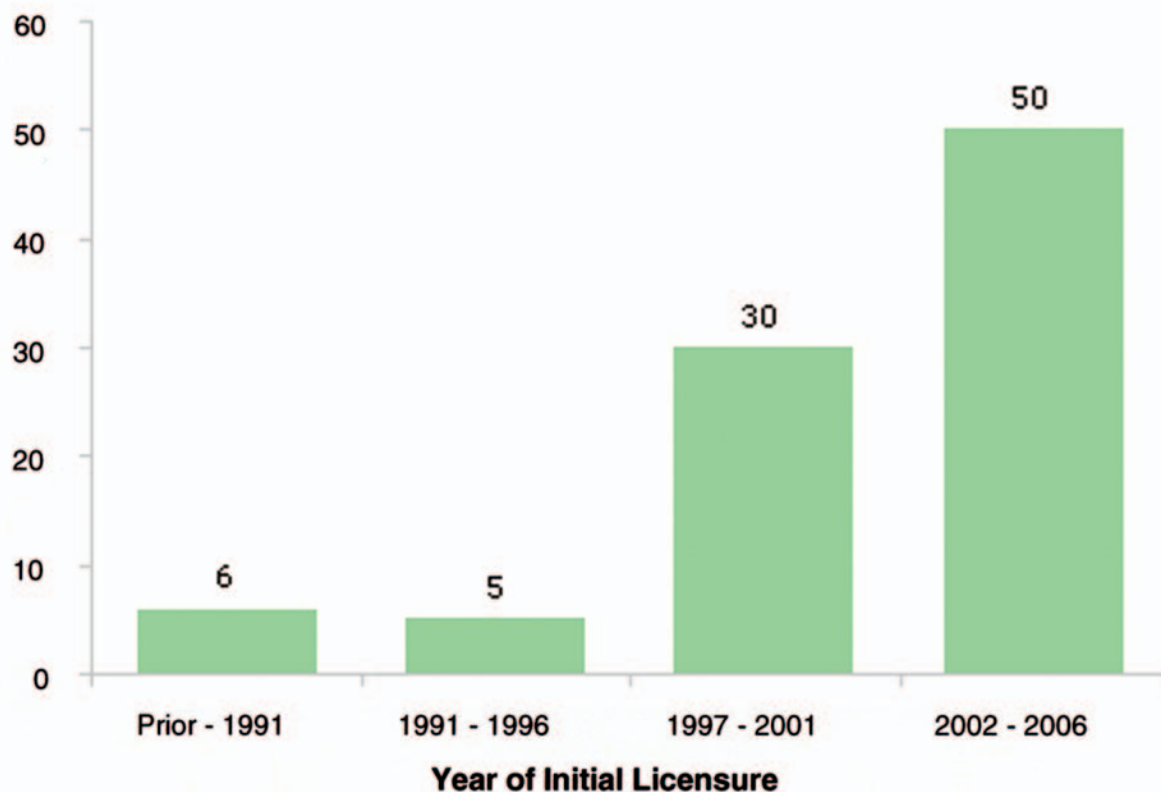
⁷⁶ Bian, J., & Morrissey, M.A. Free-standing ambulatory surgery centers and hospital surgery volume. *Inquiry – Excelsus Health Plan*. 2007; 44(2): 200-10.

Cross Blue Shield claims between 2003 and 2005 found that claims paid for ASCs increased by 22.5% compared to just 0.8% for hospitals.⁷⁷ The Commission's analysis of New Jersey hospitals indeed found that surgical volume is an important positive predictor of profitability. The erosion of surgical volume poses a financial threat to acute care hospitals as cross subsidies from profitable to less profitable health services declines.

Hospitals are further challenged by their regulatory mandate to provide certain care to all patients regardless of ability to pay while freestanding ambulatory care facilities do not face any such requirement. As a result, these facilities are likely to disproportionately attract paying patients in comparison to hospitals whom are likely to be left with residual charity cases.

In New Jersey, the number of ambulatory surgery centers has grown at an extremely rapid pace, 34% in just a four-year span from 2001 to 2005 (see Figure 8.1).⁷⁸ This mirrors national trends where physicians are increasingly providing more services outside of hospital facilities.⁷⁹ Financial incentives for physicians strongly encourage this trend. Income from services in free-standing ambulatory care facilities is shielded from subsidizing unprofitable services and is free of charity care obligations unless the physician elects to provide such care. Even those physicians that do elect to provide charity care are able to control the volume in ways hospitals are currently unable. An ambulatory assessment on free-standing facilities in part offsets this competitive advantage and provides some support for Charity Care costs.

Figure 8.1:
Number of Operating State-Licensed ASCs by Year of Initial License (2006)



Source: Avalere Health LLC. 2006 New Jersey Health Care Almanac.

⁷⁷ Avalere Health LLC. 2006 New Jersey Health Care Almanac. Available at: http://www.avalerehealth.net/research/docs/New_Jersey_Almanac/New_Jersey_Almanac_Summary.pdf.

⁷⁸ Avalere Health LLC. 2006 New Jersey Health Care Almanac. Available at: http://www.avalerehealth.net/research/docs/New_Jersey_Almanac/New_Jersey_Almanac_Summary.pdf.

⁷⁹ Pham, H.H. & Ginsburg, P.B. Unhealthy trends: the future of physician services. *Health Affairs*. 2007; 26(6): 1586-98.

The proliferation of freestanding ambulatory care facilities as a major competitor to hospitals highlights the complex relationship between physicians and hospitals. In the same day, a physician can perform procedures on patients in their own facility and then walk down the street to the hospital they are competing with to provide more complex care to sicker patients. This is a striking peculiarity to the physician-hospital relationship where two parties can simultaneously be competitors and partners.

Ambulatory care facilities argue that they are providing high quality care in a more cost effective environment than in hospital outpatient departments. These claims, in part, are based on the notion that physician ownership increases physician investment in efforts to improve quality, safety, and efficiency. While these claims may in fact be true, they are nearly impossible to verify in the current health care environment. Freestanding facilities are not required to report the same quality, safety, or financial data required as hospitals must to the State. No private entity exists that serves such a function either. Centers can pursue voluntary accreditation through private organizations; however, this process and data reporting is not transparent to policymakers or the public. This lack of transparency does not serve patients well as they are asked to “shop around” for health care services nor does it serve the State well in terms of monitoring the performance and quality of health services.

Ambulatory surgery centers are an example where current regulations are not evenly applied across facilities. In 2006, there were 181 Medicare-certified ASCs in New Jersey. However, there are just 95 state-licensed facilities.⁸⁰ The difference is most likely explained by the licensure exemption for physician-owned surgical practices with a single operating room that are not currently subject to licensure requirements by the Department of Health and Senior Services (DHSS).⁸¹ This situation arises because the Board of Medical Examiners currently has oversight over

physician practices while the DHSS regulates facilities. In the Commission’s view, these uneven licensing standards are largely without basis and should be evenly applied across all facilities providing similar services.

A. Policy Solutions

While freestanding ambulatory care facilities are undoubtedly affecting the finances of hospitals, it is less clear what the appropriate policy solution is given the current state of affairs and the already widespread proliferation of such centers. The Commission recognizes that it is neither possible to “roll back the clock” and move to a time without these facilities nor is it clear that it would in fact be desirable. Free-standing ambulatory care facilities may be providing a more convenient and cost-effective service that is reflective of long-term trends of moving more care out of the hospital and with shorter stays. However, the lack of uniform regulations and reporting of quality and performance data is a major impediment to understanding their actual impact on the health care system or the quality of care. Any rational policymaking needs to include more robust data reporting requirements on the part of these facilities with respect to quality and cost and apply uniform regulations based on the services provided rather than the specific venue as is the case with the current exemption for single operating room surgical practices.

Freestanding ambulatory facilities have also argued that they should not bear the burden of solving hospitals’ financial problems. The Commission agrees that the fiscal distress of hospitals arising from the emergence of these facilities is merely a symptom of a dysfunctional payment system that under-reimburses medical services relative to surgical and diagnostic services and publicly insured patients relative to the privately insured. If payments were more equitable across payers and services, many of these problems would disappear. Free-standing ambulatory care centers are not entirely to blame for the fiscal problems of hospitals and it is less clear what role they ought to play in remedying the situation.

Some have argued that freezing the numbers of centers at current levels would address the fiscal challenges facing hospitals. Such a policy change would grant current centers monopolistic market power by hindering the entry of competitors in local areas. Such a move

⁸⁰ Avalere Health LLC. 2006 New Jersey Health Care Almanac. Available at: http://www.avalerehealth.net/research/docs/New_Jersey_Almanac/New_Jersey_Almanac_Summary.pdf.

⁸¹ Subject to oversight by the Board of Medical Examiners

would need to be joined with payment regulation to address these monopolistic tendencies. Others have called for these centers to have similar requirements as hospitals to provide charity care. While this may be an attractive option to create a more level playing field in the marketplace, it is less clear how such a provision could be enforced or monitored. In addition, the referral mechanisms for freestanding ambulatory facilities would likely shield many of these centers from a large charity care burden regardless of regulatory requirements. Finally, some have raised questions about whether the “Codey” law⁸², a law that limits the ability of physicians to refer patients to facilities in which they have an ownership interest, should be applied to ambulatory care facilities. This question has not been clearly resolved – the Board of Medical Examiners has interpreted the law to allow for such referrals while a recent Superior Court decision articulated a narrower interpretation. Resolution of this conflict is necessary to determine what impact this law may have on the economics of hospitals.

Recommendations:

- The State should eliminate the licensure exemption for single operating room surgical practices. The Department of Health and Senior Service should assume responsibility for licensure. All surgical facilities in New Jersey should meet nationally recognized accreditation standards.
- The State should require all ambulatory care facilities to report cost and quality data similar to requirements currently imposed on hospitals. Regulatory and reporting requirements should be evenly applied across facilities.
- The State should require public posting of list prices (charge masters) and prices charged uninsured patients by all ambulatory care facilities.
- The Board of Medical Examiners should require that physicians and other licensees of the Board provide written notice to patients of any significant financial interest held by that physician or his or her practice in a health care entity to which the practitioner refers patients.

⁸² N.J.S.A. 45:9-22.4 et seq.

III. Lack of Data on Quality of Care

Data is a key ingredient of any effort to increase accountability, engage in quality improvement, or provide feedback to providers. Like other states, New Jersey’s health care system does a relatively poor job of collecting and reporting data in a systematic manner. As a result, providers do not receive data on the quality of care they provide nor do they receive feedback on the costs of clinical services. Without this knowledge, expecting providers to be accountable and responsive to variances in quality or cost is simply an illusion.

Establishing standards and measures of quality and efficiency for physicians and hospitals is a key to strengthening the acute care system. Measurement holds great potential to improve performance among hospital staff, physicians, and institutions. Tracking resource utilization, length-of-stay, end-of-life issues, and performance on key clinical indicators associated with the most frequent diagnoses, among other metrics, will be a key to raising quality, efficiency and performance.

The Institute of Medicine as well as other respected health policy leaders, recognizing the unacceptable variances in clinical practice and poor adherence to many evidence-based standards, has called on policymakers and health system leaders to engage in far reaching quality improvement efforts.⁸³ In response, quality standards have emerged across the country. However, even where such standards are widely recognized, New Jersey hospitals and physicians have made little progress in agreeing how to implement them, measure results, or how to reward, induce or coerce compliance. This has made it nearly impossible to assess clinical practice, identify leaders and outliers, or implement any system of evidence-based rewards and corrective action within a given institution.

Lack of confidence in and acceptance of performance criteria has been a major hurdle to widespread adoption of a common set of quality measures across New Jersey or the health care system nationally. Logistical barriers, including a lack of information technology (IT) systems

⁸³ Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington DC: National Academies Press, 2001.

and its associated costs has also been a significant obstacle to progress. No single institution can bear this cost in the absence of a coordinated regional or statewide effort. The source of funds to defray expenses and provide the necessary resources requires serious and careful consideration. Unless these issues can be resolved, they will mean defeat for any effort to establish quantitative standards. Discussion and more specific recommendations related to the development of clinical performance measures and a health IT system in New Jersey can be found in Chapters 15 and 16.

The implementation of professionally endorsed, evidence based, and unbiased institutional and physician metrics and reporting would be a major step forward in realizing the benefits of evidence-based medicine on a broad scale in New Jersey. Active engagement of all key stakeholders in the endeavor is essential. Though hospitals have a vital interest in physicians practicing the most cost-effective medicine, their current ability to induce such behaviors is limited. Collection and dissemination of information on physician performance, whether available to the public at large or a more limited peer group, can promote physician accountability and adherence to evidence based practice guidelines.

Many physicians regard such measures with suspicion as unwarranted intrusions into their professional prerogatives. Some find the mere suggestion of standards and the threat of publicity offensive, if not threatening, and move business to less aggressively managed hospitals. Unless the effort is based regionally or statewide, attempts to use metrics and peer-pressure will put all but the strongest institutions at a competitive disadvantage.

Physician report cards can work only if they are designed so that the information is valued and used by the physicians themselves. Standards of measurement must be widely accepted and validated if ratings and rankings have the desired effect of positively motivating and modifying behavior. Implementation of such tools demands a cooperative and collaborative effort, as well as agreement on shared goals and outcomes.

Many insurers have access to demographic and clinical data that can be used to produce performance metrics at the physician and patient level. New Jersey insurers should be strongly urged to cooperate in developing standardized quality performance reports for New Jersey similar to those developed in New York (MetroPlus) and Minnesota (HealthPartners). Such reports could represent an important component of an acute care report card initiative.

The following are important considerations for future efforts to improve measurement and reporting of clinical performance to increase quality, cost-effectiveness, and accountability:

- Broad participation in standards development encourages buy-in and reduces bias concerns.
- Regional implementation of physician report cards levels the playing field for weak and strong institutions and encourages best practices, especially in key specialties.
- Implementation may disadvantage institutions dependent on marginal providers and possibly divert business elsewhere.

Recommendation:

The State's health care system must in the long-run move toward a transparent system of measuring provider quality of care. While technically difficult, efforts should be undertaken to work toward developing a properly validated, well-accepted, independently complied, and publicly available physician report card system that measures performance and outcomes on critical, evidence-based standards of acute care practice.

1. Priority and focus should be first placed on key specialties and high-cost, high-risk conditions and diagnoses.
2. Insurers, physicians, hospitals and their respective organizations should participate in the study, research and validation required for this effort.

IV. Transparency & Accountability for Acute Care Resource Utilization Costs

Imperfect or non-existent knowledge of the cost of care and resources inhibits physicians and consumers from making informed choices, decreases trust, and diminishes accountability for decisions. The cost of hospitalization and associated resource utilization is not widely appreciated by treating physicians, much less by the public at large. Without such information, physicians and patients may make unwarranted or inappropriate demands for non-essential services, over-use or misuse hospital resources, and fail to appreciate justified denials or consider alternatives to such services. These factors tend to raise the overall level of dissatisfaction in and distrust of many aspects of the health care system. Greater financial transparency would increase comprehension of the financial impact of treatment decisions and make creation and adoption of quality and cost performance expectations for physicians rational and equitable.

Financial transparency will:

- Engage physicians in resource utilization decisions
- Remove elements of uncertainty contributing to suspicion and distrust
- Empower consumer-directed health care choices

It is worth noting that financial transparency may threaten marginal institutions dependent on higher cost services to offset uncompensated care.

Recommendation:

As part of its work, the Commission had a presentation on software capable of tracking the order entries of every physician for every medical case by type of service or supply ordered in a hospital. The Commission recommends that the State, in cooperation with leaders of the hospital industry and the medical profession, explore the availability of such software from sundry sources and its adaptability to New Jersey hospitals, with the aim of enabling every hospital to track, for every physician affiliated with the hospital, the average cost per well identified inpatient case by severity-adjusted DRG (it being understood that exceptions must be made for so-called non-standard “outlier” cases.) If such an information infrastructure is

feasible, all New Jersey hospitals should be required to use it, and financial assistance of hospitals by the State should be made contingent on the submission of such information to the State.

V. Institutional Infrastructure and Support Systems

Hospital infrastructures and support systems are in many cases ill adapted to present institutional needs, financial realities and physician practices. Attempts by physicians and hospital staffs to compensate for these deficiencies can result in practices and behaviors that can weaken the institution and diminish the quality of care.

Unlike some hospital resources, sickness, disease and trauma do not diminish on weekends and holidays. Service and coverage reductions on weekends and off-hours impact more than patient care and convenience. They can result in needlessly extending hospital stays, may place patients at greater risk for hospital-related complications, and cause waste and delay. New Jersey’s acute care institutions should consider the economic feasibility of providing a more comprehensive range of services every day of the week to ensure timely and effective care, optimize resource utilization, and control costs.

Optimizing hospital resource utilization throughout the year is not formulaic and will require study, tailored recommendations and well-managed implementation for each institution’s unique situation. The importance and role of institutional governance in such an endeavor cannot be too strongly emphasized.

While it may not be possible for a hospital to provide every service at all hours throughout the day, there are identifiable aspects of effective coverage that all hospitals can and should maintain every day throughout the year. These include the implementation of specially trained coverage for ICU units, use of physician extenders and other actions to address deficits in on-call coverage. Enhanced availability of services has the potential to improve patient outcomes, spread workload to normally less productive hours, and reduce unjustified (and unreimbursed) length-of-stay.

Recommendation

Hospitals' management should be encouraged to define and adopt standards of operation for an expanded range of services that optimize utilization of physical plant and human resources on a 365-day basis.

1. Where essential in-house resources or specialized services are unavailable or not cost-justified, management should seek to form and/or participate in regional networks to address the identified deficiencies.
2. Hospitals should invest in and incent programs such as Intensivist and physician extender programs that are proven to have a measurable impact on cost-savings, resource optimization, efficiency and effective patient care.
3. Funding of such programs must be internally cost-justified. The State should provide assistance in developing economic and business modeling for financially distressed hospitals.

VI. Availability of Emergency Department Specialty Physician Services

Physician availability, particularly among certain specialties and especially in the Emergency Department (ED), is a major limiting factor in improving the overall performance of ED services and optimizing the use of physical and human resources on a daily basis. Many New Jersey hospitals report difficulties in securing on-call availability of specialist physicians. What is happening in New Jersey is part of a national trend where physicians are less inclined to accept traditional on-call obligations as physicians become less dependent on hospital admitting privileges as services shift to non-hospital settings, payments for emergency care decrease, and medical liability concerns increase.^{84,85}

Federal law mandates that certain types of care be provided by hospitals – emergency care, obstetrical services for women in labor, and care for psychiatric emergencies.⁸⁶ As a result, hospitals are required to maintain access to on-call specialists in their emergency rooms. Many hospitals can no longer enforce ED service call obligations on physicians, and in a growing trend, must pay significant fees to physicians in order to

secure urgently needed and essential coverage. While this may not be a burden to some institutions, it is undoubtedly problematic for others. In some cases, the lack of ED on-call physicians means patients have limited access to needed medical care and lack of appropriate follow-up or continuity. Change is needed to ensure all acute care institutions have the access to critical specialty physicians needed to fulfill their obligations.

Historically, ED service obligations were more or less expected from physicians in consideration for attending privileges. A return to the former “soft” system of obligation is not anticipated. One option is a mandatory on-call requirement for all physicians. However, making on-call service “mandatory” for all physicians via regulation, legislation or hospital policy raises difficult questions of equity, bargaining power, legality and enforcement.

Fines and licensure actions seem too extreme, while suspension or curtailment of privileges is not a realistic option for many institutions. Moreover, the institutional landscape is not uniform. Requiring obligatory on-call service would be far less burdensome on physicians in suburban hospitals due to the relatively small number of charity care and Medicaid cases. Urban hospitals, in contrast, would face difficulty recruiting and retaining physicians who could expect to shoulder a substantial burden of uncompensated care. (There is also a widespread but largely anecdotal perception that charity care patients pose a higher medical liability risk than other patients.)

Paying for on-call services is a poor solution but in some cases a necessary strategy, inasmuch as hospitals are mandated to provide certain services under the

⁸⁴ O'Malley, A.S., Draper, D.A., Felland, L.E. Hospital emergency on-call coverage: Is there a doctor in the house? Center for Studying Health System Change. Issue Brief No. 115. November 2007. Washington D.C.

⁸⁵ On-call physicians are (unlike hospitals and their employees) fully exposed to tort liability and risk not being compensated for treating the uninsured (unless, as is increasingly the case, the hospital has contracted them to do so).

⁸⁶ Emergency Medical Treatment and Active Labor Act (EMTALA) – the Act mandates that patients presenting to a hospital emergency rooms have the right to an evaluation and to be stabilized if they have a medical or psychiatric emergency or receive obstetrical services if they are a woman in labor.

Emergency Medical Treatment and Active Labor Act (EMTALA). Where such arrangements provide for flat fees only and do not pay for each episode of care, there is a built-in bias toward under-delivery and over-payment. Moreover, flat fees are paid independent of any reimbursement or other compensation a physician might receive. A better system might tie payments to services actually rendered on some equitable pre determined basis.

Establishment of and participation in a comprehensive system of regionalized care or Centers of Excellence and expedited transfers may provide a medically responsible and financially sustainable means meeting public expectations of the ED service, as well as the legal demands of Charity Care and EMTALA mandates. The widespread use of such centers has the potential to change the current paradigm of ED care and alter the traditional pattern of reliance on on-call services.

The crisis in on-call service is exacerbated by the problems and risks, real or perceived, of providing care in the ED setting. The issues of compensation and liability for providing such services need to be addressed to ensure adequate and consistent on-call coverage and continuity of care.

Recommendation

Physician obligations and expectations with respect to ED service should be standardized to ensure adequate medical coverage and fulfillment of statutory mandates. These obligations should be part of hospital and physician licensure requirements through action by the Department of Health and Senior Services and the State Board of Medical Examiners.

Other actions that could be examined to increase physician on-call availability include:

1. Increased incentives for Medicaid and uninsured cases, compensation for taking calls in urban areas, and perhaps malpractice premium relief.
2. Compensation for EMTALA-related services on an episode-of-care basis rather on a flat fee basis.
3. Regional Coordination and Centers of Excellence should be examined in light of their impact on demand for on-call services.
4. Lifetime or age cap for on-call service hours.

VII. Cost Effective Staffing Models for Acute Care Services

Changes in staffing models hold potential for decreasing costs or increasing the efficiency of acute care hospitals in New Jersey. The following section explores two such models.

A. Intensivist Model for Intensive Care Units (ICUs)

Intensive Care Units (ICUs) provide patients with life-sustaining medical and nursing care on a 24-hour basis but are not typically staffed with specially trained personnel. Typically, ICU patients are among the sickest, highest risk and most expensive cases in the hospital. Using trained staff whose only responsibility is the care of patients in the unit can maximize quality of care and cost-effectiveness in the ICU. Such “intensivist” programs, when properly executed are recognized as cost-saving measures that improve the quality of patient care.⁸⁷ The Leapfrog Group estimates that more than 50,000 lives could be saved each year in US hospitals through universal implementation of intensivist programs.⁸⁸ They estimate that a hospital with 6 to 18 bed ICU could save from \$510,000 to \$3.3 million per year.⁸⁹

A minimum requirement for such a program would provide service on a 365-day basis for at least eight hours per day, preferably during hours of greatest risk and/or limited coverage. In some institutions, telemedicine and remote centers can be a highly effective and cost-efficient means to implement intensivist capabilities in whole or in part.

⁸⁷ Pronovost et al. Physician staffing patterns and clinical outcomes in critically ill patients: a systematic review. *JAMA*. 2002; 288: 2151-62.

⁸⁸ The Leapfrog Group. ICU Physician Staffing – Fact Sheet. http://www.leapfroggroup.org/media/file/Leapfrog-ICU_Physician_Staffing_Fact_Sheet.pdf

⁸⁹ Conrad, DA & Gardner M. Updated Economic Implications of the Leapfrog Group Patient Safety Standards. Final Report to the Leapfrog Group. 2005. Published at http://www.leapfroggroup.org/media/file/Conrad_Updated_Economic_Implications_2_.pdf

Recommendation

Adoption or implementation of an Intensivist Model of ICU Care should be a priority for acute care hospitals statewide and especially financially distressed institutions.

1. Hospitals should be encouraged, rewarded and/or recognized for implementing intensivist programs and capabilities.
2. The State or other organizations should enable and assist program development wherever possible.

B. Practice Extenders

Physician availability is a critical factor that impacts a hospital's ability to respond effectively to patient need and efficiently utilize its resources. Reduced services, staffs and coverage on weekend and holidays, declines in on-call physician availability and shortages of key medical specialties can limit access and availability.

Even where physicians are available to provide in-patient coverage, the pressure to maximize the use of their professional hours is often extreme, reducing the amount of time available to each case and each situation demanding their attention. These factors contribute to service bottlenecks and inefficiencies, and may result in added costs and increased risk.

While there is no short-term means for increasing the supply of specialty physicians in under-served localities in New Jersey, there are other strategies for leveraging scarce physician resources in the acute care setting that potentially offer economic and quality improvements. In many situations, "practice extenders", such as intensivists, case managers, hospitalists, physician assistants and advance practice nurses have the potential to provide cost-effective means of achieving quality and efficiency goals in appropriate circumstances. Advanced practice nurses, for example, have independent practitioner (IP) status which enables them to be independently compensated. Recognition of and compensation for the services of other practice extenders, such as Physicians' Assistants ("PAs"), would expand their use, helping to realize more effective and cost-efficient resource utilization.

According a class of practice extenders such as Physicians' Assistants IP status might facilitate this, and

could allow greater flexibility in matters such as getting orders co-signed within narrow time constraints. On the other hand, this may raise new issues of practice autonomy, training and expertise, and liability. It is also not clear whether and under what circumstances Physicians' Assistants themselves might desire or accept independent status. Any such change will require further study and should not distract attention from the need to expand their utilization through recognition of and compensation for the value added.

Other capabilities such as telemedicine services could, if appropriately compensated, help multiply the effective reach of vital physician services. Financial incentives or support from the State or other organizations may be required to overcome cost barriers to acquiring the IT infrastructure needed for telemedicine and remote monitoring.

Recommendation

Hospital management should explore and expand the use of practice extenders and other options for leveraging, extending and augmenting the professional presence and expertise of physicians.

1. Payers should provide enhanced compensation for the use of selected practice extenders, such as Physician Assistants and Advanced Practice Nurses, even if not separately compensated as "Independent Practitioners" in both cases.
2. Hospitals should work closely and cooperatively with its physicians and regional hospitals to optimize the benefit of such efforts for patients, doctors and the institution itself.
3. The State should assist financially-distressed institutions in identifying qualified consultants and solution providers who can help define and implement such initiatives.

VIII. Coordination of the Continuum of Care

New Jersey's health care system does not adequately ensure the management of a patient from admission through in-patient treatment to discharge and outpatient follow-up. Lack of organizational structures and financial incentives for such a continuum of care adversely affects medical outcomes and increases the total cost of medical care. Discontinued care or lack of

follow-up can result in a readmission which might have been avoided by a more timely intervention.

The problem is made worse by the practice of some physicians who restrict their engagement with charity care patients to a single ED encounter, limit the range of services they are willing to perform, or fail to manage the clinical condition to conclusion. Reimbursement and liability concerns are likely drivers, but fall short of excuses for such behaviors, which in extreme cases can amount to the virtual “abandonment” of the patient. This increases clinical costs, creates liability exposure, may place patients at increased risk and degrades health care quality.

There are at least three key components to establishing a continuum of care that are within the existing capabilities of New Jersey’s acute care facilities. Hospitals can establish guidelines to assure patients are admitted to the most medically appropriate service, insist ED physicians manage patients to an appropriate point of transfer, and ensure discharge procedures provide for appropriate follow-up, after-care, or outpatient services.

Hospitals traditionally do not question admission to a primary care provider’s service or make an independent determination whether another service or specialist care would be more appropriate and efficient. However, procedures that ensure patients are admitted to the appropriate service will increase their likelihood of receiving well-managed treatment from the onset of care through discharge or transfer. Consultation and/or recruitment of other providers should be coordinated by the appropriate admitting physician. In situations where hospitals lack needed specialty resources, regional relationships could fill the gap.

Hospital policies must clarify the scope of physician responsibility for all ED cases, and articulate unambiguous professional, ethical and legal standards to ensure patients receiving treatment in the ED service are managed through to clinical resolution and appropriately stabilized, discharged or transferred. Stronger inducements, including legislative mandates, may be necessary if such encouragements prove insufficient.

Utilization of appropriate post-discharge care can mean better outcomes, more compassionate care, and greater cost-efficiency. This may include local or regional access to long term ventilation units, vent/dialysis units, long-term acute care facilities (LTACs), nursing homes, and hospice care. Discharge procedures should encourage such choices and efforts should be made to reduce or eliminate any financial barriers that may inhibit considering such alternatives.

Managing the continuum of care for the highest cost diagnoses (DRGs) may offer the best opportunity for realizing a measurable benefit from a coordinated approach. CHF (congestive heart failure) is a good example, representing one of the most common and costliest DRGs. Coordination of in-patient care and outpatient support through specialists, anticoagulation and/or CHF clinics is likely to prove a readily available, cost-effective strategy.

Recommendation

- Encourage coordinated care through a system of appropriate incentives and standards for achieving measurable results that will at a minimum:
 1. Assure patients are admitted to the most medically appropriate service,
 2. Require ED physicians to manage patients to an appropriate point of transfer, and
 3. Establish discharge procedures that provide for appropriate follow-up.
- Each acute care hospital should develop specific guidelines for implementing coordinated care.

IX. Information Technology Systems to Promote High Performance

Health IT systems hold great potential to improve the real-time availability of data to enhance the clinical and financial performance of acute care hospitals. Physician services would be enhanced through ready access to clinical data to optimize clinical decision-making. Hospitals would be better able to monitor the performance of individual clinicians as well as their own institutional performance relative to peer institutions.

The Commission strongly endorses efforts to increase the diffusion of health IT systems and efforts to exploit current resources. Further discussion can be found in a separate chapter on information technology later in this report (Chapter 16).

X. Conclusion

The crisis in acute care facing many communities and institutions in New Jersey is profoundly affected by the relationship between the hospitals that provide access to services and the physicians who provide the care. While these stakeholders share many interests and goals in delivering effective and high quality medical care, in too many instances financial pressures, structural

inefficiencies, imperfect information and irrational patterns of traditional practice, resource allocation and use defeat or deflect the achievement of these ends. In this chapter, the Commission called for better alignment of payment incentives for physicians and hospitals, more evenly applied regulations for ambulatory surgery centers relative to hospitals, transparency of performance measures and cost data, initiatives to improve efficiency of hospital operations, and incentives to better coordinate care across the full continuum. These recommendations can be part of the answer to rescuing New Jersey's most at-risk institutions, bringing quality care to underserved communities, and raising the level of health care available to all persons seeking it within the State.



Chapter 9: State Regulation Impacting Acute Care Hospitals

Key Points

- **This chapter focuses on two general areas of regulation: Certificate of Need (CN) and licensure requirements of health care facilities. Action is needed in both areas to evenly apply certain requirements across different types of facilities.**
- **The current CN program places hospitals at a competitive disadvantage relative to free-standing facilities. A comprehensive review of the CN program is needed to ensure that the requirements do not place one type of a facility at a competitive disadvantage when similar services are being provided.**
- **CN requirements should be subject to a regular review process to respond to changes in the health care system.**
- **Current licensure exemptions for surgical practices with single operating rooms are not justified on either quality or safety grounds. Licensure should be required of all ambulatory surgery centers, including single operating room physician surgical practices.**
- **The limited focus of current data collection efforts on hospitals is too narrow for modern health system planning and evaluation. Enhanced data collection from ambulatory care facilities is needed and should be required.**

There are numerous State regulations that influence the hospital market in New Jersey. The Commission focused on three general areas: the CN program, licensure requirements for health care facilities, and the governance requirements for non-profit hospital boards. All three issues influence the economics and performance of hospitals in important ways. CN programs are intended to influence the supply of health care facilities and services in the State and thus cost and quality through an approval process for the opening or closing of facilities and/or certain clinical services. The licensure program helps ensure a certain level of quality for individual health care facilities. Governance requirements are intended to ensure that community assets are effectively managed in service of the community.

As part of the Commission's effort to examine the regulatory landscape in New Jersey, a subcommittee on Regulatory and Legal Reform was formed to provide guidance. A major theme that emerged from the subcommittee's deliberations was the need to ensure that regulatory requirements are evenly and appropriately applied. The unevenness arises when regulations or standards are differentially applied to facilities that are providing the same service. Another major area addressed in the subcommittee's deliberations was the governance of non-profit hospitals – the Commission wholeheartedly agreed with the critical importance of this issue and as such has devoted the subsequent chapter in this report to governance reforms (see Chapter 10).

I. Certificate of Need Programs – Challenges to Effective Health System Planning

Although national studies have shown that CN programs have failed to achieve some of their original goals⁹⁰, the program in New Jersey continues to play an important role in preventing over-proliferation of services where volume and quality are related. In addition, it continues to provide a process for the orderly closure of an existing facility. CN programs have been criticized for, in effect, granting existing facilities a “franchise” by limiting/precluding competition.⁹¹ Thus, the success of CN in controlling costs is unclear. While some research suggests that the presence of a CN process lowers health care costs, other research finds the opposite.⁹² In addition, the CN process is applied unevenly across services and providers, leading to unintended consequences. For example, many states’ CN programs focus on hospitals’ ability to increase bed capacity, but the same programs do not restrict purchase of new, expensive imaging technologies, or restrict the building of new ambulatory surgery centers. Research conducted in the late 1970s suggested that CN exacerbates hospitals’ purchase of unneeded new technology, because hospitals race to be the first to offer a new technology before it becomes subject to the CN program.⁹³

CN programs were originally designed to control capital expenditures by hospitals, which is understandable given the era in which these programs were developed. Advancements in technology, however, have enabled care that was once only provided in hospitals to be shifted to freestanding ambulatory settings, but in some states, including New Jersey, these settings have been exempted from CN programs. Regardless of the reason

for these exemptions of certain provider types from CN requirements, the result is the creation of a competitive advantage for these providers relative to hospitals.

Some states believed these market-based economic forces obviated the need for their regulatory processes and discontinued their CN programs. Fifteen states have terminated their CN programs. New Jersey has not repealed its CN program, but in the 1990s the State began reviewing the CN process to allow more competition among health providers. The largest changes to New Jersey’s CN program occurred in 1998 with the Certificate of Need Reform Act, which exempted ambulatory surgery centers, several technologies, basic obstetrics and pediatric services and residential substance abuse treatment programs.⁹⁴

Recommendation

The Department of Health and Senior Services should conduct a comprehensive review of the CN and licensure programs to ensure that regulatory requirements do not place hospitals at a competitive disadvantage. CN requirements should be subject to a regular review process to respond to changes in the health care system.

While the evidence is mixed on the ability of CN programs to contain health care spending, proven relationships between volume and quality for certain clinical services argue for the continuation of the CN program for certain services. The State should ensure that CN programs particularly focus on clinical services where this relationship has been demonstrated. Licensure offers an additional policy tool to ensure minimum volume thresholds are reached to optimize quality.

⁹⁰ The Federal Trade Commission, Department of Justice, Improving Health Care: A Dose of Competition (Washington, D.C.: FTC, DOJ, 2004) Available online: http://www.justice.gov/atr/public/health_care/204694.pdf

⁹¹ Havighurst, C.C., “Monopoly Is Not the Answer,” *Health Affairs* Web Exclusive, (August 9, 2005). Available online: <http://content.healthaffairs.org/cgi/content/citation/hlthaff.w5.373/DC1>.

⁹² Piper, T.M., “Certificate of Need: Protecting Consumers’ Interests,” (June 10, 2003). Available online: <http://www.ftc.gov/ogc/healthcare-hearings/docs/030610piper.pdf>.

⁹³ Salkever, D.S. and Bice, T.W., “The Impact of Certificate of Need Controls on Hospital Investment,” *The Milbank Memorial Fund Quarterly, Health and Society*, Volume 54, Number 2, (Spring 1976).

⁹⁴ Sagness, J., “Certificate of Need Laws: Analysis and Recommendations for the Commission on Rationalizing New Jersey’s Health Care Resources,” (January 12, 2007). Available online: http://nj.gov/health/rhc/documents/con_laws.pdf.

The Commission grappled with the rapid proliferation of ambulatory surgery centers and their economic impact on hospitals. However, at this time, it is impossible to roll back the clock and CN does not appear to be a useful policy tool to address this issue. Relying on it would simply grant existing ambulatory surgery centers enhanced market power.

II. The Licensure of Health Care Facilities

A. Ambulatory Care Facility Resources in New Jersey

The New Jersey Department of Health and Senior Services (DHSS) licenses several types of ambulatory care centers. Based on analysis of information on ambulatory care centers data provided by DHSS, below is a description of the kinds of services provided in each type of ambulatory care center:

- Hospital-based centers – includes centers that provide substance abuse services and a variety of other facilities such as sleep centers, dialysis units and clinics;
- Free-standing centers – includes ambulatory surgery centers and imaging centers;
- Federally Qualified Health Centers (FQHCs) – public and private non-profit organizations that provide primary care to federally-designated medically underserved areas and populations and are important sources of primary care for uninsured Medicaid patients;
- Other centers – includes Planned Parenthood centers and other clinics.

Table 9.1 presents the number of these ambulatory care centers in each of the eight market areas used by the Commission for its analyses.

Table 9.1:
Number of Ambulatory Care Centers by Market Area and Type

Market Area	Hospital-based Ambulatory Care Centers	Free-Standing Ambulatory Care Centers	Federally Qualified Health Centers	Other Ambulatory Care Centers
Atlantic City	12	49	15	4
Camden	31	69	6	2
Hackensack, Ridgewood and Paterson	23	101	10	5
Morristown	14	56	6	3
New Brunswick	7	72	4	2
Newark/Jersey City	30	93	16	6
Toms River	10	66	8	2
Trenton	10	16	3	-
Total	137	522	68	24

As Table 9.1 shows, the vast majority of the ambulatory care centers are in the freestanding care center category that comprises ambulatory surgery centers and imaging centers.

The Commission noted two major areas where licensure requirements are not evenly applied with respect to ambulatory care centers. Currently, free-standing ambulatory surgery centers are not required to report clinical data on volume, costs, and quality in ways that hospitals are. In addition, ambulatory surgery centers (i.e. surgical practices) with single operating rooms are completely exempt from licensure requirements. In both cases, quality improvement and health system planning processes are hindered by these uneven requirements.

Recommendations

The Department of Health and Senior Services should require licensure for all ambulatory surgery centers and surgical practices with operating rooms.

Patient safety and quality goals require monitoring of all facilities. Although the Board of Medical Examiners has oversight over physician practices, the current exemption of physician offices with single operating rooms from DHSS licensure requirements is not justified. Elimination of this exemption would bring more uniform requirements to facilities providing similar services. In addition, it will make the data collected comprehensive and thus more meaningful with respect to health system planning.

The Department of Health and Senior Services should compile and maintain an inventory of non-hospital health care resources and a database to assess their use.

A necessary component of health services planning is data to assess the needs of the population and compare them with the supply of health care services. However, New Jersey, like many states, does not have a comprehensive data collection process to support needs assessment of many non-hospital health care services.

Instead, existing data collection efforts focus on inpatient services. However, inpatient hospital services comprise less than half of total health care spending, and for the remaining facilities-based health care services, there is a dearth of data in general, and in particular, in New Jersey. Some states require freestanding ambulatory surgery centers to provide patient volume information by surgical specialty, payer source, patient age, etc. New Jersey does not collect similar information, although the State requires ambulatory surgery centers and other freestanding ambulatory care centers to report data for the assessment that helps fund charity care subsidies to hospitals.

Given the number of ambulatory surgery centers in New Jersey and the debate about whether they and other freestanding ambulatory centers are a factor in the troubled financial condition of the State's acute care hospitals, New Jersey should begin its expanded data collection with ambulatory surgery centers. The State should consider requiring all ambulatory surgery centers to submit billing claims data similar to the data hospitals currently submit to the State. The DHSS has been collecting outpatient same day surgery data from hospitals for several years, but in an inpatient bill format. However, in January 2008, the Department is planning to switch to collecting hospital outpatient same-day surgery data in an outpatient bill format and to group the data into ambulatory patient classifications that the Medicare Program uses, so it will be positioned to expand data collection to freestanding ambulatory surgery centers. This would allow the Department to analyze hospital outpatient surgery data and freestanding ambulatory surgery utilization data together to understand the entire market for these services. In addition, the State should maintain a database of the number of operating rooms in hospitals and freestanding ambulatory centers.

III. Conclusion

The Commission strongly endorses the view that regulation and licensure requirements ought to be more evenly applied across health care facilities. The current focus on hospitals has not kept pace with changes in the health care system and has contributed to an uneven playing field with respect to the CN program,

requirements for licensure, and data reporting. A consistent theme of the Commission's discussion was the need for consistency based on clinical services, not facility type. The Commission recommends a review of CN requirements and expanded licensure and data reporting requirements with this underlying principle in mind.



Chapter 10: The Governance of New Jersey Hospitals

Key Points

- **Nearly all New Jersey hospitals are non-profit institutions – while many of these non-profit boards have exercised effective oversight and governance, some have failed to keep pace with best practices for non-profit governance. This has negatively affected hospital performance in some instances.**
- **The composition of hospital boards helps ensure that the hospital is responsive and accountable to the community. Hospital boards should ensure that they are representative of key stakeholders complemented by adequate technical expertise in key areas of oversight.**
- **Transparency helps ensure community accountability. Hospital boards should maximize transparency of financial performance data and measures of clinical quality.**
- **Conflicts of interest can threaten the integrity of the governance process. Hospital boards should have strong and explicit conflict of interest policies.**
- **Effective oversight requires that hospital boards are adequately trained and engage in best practices for financial oversight. Hospital boards should establish effective training programs and follow best practices for hospitals in audit and compliance committees.**
- **General principles of fiscal responsibility and transparent governance may be derived from principles articulated in the Sarbanes-Oxley Act of 2002. The Department of Health and Senior Services should review those principles and require that hospitals adopt those practices appropriate to hospital governance.**

Many New Jersey hospitals are facing crises for reasons external to the institutions themselves. As the Commission discusses elsewhere in this Report, shifts in the structure of health care delivery and shortfalls in payment from important funding sources have created new burdens for hospitals nationally. Hospitals' problems are not always external. In some instances, the governance of hospitals may not have kept pace with changes in the industry or the broader economy; in others, hospital governance itself may be at fault for institutional distress and even failure. In his classic "Burning the Seed Corn" (1996) health policy analysts Jeff C. Goldsmith chronicled how during the 1990s many hospital Boards in California presided over the

spending of hospital reserves to prop up physician incomes and perpetuate redundant hospital capacity.⁹⁵ In their "The Fall of the House of AHERF: The Allegheny bankruptcy" (2000) Lawton R. Burns et al. offer as a lesson for Boards and managers a trenchant analysis of the rise and fall of one of America's largest non-profit health systems.⁹⁶ In their "Corporate Structure and Capital Strategy at Catholic Health Care West" (2006)

⁹⁵ Jeff. C. Goldsmith, "Burning the Seed Corn," *Healthcare Forum Journal* (March/April, 1996): 19-23.

⁹⁶ L R Burns, J Cacciamani, J Clement, and W Aquino, "The fall of the house of AHERF: the Allegheny bankruptcy," *Health Affairs*, January/February 2000; 19(1): 7-41.

James C. Robinson and Sandra Dratler conclude that “The ‘trust me’ era of nonprofit accountability is being replaced by an attitude of ‘trust but verify’.”⁹⁷

Recognizing that most factors creating the dire position of many New Jersey hospitals are external, the Commission nevertheless determined that it must address the governance of our overwhelmingly nonprofit hospitals for two reasons:

- The management and long-term planning of nonprofit hospitals is governed by unpaid boards of directors, comprising community volunteers. A discussion of the health of New Jersey hospitals would be incomplete were these essential bodies ignored.
- Recent New Jersey history shows that communities may on occasion be ill-served when the nonprofit boards follow paths that drive their hospitals unnecessarily to significant fiscal difficulty. This history suggests that poor decision-making may be traceable to failures of institutions to ensure that board members have access to key information in a timely fashion, and to subversion of proper board oversight rules by the excessive empowerment of small cliques of board members or hospital management.

Many New Jersey hospital boards have adapted to recent decades’ transformation of the business of nonprofit hospitals. They are populated by dedicated members who are regularly provided with detailed information on their hospitals’ performance in patient care, financial stability, and community service. They have tracked the changes in hospital structure, payer reimbursement, and product line competition. In New Jersey, as elsewhere in the United States, this adaptation is not universal. Good governance is central to the success of New Jersey’s hospitals. The Commission recommends in some instances that all New Jersey hospital boards be encouraged to adopt “best practices” – methods of governance commensurate with their sophisticated range of obligations. In other instances, the Commission recommends that the adoption of methods

be made obligatory and that the Department of Health and Senior Services update its regulations to mandate certain governance measures.

I. History

A. Hospital Boards as Stewards of Local Charities

Fifty years ago, nonprofit hospitals operated as local community charities, and as workshops for local physicians. The scope of the operations of the hospitals was modest by modern standards. Boards of directors, made up of local businesspeople and professionals, served the important but relatively straight-forward roles common to the governance of other community charities. Directors raised charitable donations (then a more significant source of hospital revenue), encouraged volunteer participation in hospital life, and lightly oversaw the activities of a management that was lean and uncomplicated by today’s standards.

The hospital was more charity than business. The law imposed few duties on the directors. They were not responsible for the quality of care delivered by the hospitals’ employed nurses or the competence of the private physicians who used the hospitals as extensions of their private practices. Hospitals required little in the way of legal counsel – an attorney serving on the board was generally sufficient to handle minor matters that arose. Hospitals often reflected their neighborhood, and community residents came to believe the hospital they used was in a very real sense “theirs.” This halcyon state of affairs was possible because medicine was genuinely simpler then, requiring less in the way of expensive equipment and specialized technical personnel. Perhaps most significantly, medicine, and therefore hospitals, occupied a small footprint in the economy; care was relatively cheap, structures of reimbursement were rudimentary (frequently involving patient self-payment), and finances of the operation were too minor to draw significant notice of government, business, or even the commercial payers – such as they were.

⁹⁷ James C. Robinson and Sandra Dratler, “Corporate Structure And Capital Strategy At Catholic Healthcare West,” *Health Affairs*, January/February 2006; 25(1): 134-147.

B. From Charity to Big Business: Protecting Patients' and the Community's Interests

The surge in health care sophistication has brought many changes in hospitals, including increasing demands on nonprofit boards. With professional and technological advances – as, that is, medicine was capable of doing more for patients – came increasing prominence of third-party payment. Medicare, Medicaid, and the proliferation of commercial insurance brought more funding into hospitals. No longer just community charities, hospitals increasingly became big businesses. Even relatively modest community hospitals realized revenues of hundreds of millions of dollars a year. Larger hospitals and health systems generated billions of dollars each year. The scale of their business rendered hospitals even more significant engines of employment and commerce. As medicine, and therefore hospitals, could do more for patients, expectations for high-quality, technically proficient care increased.

With these changes have come increased demands on hospital boards. Recent events have focused attention on the quality of performance by hospital boards. The United States Senate,⁹⁸ IRS⁹⁹ and lenders have been particularly vocal in the last two years about nonprofit hospital boards' need to reform their governance practices. In addition, some state courts and Attorneys General have examined boards' conduct with increased scrutiny.¹⁰⁰ The passage of the Sarbanes-Oxley Act¹⁰¹ focused significant attention on business enterprises which has trickled down to nonprofits, especially hospitals. Hospitals have been particularly in the

spotlight both because they are important to health and welfare and because they tend to be very large, complex enterprises. Many "best practice" recommendations for improved corporate governance have already been adopted by New Jersey hospitals, although this adoption has apparently not been universal. Taken together, these sources of guidance suggest several categories of structure that could be incorporated in New Jersey hospital regulation to ensure appropriate governance of these important community resources.

II. Proposed Governance Reforms

Many New Jersey hospital boards are well-organized, well-run, and successful. It is clear, however, that there is a need to ensure that *all* of our non-profit hospital boards meet basic standards of competence, transparency, and community service. It may be that many boards already meet or exceed the standards set out below. Regulation of these important community resources is irresponsible, however, if it does not insist that *all* boards meet the minimum standards driving these recommendations.

Our concern in this regard finds resonance in the work of many governmental and professional voices that have recently expressed concern that too many members of nonprofit hospital boards are not serving their communities properly. One pithy set of recommendations has been provided by former Massachusetts Attorney General Tom Reilly.¹⁰² It sets out guidelines in a thoughtful and useful manner, and we reproduce it below:

⁹⁸ Senate Finance Committee, Exempt Status Reforms, (Staff Discussion Draft 2006), available at www.senate.gov/~finance/hearings/testimony/2004test/062204stfdis.pdf (last visited Oct. 20, 2007).

⁹⁹ Available at http://www.irs.gov/pub/irs-tege/good_governance_practices.pdf (last visited Oct. 20, 2007) (the IRS opines that boards following good governance practices are more likely to pursue an exempt purpose, act for the public's interest, and avoid pursuit of private interests).

¹⁰⁰ See David M. Studdart *et al.*, *Regulatory and Judicial Oversight of Nonprofit Hospitals*, 356 NEW ENG. J. MED. 625 (2007); Thomas L. Greaney and Kathleen M. Boozang, *Mission, Margin, and Trust in the Nonprofit Health Care Enterprise*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 1 (2005).

¹⁰¹ Public Company Accounting Reform and Investor Protection Act of 2002 ("Sarbanes-Oxley Act"), P.L. 107-204, 116 Stat. 745.

¹⁰² Attorney General Tom Reilly's 10 Practical Tips for Non-Profit Hospital Boards, available at <http://www.lawrenceassociates.com/Files/MA%20AG%20Tips%20for%20Hospitals.pdf>.

10 Practical Tips for Non-Profit Hospital Boards

- 1 Hold management accountable.** The board should set benchmarks, and the board must ask about benchmarks not met, deadlines missed, and failure to meet budget projections. If the initial inquiry raises new questions, the board should pursue those new questions as well. The board needs full information in order to act decisively.
- 2 Monitor the cash available to the hospital.** Scrutinizing an income statement is important, but to accurately track the financial health of the institution, particularly a distressed hospital, the board should also follow the cash.
- 3 Include the entire board in key decisions.** The various constituencies within the hospital must work together and make decisions together; the board should not be dominated by a single person or a small group of insiders. Providing for a diverse board and implementing term limits for trustees will, in most cases, aid efforts to create a wholly engaged, fully active board that can better deal with the ever-changing array of challenges facing hospitals.
- 4 Establish a strong conflict of interest policy and follow it.** A majority of the board should not have conflicts, even if those conflicts are disclosed and properly dealt with upon board votes.
- 5 Provide meaningful orientation and continuing education programs.** New trustees need effective, comprehensive, and up-to-date orientation programs and materials. All trustees need broad information about the hospital's current situation, history, environment, and strategic plan in order to make informed decisions.
- 6 Hold regular meetings focused on setting policy** in areas such as safety, quality, and strategic concerns.
- 7 Establish a three to five year strategic plan with a three to five year budget.** The board needs to know where it is going, establish benchmarks to measure progress toward its goals, review whether it is meeting those benchmarks, and have contingency plans ready in case progress falters.
- 8 Do not approve a budget that results in an operating deficit,** except in very unusual circumstances. When a hospital does fall into a deficit situation, the board and management should develop plans to regain profitability as soon as possible, and almost always within three years. Financially distressed hospitals must also develop short-term (monthly or quarterly) recovery plans, budgets, benchmarks, and contingency plans.
- 9 Focus on the performance of the organization,** rather than on proposed transactions with external parties. The board needs to concentrate on internal steps that the organization can take to improve its efficiency, cut its costs, and improve its quality and safety. This focus is most important for financially distressed hospitals. The board should begin by improving what it can at home, and then look to outside opportunities.
- 10 Do not expect the institution to grow its way out of problems.** The strategic plan must look beyond growth to find other ways to strengthen performance.

Many of these points are quite properly framed as recommendations. Members of boards are people of good will, often devoting many hours each month to their institutions. We recommend, however, that the New Jersey Department of Health and Senior Services impose regulatory obligations on hospital boards in three areas: board composition and education; required board activities; and public disclosure/transparency.¹⁰³

A. Board composition and education

Hospital boards must be efficiently functioning bodies. Board members have trouble functioning effectively or engaging wholeheartedly when boards are too large. The recent trend in board membership is to limit the size of boards. In addition, extremely long-term board membership limits member effectiveness, reduces independence from management, and constrains the power of innovation. We therefore recommend:

Recommended Best Practices:

- Hospital boards should be limited in size proportionate to the scope of its enterprise, but ordinarily to no more than 20 members.
- Members should serve fixed terms of three years.
- Members should be limited to three consecutive three-year terms, and may be reappointed to another term only after a three year period off the board.
- The terms of board members should be staggered to foster continuity.

Boards should be populated with two considerations in mind: representation of key stakeholders, and access to expertise necessary to accomplish board business. Target stakeholders should include community members, physicians, employees, and patients. Targeted expertise should include health care quality and delivery, financial and accounting, legal, and patient advocacy. Many boards' director nomination procedures are entirely internal and closed, and are not likely to surface

¹⁰³The implementation of many of these recommendations is within the current authority of the Department. If the Department lacks current authority to regulate in these areas, we recommend that the New Jersey Legislature empower the Department to do so.

candidates not already known to current board members. To serve representational and expertise goals, and to provide opportunities for community involvement in the composition of the hospital's governing body, the Department's regulations should be amended to require boards to adopt the following procedures:

Recommended Regulatory Adoptions:

- The board should publish a notice of board membership openings at a time and in a manner calculated to generate meaningful community input (e.g. local newspapers, hospital website, and other forms of outreach that would be expected to reach target representational constituency).
- The notice should identify the target representational constituency and/or expertise category, as relevant, that the board seeks to satisfy with the noticed appointment.
- Potential board members should complete an application that identifies the extent to which the candidate meets the criteria set by the board; assures the candidate's commitment to the hospital's mission; provides references; and identifies any possible conflicts that may interfere with the candidate's board service.
- The candidate may not be, or have a conflicted relationship with, the hospital's auditor.¹⁰⁴
- The board should explore the feasibility of including an employee as a member.

The nominating committee should clearly convey to candidates what the service expectations will be. The Commission recommends that boards adopt practices providing the following information:

¹⁰⁴Accountants are ethically prohibited by their own code from serving on the boards of entities for which they perform audits. The Code of Professional Conduct of the American Institute of Certified Public Accountants [hereinafter AICPA] rule on independence prohibits transactions, interests, and relationships that impair the member's independence; directorships are expressly prohibited under the rule. The NYSE precludes from service as a director one who is "affiliated with or employed by . . . a present or former internal or external auditor of the company . . . until three years after the end of the affiliation or the employment or auditing relationship." Listed Company Manual § 303A.02(b)(iii)(A) available at: http://www.nyse.com/Frameset.html?nyseref=http%3A/www.nyse.com/regulation/listed/1182508124422.html&displayPage=/lcm/lcm_section.html. See generally, *Developments in the Law, And Now, the Independent Director: Have Congress, the NYSE, and NASDAQ Finally Figured Out How to Make the Independent Director Actually Work?*, 117 HARV. L. REV. 2181, 2190 (2004).

Recommended Best Practices:

- Attendance at a general orientation on nonprofit governance (as required by New Jersey law¹⁰⁵) as well as an orientation specific to the entity s/he will be serving;
- Number of hours per month required to prepare for and attend meetings;
- That the board member will be automatically terminated upon
 - absence from a certain percentage of meetings, or
 - failure to comply with the conflict of interest policy;
- Directors are often required to contribute financially to the hospital as a condition of service. Such a requirement should not be a necessary condition of membership on a hospital board.

Upon appointment, and prior to orientation, directors should be provided with information necessary for their successful service in a properly organized board book or similar mechanism (e.g. dedicated webpage). This information is listed below.

Recommended Best Practices

- The entity's most recent annual report to the Secretary of State, audited financial statement and Form 990.
- An organizational chart, the names and contact information for every corporate member, director and officer, the identity and contact information for the board "staff person", and the composition of each board committee.
- The articles of incorporation and corporate bylaws.
- The medical staff bylaws.
- The charters for each committee to which the director is assigned, as well as the Joint Commission standards that apply to that committee's work.
- The prior year's board minutes as well as the minutes of each committee to which the board member is assigned.
- The names of hospital and medical staff leadership as well as general descriptive information including the number of beds and available services.
- The hospital's code of ethics.
- The hospital's corporate compliance and whistleblower protection policy.

¹⁰⁵N.J.S.A.26:24-12.34.

The Commission considered whether nonprofit board members should or may be compensated for their services. The IRS's draft Good Governance Guidelines, which takes the position that "charities should generally not compensate persons for service on the board," has been criticized in some quarters. The Independent Sector's recently-published Principles of Good Governance and Ethical Practice also discourages director compensation. In addition, New Jersey nonprofit corporate law weakens director immunity from liability for directors receiving compensation.¹⁰⁶ On the other hand, some have urged that compensation of directors is appropriate in certain circumstances in which the board needs access to a scarce pool of experts, who may be unwilling to serve without compensation. It is estimated that only two percent of nonprofits nationally compensate board members. Health care organizations (particularly larger organizations) are more likely to compensate directors, although even in that setting the practice is rare. A recent Urban Institute Survey found no correlation between director compensation and board engagement.¹⁰⁷ At this time, the Commission was not ready to recommend payment, although the issue might be explored further.

B. Board Functions

Many of the board's most essential functions – assuring the quality of patient care – are already codified in regulations and standards of the Department of Health and Senior Services, the Centers for Medicare and Medicaid Services, and the Joint Commission. Some additional financial and ethical standards have been recommended in recent years. Many New Jersey hospital boards have adopted most or all of these recommended procedures; all should do so. Hospital boards should be required to:

Recommended Regulatory Adoptions:

- Establish and adopt a written conflict of interest policy and procedure for board members.
- Create and disseminate to all employees a written whistleblower policy.
- Create and adopt a written document retention and destruction policy.
- Review and approve the Form 990 prior to its submission to the IRS.

There has been much discussion recently regarding the benefits of State involvement in ensuring that hospitals in New Jersey are operating with reasonable financial security. This Report discusses a proposed State role in creating and implementing an "early warning system" that would engage hospital boards in situations in which key indicators suggest severe financial distress. This "early warning system" is described in detail in Chapter 15 of this Report. All members of the board should be informed of this system, and information on this system should be included in the orientation of new board members.

Board bylaws should provide for the creation and operation of an Audit and Compliance Committee. In particular, the regulations should require the following structure:

Recommended Regulatory Adoptions:

- Audit and Compliance Committee¹⁰⁸
 - Comprised of independent (non-employee) members.
 - Governed by a charter enumerating its duties to oversee and ensure the existence of reliable internal financial controls, receive complaints or concerns from the internal auditors, and oversee the annual independent audit.¹⁰⁹
 - Vested with the authority to select an independent auditor, receive the audit letter at the conclusion of the audit, and retain its own legal counsel.¹¹⁰
 - Ensures rotation of the audit partner or firm every four years.
 - Meets with the audit firm in executive session to, at a minimum, discuss the audit letter.
 - Ensures that the Compensation Committee has reviewed key officers' compensation packages, including (non-qualified) deferred compensation

¹⁰⁶N.J. STAT. ANN. § 15A:6-14 provides that trustees who serves without compensation shall "not be personally liable to the corporation or its members for damages for breach of duty as a trustee," irrespective of the protections enumerated in the certificates of incorporation.

¹⁰⁷Francie Ostrower, *Nonprofit Governance in the United States: Findings on Performance and Accountability from the First National Representative Study*, The Urban Institute Center on Nonprofits and Philanthropy at 11, available at http://www.urban.org/UploadedPDF/411479_Nonprofit_Governance.pdf (last visited July 8, 2007).

and income from other sources for hospital work, as well as non-taxable fringe benefits and expense reimbursements over certain amounts.¹¹¹

- Empowered to receive reports on the contracting and compensation processes for the hospital's most significant independent contracts, including those receiving more than \$100,000 in compensation in any year.

The retention of experts essential to assist the board in decision-making is a core function of a governing board. New Jersey law insulates board and committee members from liability “if, acting in good faith, they rely on the opinion of counsel for the corporation or upon written reports setting forth financial data concerning the corporation and prepared by an independent public accountant or certified public accountant or firm of accountants....”¹¹² The legislature’s conferral of protection in such circumstances signals that directors should oversee the selection of these individuals or firms to ensure quality and independence, and to ensure that such experts do not serve dual roles as directors. Such governance norms should include requiring that:

Recommended Best Practices:

- The board should review and approve management’s recommendation of legal counsel to the hospital.
- Management should fully discuss the process for retention of the hospital’s legal counsel when seeking board approval.

In addition, the Department should mandate the following through regulation:

Recommended Regulatory Adoptions:

- Any contribution received from a vendor or contractor to the hospital should be reported to the hospital board.
- Legal counsel may not also serve as a director¹¹³.

C. Transparency

Transparency is essential to successful governance and service to the community. Transparency norms should address openness between management and the board, between board committees and the board as a whole, between the nonprofit hospital and the community which it serves, and between relevant agencies and stakeholders and the nonprofit hospital. Non-profit governance is most accurately described as one governed by confidentiality rather than transparency – regulations seeking to transform governance should transform this tradition.

Transparency reforms should begin at the board and management level. All committees, including the executive committee, should report all of its decisions, actions, and recommendations at every board meeting; the board should retain the ultimate power to reverse a

¹⁰⁸See generally, Ellen P. Aprill, *What Critiques of Sarbanes-Oxley Can Teach about Regulation of Nonprofit Governance* 8 available at <http://ssrn.com/abstract=952563> (Jan. 2007) (surveying the recommendations of various entities).

¹⁰⁹California, for example, requires nonprofit entities with annual revenue in excess of \$2 million to undergo annual audits by an independent accountant, overseen by a board audit committee. The audit must be disclosed to the public and the California attorney general. Nonprofit Integrity Act, Cal. S.B. 1262. See also, MASS. GEN. LAWS ANN. Ch. 12, § 8F (West 2006) (public charities whose annual revenues exceed \$500,000 to file audited financial statements with the Public Charities Division); N.H. REV. STAT. ANN. § 7:28 (2006) (requires charities with an excess of \$500,000 revenues to file audited financial statements with attorney general). In 2005, four states, Arizona, Colorado, Connecticut and Kansas enacted legislation addressing charitable organization financial disclosure and auditing. Ariz. S.B. 156; Colo. Legis. Serv. Ch 290 (2005) (S.B. 05-205); 2005 Conn. Legis. Serv. P.A. 05-101 (S.B.946); 2005 Kan. Sess. Laws Ch. 83 (S.B. 121).

¹¹⁰See National Association of College and University Business Officers, *Advisory Report: The Sarbanes-Oxley Act of 2002: Recommendations for Higher Education* (November 20, 2003) available at <http://www.nacubo.org/Documents/news/2003-03.pdf> (last visited December 21, 2007).

¹¹¹Sarbanes-Oxley principles require that the compensation committees of boards of non-profit firms perform this function; the Audit and Compliance Committee should merely be charged with confirming that the Compensation Committee’s report in this regard has been accepted by the board.

¹¹²N.J.S.A. 15A:6-14.

¹¹³Such service is not precluded by the Rules of Professional Responsibility. ABA Comm. on Ethics and Professional Responsibility, Formal Op. 410 (1998). See, also, Ellen B. Kulka, *Attorneys Services as Trustees of Nonprofits*, 189 N.J. LAW. 14 (Feb. 1998) (observing without approbation that directors sometimes also act as legal counsel (frequently pro bono); discussing the possibility of a higher standard of care for the trustee-attorney).

committee decision.¹¹⁴ Directors should be given the opportunity to submit meeting agenda items. The board should have a staff person assigned directly to it, with the attendant right of any director to request that this “staffer” collect information, prepare a report, or obtain the presence of any senior or middle manager, all without the necessary mediation of the CEO or other top manager. Any director should be able to call a meeting, or request the presence of the board’s legal counsel at a meeting. Some part of every meeting should be outside of the presence of management. Many boards likely operate in this fashion already. Transparency with the community at large is a less common practice. Boards should revisit the confidentiality provisions contained in their bylaws or committee charters, to narrowly circumscribe them to be consistent with this more liberal notion of transparency.

A hospital’s dire financial straits, and the strategic solutions under board consideration, should come as a surprise to neither the community (including patients and employees) nor the State. Rather, sufficient notice of an impending closure should facilitate the planned replacement of services to the community and the opportunity for employees to find alternative employment. Notice of financial instability at an appropriately early time may enable bondholders and/or the State to help the hospital develop strategies to salvage all or some of the hospital’s services, or to expedite closure, thereby avoiding further dissipation of assets. Elsewhere in this Report, the Commission sets out a series of “early warning” indicators and a series of steps to be taken when the conditions signaled by those indicators arise (see Chapter 15).

¹¹⁴The Revised Model Act does anticipate and permit board actions without a board meeting by unanimous written consent. REV. MODEL ACT § 8.21. The ALI draft Principles represent a significant step forward in this area, and could be further improved through the enhancement of transparency obligations. The comments to the draft ALI principles observe that “In general, the executive committee acts for the board between regular board meetings, and may exercise all powers of the board unless expressly limited by statute or the organizational documents.” Comment b.2 to § 325 at 173. The comments further elaborate that the executive committee should not usurp the board, may be reversed by the board, and should not be allowed inordinate power. *Id.* at 174.

¹¹⁵Other documents to be posted might include medical staff bylaws, audited financial statements, key committee charters, record retention policies, information on bond covenant violations.

¹¹⁶These might include outcomes of significant legal actions, Joint Commission inspection reports, health and safety code violation reports.

All community members should have access through a prominent section of the hospital’s web page (e.g. Community Relations), and upon request to the hospital’s public information office, to important institutional documents. The list of recommended information is listed below.

Recommended Regulatory Adoptions:

- The articles of incorporation, including the corporate mission statement;
- The members of the board of directors, their term of office, and a brief biography of each member;
- The board bylaws;
- The medical staff bylaws;
- The three most recent Forms 990;
- Management compensation, both direct and indirect;
- The three most recent annual reports;
- The board’s conflict of interest policy;
- Strategic plans approved by the board that significantly affect the provision of services in the community;
- The hospital’s charge master and its sliding fee provisions for the uninsured as well as the hospital’s billing and collection practices for the uninsured;
- Others.¹¹⁵

In addition, the web site should contain in readily accessible formats, health quality and price information, as the Department of Health and Senior Services deems appropriate. This information should be required to include:

Recommended Regulatory Adoptions:

- Reports on infection rates in formats approved by the Department;
- Quality measures and outcomes as approved by the Department;
- Information on sentinel events as approved by the Department;
- Pricing information for a sample of services approved by the Department;
- Information regarding the availability of charity care;
- Others.¹¹⁶

New Jersey hospitals are beginning to be acquired by multi-state systems whose parents are incorporated outside of New Jersey. This raises the policy question of the extent to which New Jersey stakeholders should have

access to information about these out-of-state “owners.” New Jersey law provides that every “domestic corporation and every foreign corporation authorized to conduct activities” in New Jersey must file an annual report with the Secretary of State.¹¹⁷ Neither this report, however, nor the IRS Form 990 is required to disclose the identity and location of out-of-state corporate parents. This information should be disclosed in the hospital’s annual report, which should be posted on the hospital’s web page.

D. Additional Governance Reforms

The passage of the Sarbanes-Oxley Act caused an intensive examination of the state of corporate governance in the United States, and in particular an examination of the extent to which reforms mandated by that law should apply to nonprofit corporations.¹¹⁸ Many of the recommendations in this chapter are drawn from Sarbanes-Oxley principles. Other reforms could be drawn from those principles, including requirements that:

- Hospital chief executive officers and chief financial officers personally certify the validity of key financial statements such as the Form 990;
- Hospitals not extend personal loans to officers and directors;
- Hospitals adopt a mandatory document retention program; and
- Hospitals adopt whistleblower policies that permit anonymous, confidential reporting of wrongdoing and protect employees from retaliation.

These and other additional governance reforms require further examination and discussion with interested parties. That process should be undertaken to identify other appropriate governance reforms.

Recommendation:

The Department of Health and Senior Services should review guidance on the application of Sarbanes-Oxley principles to hospital governance, discuss possible reforms with interested parties, and adopt by regulation those additional requirements that will ensure the integrity and transparency of hospital governance in New Jersey.

III. Conclusion

New Jersey’s hospitals have been buffeted by many market and regulatory forces out of their control. The Report discusses in Chapter 15 an “early warning system” that would assist board members in their obligation to respond to these forces. Some hospital problems are, however, within the control of its board. The Commission has concluded that inadequate attention to the relationship between hospital health and hospital governance may in some situations play a role in hampering the vital mission of our hospitals. We therefore conclude that steps should be taken – some in the form of recommended best practices and some in the form of mandatory regulation – to facilitate the maintenance of responsible board oversight of New Jersey’s hospitals. These recommended practices would increase accountability by improving the transparency and representativeness of hospital governance, ensure integrity of the process by limiting conflicts of interest, and enhance oversight of hospital finances and performance through board training and well-functioning oversight committees.

¹¹⁷N.J.S.A. 15A:4-5.

¹¹⁸See Francie Ostrower, *Nonprofit Governance in the United States: Findings on Performance and Accountability from the First National Representative Study*, The Urban Institute Center on Nonprofits and Philanthropy, available at http://www.urban.org/UploadedPDE/411479_Nonprofit_Governance.pdf (last visited December 21, 2007); Lumen N. Mulligan, *What’s Good for the Goose is not Good for the Gander: Sarbanes-Oxley-Style Nonprofit Reforms*, 105 Mich. L. Rev. 1981 (2007).



Chapter 11:

Adequacy of the Ambulatory Care Safety Net and Other Access Barriers

Key Points

- **Many patients come to emergency rooms with conditions that are preventable or best treated by a primary care provider – this is due in part to deficiencies in the ambulatory safety net. New models of care management are needed to decrease reliance on traditional emergency room care.**
- **Ambulatory safety net clinics have limited access to specialty care. New programs to increase the supply of specialty care should be pursued.**
- **Mental health and substance abuse are major public health issues and a common cause of ED visits and inpatient admissions. The State should explore expanding mental health and substance abuse services with a focus on wellness and recovery needs while maintaining acute inpatient options.**
- **Low Medicaid rates limit physician willingness to care for Medicaid patients. Rates should be set at 75% or more of current Medicare rates.**
- **Uninsured patients face the highest prices for hospital-based care. The current system should be abandoned and replaced by a system of sliding scale fees based on income with a maximum price for uninsured New Jersey residents of no more than what Medicare pays for the same service. Hospital policies should be publicly available on the hospital's website and elsewhere.**
- **Efforts should be undertaken to enhance the physician workforce in underserved areas through loan forgiveness, medical school expansions, programs to increase the diversity of medical students, telemedicine, and advocacy to increase the number of Medicare-funded training residency training positions.**
- **Special-needs populations face unique barriers to accessing care. Accommodations and programs are needed to address barriers such as transportation, communication support, and barrier-free access.**

One of the goals of a health care system is that it ought to be equitable – people should have the same health care experience regardless of socioeconomic status. Despite being the richest nation in the world, the US health care system leaves millions without insurance coverage and ranks poorly on measures of health system performance and equity in access relative to our massive investment in health care.¹¹⁹ New Jersey is not unlike much of the rest

of the nation in the types of challenges vulnerable populations face related to health and health care.

In addition to the impact on individuals, hospitals are profoundly affected by the availability of care throughout the community. In many ways, hospitals serve as the provider of last resort and deficiencies in the ambulatory care system ultimately manifest themselves in hospital emergency rooms. The Commission sought to examine the adequacy of the safety net and formed a subcommittee

¹¹⁹Davis, K., et al. *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, The Commonwealth Fund, May 2007

on “Access and Equity for the Underserved.” The Commission, guided by the subcommittee, examined deficiencies of the ambulatory care system that create pressures on hospitals and barriers for vulnerable populations seeking high quality care.

The Subcommittee and Commission’s deliberations focused on the following gaps and barriers:

1. Over-reliance on hospital emergency rooms due to access barriers for ambulatory care;
2. Disparate and/or disconnected local health planning, in connection and in cooperation with community-based partnerships;
3. The dearth of primary and specialty healthcare providers available in certain areas and for certain populations;
4. Transportation barriers for certain populations;
5. Cultural and communication barriers, including access for individuals who have mobility impairments, or are deaf, hard of hearing, blind or visually impaired;
6. Language barriers for persons for whom English is not their primary language;
7. Medical and dental care needs for individuals with developmental disabilities;
8. Lack of health insurance;
9. Historically low Medicaid reimbursement rates that compromise access.

Barriers to care can be broadly categorized as either economic, environmental, or both. Economic barriers include lack of access to health insurance, hospital finances, and Medicaid reimbursement rates. Environmental barriers include lack of geographic proximity to some other locus of care as a viable alternative to a hospital emergency room, inadequate transportation availability, language and other cultural or communication difficulties, physical access barriers for individuals with mobility impairments, well-established behaviors (one may be accustomed to accessing care through a hospital emergency room), and traditional focus on and funding of acute versus preventative care.

Three general notions provided the underpinning for the Commission’s deliberations and formulation of recommendations:

- (1) The relationship between a community and its hospitals is complex. A lack of services within a community, for example, often results in inappropriate or over-reliance on a given hospital, which strains the hospital’s finances and overall capacity. Conversely, hospital closures frequently strain community services and negatively impact capacity. What would ideally be a symbiotic relationship is often fraught with tension.
- (2) Health disparities associated with income, race, ethnicity and disability are due to a range of factors including: differential financial access to health care, differential physical access to care (e.g. distance), differential income and associated environmental conditions, and variations in personal and cultural preferences. While health care access is only part of the solution to health disparities, it is an important component. Indeed, barriers to accessing quality health care are at a least a contributing factor to the grim reality that death rates from heart disease are more than 40 percent higher for African Americans than for whites and that Hispanics are nearly twice as likely as non-Hispanic whites to die from complications of diabetes.
- (3) One of the most significant predictors of access to health services and treatment is health insurance coverage.¹²⁰ Policy changes that fall short of universal coverage will not address the root cause of current problems in New Jersey’s health care system.

I. Excess Use of Emergency Rooms for Primary Care or Preventable Conditions

Hospitals are in trouble, at least in part, because they are serving patients that are not matched with the proper level of care at the right time. Hospitals in low-income areas all too often report a large volume of cases that come to their emergency departments with late stage illnesses such as cancer and kidney failure or come repeatedly for chronic conditions such as asthma,

¹²⁰Institute of Medicine. *Insuring America’s Health: Principles and Recommendations*. Washington, DC: National Academies Press, 2004.

diabetes, and congestive heart failure. President Bush recently remarked that, “people have access to health care in America. After all you just go to the emergency room.”¹²¹ This view reiterates the false belief that emergency rooms can substitute for reliable and regular medical care. It also ignores the need for timely, cost-effective care – the Institute of Medicine estimates that 18,000 Americans die prematurely each year due to lack of health insurance.¹²² A September 2007 Rutgers Center for State Health Policy report (Rutgers Study) found that emergency department visits are on the rise in New Jersey and that a significant percentage of the visits may have been avoided through better access to primary care.¹²³

Recommendation:

Successful patient case management models should be supported and replicated in order to address the large volume of ambulatory care sensitive conditions in Emergency Departments.

For example, certain case study hospitals included in the September 2007 Rutgers Study have developed “fast track” systems to separate emergent from other cases in the emergency department. Under this model, patients are routinely referred to outpatient clinics for non-emergent care. Other hospitals are having success as a result of developing elaborate case management and chronic disease management systems within the emergency department itself. While this is a clear departure from the traditional role of the emergency department, these facilities have decided that community need and patient preference have made the departure necessary.

Additionally, New Jersey should seek to replicate and implement emergency room (ER) diversion programs. Under such programs, hospitals employ a nurse to provide care management to patients after their ER visit. For Medicaid clients enrolled in an HMO, after the ER visit, the care manager works with the patient and the HMO in order to ensure that the proper follow-up care is

coordinated with the patient’s primary care provider. In cases of Medicaid fee-for-service, the care manager connects the patient with a Federally Qualified Health Center (FQHC) to provide them with a medical home. The goal is to provide primary care as part of the continuum of care needed to prevent complications of chronic diseases and other acute episodes of illness.

II. Challenges Accessing Specialty Care at Community Health Centers

Through a network of ninety-six satellite sites located statewide, New Jersey’s nineteen Federally Qualified Health Centers (FQHCs) provide high quality preventive, primary, and acute care medical services for its medically underserved population. In addition, community-based health centers, such as Volunteers in Medicine, family planning centers, and the like provide similarly necessary services.

While the FQHCs and community health clinics are models for providing high quality primary and preventive care services, most of these sites are not equipped to provide specialty care services for a wide range of specialty care needs of their patient population. At present, for example, most FQHCs provide specialty care services through referrals to specialists affiliated with local hospitals or specialty care clinics as needed. These referrals generally require payment on the part of patients to the specialty provider. Only a handful of these health centers have on-site specialty care services for selected specialties.

Since many of the medically underserved areas also suffer from severe shortages in health care providers, in many instances, the current referral system fails to provide timely treatment for the health center patients often resulting in harmful health effects, high number of emergency department visits, and costly hospitalizations.¹²⁴ It should be noted that federal legislation

¹²¹July 10, 2007; Cleveland, OH:
<http://www.whitehouse.gov/news/releases/2007/07/20070710-6.html>

¹²²Institute of Medicine. Hidden Costs, Value Lost: Uninsurance in America. Washington, DC: National Academies Press. 2003.

¹²³“Hospital Capacity, Patient Flow, and Emergency Department Use in New Jersey,” Derek DeLia, Ph.D., September 2007. Available online at: <http://www.cshp.rutgers.edu/Downloads/7510.pdf>

¹²⁴For additional discussion of recommendations related to the FQHCs’ role in New Jersey, go to:
<http://www.njpca.org/Medical%20Home%20Document.pdf>

increasing the number of FQHCs across the country would provide a meaningful impact on the medically underserved community.

Recommendation:

Increase the primary care infrastructure and supply of specialty care to patients served by FQHCs and community-based clinics. This effort will require identifying willing providers and financing such care.

One solution proffered to pursue this recommendation was to encourage the New Jersey Primary Care Association (NJPCA), in collaboration with the Medical Society of New Jersey (MSNJ) and New Jersey Hospital Association (NJHA), to work to establish an expanded network of specialty care providers and hospitals to provide additional specialty care support for the health centers. By negotiating letters of agreement with specialists and participating specialty care clinics and hospitals, health centers could refer their patients as needed.

A related solution would encourage FQHCs and other clinics to provide on-site specialty care along with primary care. The NJPCA has identified three approaches to providing on-site specialty care. Since case overload is a major reason for backlog in the existing system of specialty networks, the first approach would be to recruit retired specialists to provide volunteer specialty care services on-site at the health centers. Costs associated with this approach include the cost of maintaining a valid license, the cost of Continuing Medical Education (CME) credits and the cost of malpractice liability coverage. Legislative support at the national level is also needed to extend medical malpractice liability protections to volunteer physicians at community health centers. (H.R. 1313, the “Community Health Center Volunteer Physician Protection Act of 2005” was introduced in November 2005 to amend the existing Public Health Service Act to provide liability protections for volunteer practitioners at health centers.) A New Jersey alternative to this Federal legislation was introduced in 2003. While these bills would act as a catalyst to help bolster the infrastructure of physicians who volunteer service, both have been stalled in the process.

A second option would be to hire retired specialty care physicians on a part-time basis at the health care centers. Once employed, these physicians would be eligible for malpractice coverage under the Federal Tort Claims Act of 1992.

Under a third approach, health centers would contract with practicing specialists to provide on-site services for a few hours each week in high priority specialty areas. Physicians from FQHCs and community clinics should also be encouraged to join the medical staff of a single local hospital – in order to encourage patient care through a team approach.

III. Mental Health and Substance Abuse Services

Local hospitals are an integral part of the community mental health and substance abuse systems with much of the emphasis placed on meeting the most acute, serious needs of these populations. Many hospitals offer a continuum of psychiatric and substance abuse services, which function as acute care diversion services, as well as step-down options from more intensive services. These hospitals, embedded in the community, are critical in responding to the needs of the community members. Users of mental health services depend on local hospitals that provide mental health treatment in addition to other services. It is worth noting that an estimated one in five people in New Jersey will experience a diagnosable mental illness, and that the National Association of Mental Health Program Directors estimates that people with mental illness live, on average, 25 fewer years than do persons not so afflicted. When hospitals close, it is imperative that these critical services remain available to the community at the same level of accessibility and clinical intensity.

While hospitals serve as an important part of the mental health and substance abuse treatment system, many patients seeking medical treatment in emergency rooms present with signs of mental health or substance abuse problems. According to the 2007 Rutgers Study, New Jersey hospitals have increasingly become providers of care for mental health and substance abuse patients, particularly through the emergency department. A number of emergency department physicians have attributed this rise to a decrease in the number of

psychiatric beds and detoxification services and insufficient funding for community-based mental health and substance abuse care. Many admissions to emergency rooms are often related to drug or alcohol misuse. Substance abuse-related emergency room visits represent an opportune moment for screening, brief intervention, and referral to treatment services. Currently, this practice is not widely implemented.

The continuum of preventive, non-acute care provided by community-based and hospital providers is less expensive, effective, and preferable to costly emergency-based care. Available services and funding sources from hospital closures could be transitioned to replacement community or hospital-based services, and when possible, to more wellness and recovery-oriented services.

Recommendation:

State health policy should expand mental health and substance abuse capacity in the community, prioritize funding for mental health and substance abuse services, and insist on tailoring services to patients' wellness and recovery needs. In addition, it is also critical that acute psychiatric and detoxification services, emergency and acute hospital inpatient care continue to be available in a hospital setting.

As noted above, this could be funded through a reallocation of resources available once a hospital closes. Similar resource shifts should likewise occur for substance abuse services, now available on an inpatient basis in only limited parts of the State.

IV. Disconnect between community needs and the Certificate of Need process

The Subcommittee noted that the existing Certificate of Need (CN) process, which, in relevant part, examines availability and continuity of community resources when a hospital is considering closure, is ripe for examination and can be strengthened.

Recommendation:

Institute a community-based health planning process that encourages partnerships and includes community resources so that access to basic and essential healthcare services is a proactive, rather than a reactive endeavor.

V. Historically Low Medicaid Reimbursement Rates Limit Access

New Jersey's historically low provider reimbursement rates for fee-for-service Medicaid are well documented. A comparison of all states in 2003 found that New Jersey had the lowest reimbursement rates in the nation. Low rates have been directly associated with adversely impacting access to a variety of healthcare services.¹²⁵ Indeed, the abysmally low reimbursement rates have severely impacted the availability of healthcare professionals who are willing and/or financially able to offer services to Medicaid patients.

Recommendation:

To improve the availability of quality care, the Commission recommends that New Jersey set provider reimbursement rates for Medicaid and other state-funded health care services at 75% or more of current Medicare rates.

The Commission did note that Governor Corzine's 2008 Budget Initiative to include \$5 million (a \$20 million figure once annualized and matched with federal dollars) to increase Medicaid rates for services to children was a first and meaningful step to address this long-standing concern.

VI. High Prices for the Uninsured

Uninsured patients seeking care at New Jersey hospitals and elsewhere often face the highest prices for services of any patients entering the door. In nearly all cases, they are least able to afford it and receive extremely high bills following discharge. While they often can't and don't pay the entire bill and can frequently negotiate a discount, this sometimes only happens after facing collection procedures such as wage garnishment, levies on bank accounts, and property liens.

This unfair and objectionable situation arises from the fact that the no organized entity negotiates prices on behalf of the uninsured. This practice has been under

¹²⁵Zuckerman, S., McFeeters, J., Cunningham, P., Nichols, L. Changes in Medicaid physician fees, 1998-2003: implications for physician participation. *Health Affairs*, 2004; W4: 374-84.

scrutiny in recent years but the hospital industry has yet to adopt a uniform solution that could at least bring charges for uninsured patients in line with what most patients pay by way of their insurer.

Recommendation:

Uninsured patients who are residents of New Jersey should be charged on a sliding scale based on income with a maximum set at the price Medicare pays hospitals for the same services. A hospital's sliding scale policy (i.e. prices charged the uninsured) should be publicly available on the hospital's website.

This maximum price would add a small dimension of fairness to current billing practices despite the fact that the uninsured would continue to face bills that would be beyond their financial means. Hospitals should be required to develop a sliding fee schedule based on income where the Medicare rate would be the maximum financial exposure for an uninsured patient from New Jersey. Fairness also dictates that hospitals should make their sliding scale policies publicly available on their website so that patients can know what to reasonably expect when hospitalized at a given institution.

VII. Workforce Issues and Graduate Medical and Dental Education

According to the New Jersey Council of Teaching Hospitals, New Jersey's teaching hospitals provide 70 percent of the medical care to the uninsured and underinsured. Faculty medical staff and physician residents are key care providers to New Jersey's medically underserved. New Jersey ranks 18th in the nation as to the number of physicians in training relative to the State's population. Furthermore, New Jersey has a particularly high percentage (39.7%) of practicing physicians who are International Medical Graduates (IMG), ranking us 2nd in the nation.

According to the Medical Society of New Jersey, our State is currently experiencing a shortage of physicians in the fields of obstetrics and gynecology, pediatric subspecialties, neurosurgery, anesthesiology, family practice, and general surgery. There is a similar shortage of dentists and other oral health practitioners. A September 2000 GAO report, "Factors Contributing to

Low Use of Dental Services by Low-Income Populations," discusses not only the low Medicaid reimbursement rates for dentists but also the short supply of dentists in many areas.¹²⁶

Workforce policy is a critical issue demanding attention as New Jersey attempts to rationalize the health care system. However, the issue is complex and was beyond the scope of this Commission. A study of workforce issues is warranted and should be undertaken as part of a separate commission. Several suggestions arose in this Commission's deliberations that warrant future consideration:

- Provide loan forgiveness and scholarships to professionals willing to serve in medically underserved areas or in professional specialties experiencing workforce shortages. Targeting incentives to areas of greatest need is important for making health care services available where they are needed most. For example, Medicaid could focus its Graduate Medical Education (GME) funding to the specialties experiencing the greatest workforce shortages. This funding would provide relief to practitioners in potentially vulnerable institutions by in essence providing additional funding for uncompensated care.¹²⁷ Advocacy is also needed on the federal level to increase annual awards to physicians by the National Service Corps to encourage more doctors and dentists to practice in underserved areas while addressing rising medical/dental student debt.
- Boost class sizes in existing medical schools and establish new medical schools.
- Advocate increasing the number of residency training positions funded by Medicare to accommodate additional medical/dental school graduates.
- Increase minority recruitment and training in the State's medical schools. The percentage of minority enrollees in medical schools remained

¹²⁶<http://www.gao.gov/archive/2000/he00149.pdf>

¹²⁷Gbadebo, A.L., Reinhardt, U.E. Economists on academic medicine: elephants in a porcelain shop? *Health Affairs*, 2001; 20: 148-52.

essentially unchanged between 1970 and 1996, and continued at a rate lower than minority representation in the general population. Addressing this trend is important because minority physicians most often serve in minority communities and underserved areas. State policy should establish goals to encourage the recruitment and training of health care providers whose race, ethnicity, and language reflect the composition of the state and communities in need.

- Develop telemedicine programs for remote areas. Telemedicine approaches enable the transfer of medical information – including medical images, two-way audio and videoconferences, patient records, and data from medical devices – for diagnosis, therapy and education. New Jersey should make use of currently available technology to develop and support telemedicine systems that provide medical expertise to underserved geographic areas of the State. Specifically, New Jersey could explore exercising Medicaid options for reimbursing telemedicine services and protect patients by requiring out-of-state physicians to be licensed to provide telemedicine services.

VIII. Lack of Practical Transportation Options Hinders Access to Care

For those individuals who are not Medicaid eligible, transportation was noted as a significant barrier to accessing healthcare – especially in more rural communities and other areas where a robust transportation infrastructure for seniors and those with disabilities is unavailable. In addition, the lack of coordination among existing systems which serve specialized populations creates duplication and increased costs.

Transportation needs are best resolved through local planning and should figure prominently in the community and regional planning noted above. The federal government has initiated a “United We Ride” initiative that requires states to enhance access to transportation to improve mobility, employment opportunities, and access to community services for persons who are transportation-disadvantaged, including

seniors, individuals with disabilities, and low income households. (New Jersey’s Department of Human Services manages this initiative.)

Recommendation:

The health care community should be engaged in the “United We Ride” planning initiatives to ensure the transportation needs of the medically underserved are addressed.

When available, transportation for persons who are Medicaid eligible may be coordinated with existing county Para-transit trips. This will increase cost efficiency and reduce duplication of trips routing.

IX. Barriers for Special Needs Populations

Cultural and communication barriers exist for a number of special needs populations, including access for individuals with disabilities, including persons who are deaf, hard of hearing, blind, or visually impaired, or those for whom English is not a primary language.

A. Individuals who are Deaf or Hard of Hearing

Generally speaking, the health care access needs of deaf and hard of hearing populations are similarly affected by the same access and equity issues described for other vulnerable groups. One complicating factor, however, is the ability of health care professionals to meaningfully communicate with persons who are deaf or hard of hearing, such that the quality of care rendered is not compromised. A 2005 study examining health care system accessibility issues of deaf people found communication to be a pervasive problem and barrier.¹²⁸

Technological advancements are increasingly available, as are traditional resources such as American Sign Language interpreters, although in diminishing supply. These resources can provide meaningful communication for those with special needs. Access remains largely dependent, however, upon a healthcare facility’s investment in and commitment to ensuring adequate availability of human or technological resources with those who require such assistance.

¹²⁸Steinberg, A.G et al. Health care system accessibility: experiences and perceptions of deaf people. J Gen Intern Med. 2006; 21(3): 260-66.

B. Individuals who are Blind or Visually Impaired

The ability to access health care is often dependent on the ability to complete health forms. Lack of alternative media for medical forms and the availability of staff to read forms creates a major barrier for sight impaired individuals. A 2007 study conducted by the National Council on Disability points to the importance of providing health care forms and information in alternative formats for those with visual impairments.¹²⁹ As with other populations, access to transportation is also an important issue.

C. Individuals with Physical Disabilities

Generally speaking, the health care needs of individuals with physical disabilities are similarly affected by the access and equity issues noted above. Two complications, however, are barrier-free access to the locus of care and meaningful access to transportation. The previously cited National Council on Disability report identified access to transportation as a significant barrier to accessing health care. An example of a substantial barrier for this population is the lack of availability of accessible examination tables for persons who are non-ambulatory.

D. Individuals with Developmental Disabilities

The medical needs of individuals with developmental disabilities range enormously in their complexity. A 2002 Surgeon General's report outlined the challenges in obtaining these services.¹³⁰ For those with a mild to moderate disability, access to traditional hospital venues and/or community care clinics may suffice for routine medical or dental needs. For those with significant developmental disabilities, however, access to specialty medical and dental care, as well as mental health care (if needed) is critical. Additional behavioral supports may

be required for patients with challenging behaviors in order to facilitate the exam and treatment provided by the physician or dentist. A 2005 report by the Special Olympics highlights the gaps in health care for those with developmental disabilities.¹³¹ The issue of transportation, akin to that which was noted for individuals with physical disabilities, is also a barrier to accessing health care services. It should also be noted that the recently-enacted Danielle's Law has rendered some unintended stressors upon hospital emergency rooms, as the frequency of such visits has increased.

Recommendations:

While it is difficult to generalize the accessibility concerns of special needs populations, basic accommodations such as communication support, barrier-free access, and specialized care are not always costly and should be prioritized.

One example of an important and low-cost effort towards effective communication is the Communication Picture Board, prepared through a collaboration of the New Jersey Department of Health and Senior Services/Office of Minority and Multicultural Health and the New Jersey Hospital Association. This board utilizes a variety of pictures to enhance one's expression of needs, and is designed for use by emergency service personnel and frontline intake staff to better enable effective communication with the public.

The establishment of Centers of Excellence for medical, mental health and dental care for individuals with developmental disabilities should be explored.

For individuals with developmental disabilities, the dearth of medical and dental specialists is particularly acute. Accessibility and communication are significant barriers to medical and dental services.¹³²

¹²⁹National Council on Disability. Implementation of the Americans with Disabilities Act: Challenges, Best Practices, and New Opportunities for Success. 2007. Available at: http://www.ncd.gov/newsroom/publications/2007/implementation_07-26-07.htm

¹³⁰U.S. Surgeon General. Closing the Gap: A National Blueprint to Improve the Health of Persons with Disabilities. 2002. Available at: <http://www.surgeongeneral.gov/topics/mentalretardation/retardation.pdf>

¹³¹Special Olympics. The Health and Health Care of People with Intellectual Disabilities. 2005. Available at: http://www.specialolympics.org/NR/rdonlyres/e750katixbkneht-truutheossutueniq7hsd6ev6bg3astpgwfmmbbzfwy5ph2tbjoiz3gnjuzum6hhbjgljh6nl36d/CACW_Health.pdf

¹³²See <http://rtc.umn.edu/nhis/> & <http://www.Pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1783697&blobtype=pdf>

X. Language

The increase in immigrant groups in New Jersey, coupled with higher incidence of chronic health care conditions requiring regular health care monitoring, argues strongly for health care services that can adequately serve linguistically, ethnically and culturally diverse families.

Recommendation:

New Jersey's health care system must provide appropriate *professional* interpretation and translation services along with outreach and educational materials in the language of patient populations and should be reimbursed for such services by all payers.

The health care system too often relies on makeshift methods to overcome language barriers, compromising quality and equity. Translation services and language appropriate outreach and education should be a priority. Title VI of the Civil Rights Act and U.S. Department of Health and Human Services regulations prohibit all recipients of federal funding, either directly or indirectly, from discriminating on the basis of national origin to provide equal access to services and activities. All such entities are obligated to take steps to provide meaningful access to services for people with limited English proficiency, with specific guidance for healthcare organizations issued by DHSS through the Office of Minority and Multicultural Health. This guidance reiterates the various methods and criteria for satisfying this obligation through professional interpreters (not patients' family members) and translated materials.

Since most health care providers (hospitals, doctor's offices, health maintenance organizations, nursing homes, community health centers, etc.) receive some federal funding, virtually all health care providers are obligated to provide appropriate language access to patients with limited English. In 2000, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) stated that federal Medicaid and SCHIP funds can be used for language services and activities for Medicaid beneficiaries. Several states have taken advantage of this method to maximize federal funding in this area and reimburse providers for this service. Since language access is a significant barrier to health care and relevant to racial and ethnic health disparities, this method for reimbursement should be adopted by New Jersey.

XI. Conclusion

Vulnerable populations are profoundly affected by the problems in our State's health care system. Low-income patients struggle to access specialty care in community health centers, poor reimbursement rates impose barriers for Medicaid beneficiaries, uninsured patients seeking hospital-based care are charged the highest prices, deficiencies of the mental health care system manifest in crowded hospital emergency rooms, and special-needs populations face unique barriers to accessing care. The Commission has put forth a range of recommendations aimed at reducing these barriers and improving health equity.



Section IV:

Prioritizing Financial Assistance to Financially Distressed Hospitals

A principal task of the Commission was to develop a framework for determining which New Jersey hospitals should receive state support in the face of financial distress. The following section puts forth the framework adopted by the Commission that defines hospitals as essential or non-essential and financially viable or not viable. The obvious implication of this work is the development of public policy to support essential hospitals that experience financial distress while allowing other hospitals to be subjected to market forces and potentially close.

The following section explores a range of issues related to the essentiality of hospitals and support that should be provided in such cases. The specific focus of individual chapters follows:

- Identifying New Jersey's Essential Hospitals (Chapter 12)
- Supporting Essential, Financially Distressed Hospitals (Chapter 13)
- Facilitating the Closure of Non-Essential, Financially Distressed Hospitals (Chapter 14)
- Improving State Oversight to Provide Greater Accountability for State Resources (Chapter 15)



Chapter 12: Identifying New Jersey's Essential Hospitals

Key Points

- **This chapter outlines a framework for identifying hospitals that warrant state support by assessing “essentiality” and “financial viability.”**
- **Hospitals would be deemed essential based on their level of care for financially vulnerable populations, their provision of certain essential services, and providing a high fraction of health services in the hospital's market area.**
- **Financial viability is determined by three measures: profitability (operating margin), liquidity (days cash-on-hand), and capital structure (long-term debt to capitalization).**
- **Hospitals that are more essential and less financially viable should be the focus of the State's effort to provide financial support. Market forces should be allowed to govern in other cases.**
- **Qualitative factors are important considerations in the final policy determination of whether a given hospital should receive support.**
- **The determination of hospitals' relative essentiality and financial viability score is a dynamic process meaning that the relative scores of hospitals on each measure will change from year to year. Closure of an area hospital is but one factor that will induce such changes.**

This chapter describes the Commission's approach to identifying hospitals that provide essential services in their market area, but are in financial distress and may warrant financial assistance from the State.

I. Development of Framework for Evaluating Hospitals

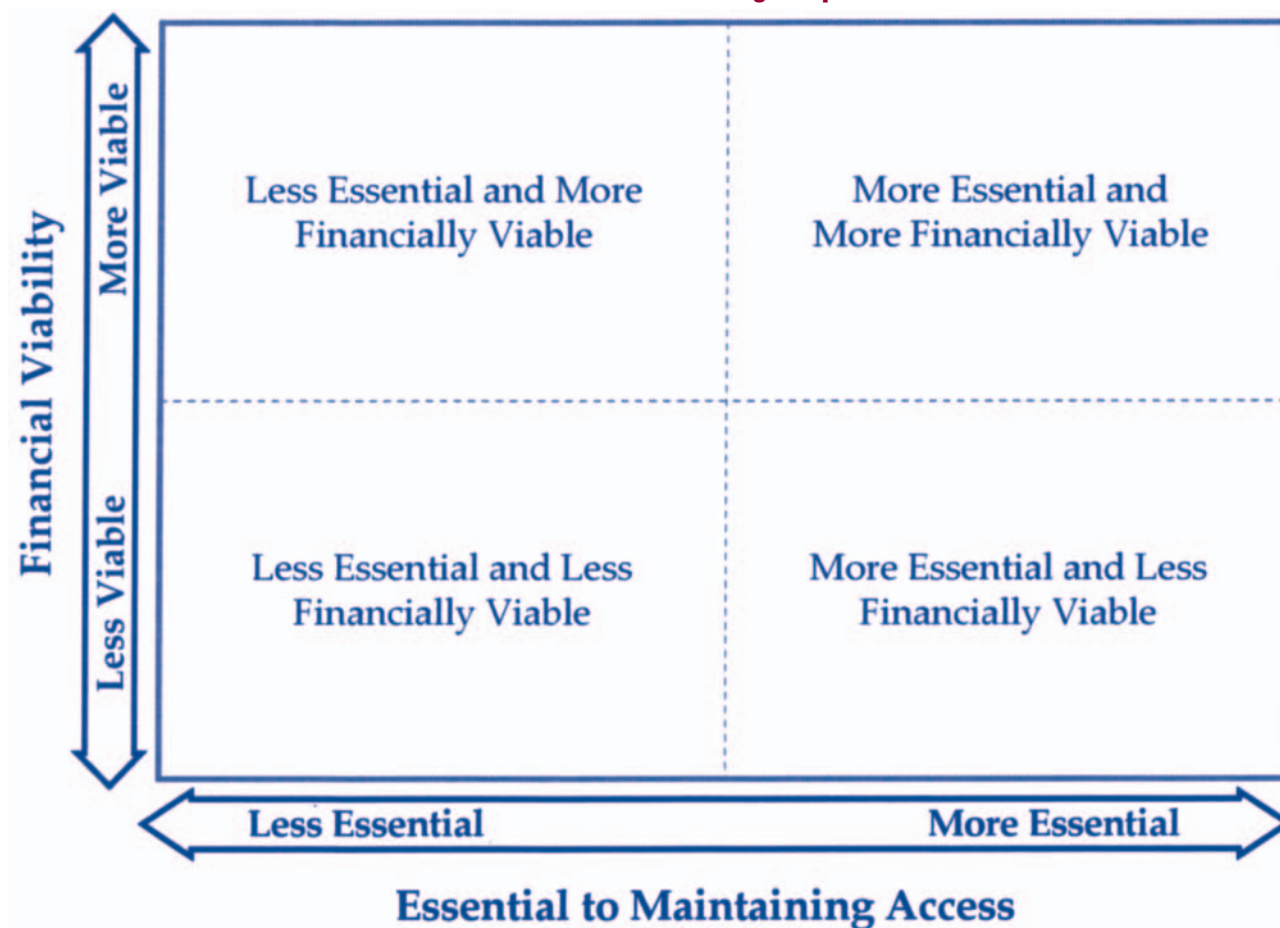
The purpose of developing criteria to identify essential hospitals and a method for scoring or ranking hospitals using the criteria is to provide a framework for determining which financially distressed hospitals are essential to meeting community needs for access to hospital care (and hence should be potentially eligible for state assistance), and which are not.

The Commission adopted an approach to categorizing acute care hospitals in New Jersey with respect to their potential eligibility for state support that involved assessing the relative “essentiality” and “financial viability” of each hospital in the State.

Figure 12.1 illustrates the analytical framework used in this approach. In using this framework, selected metrics associated with a hospital's “essentiality” are combined to develop an overall weighted “essentiality” index or plot point. Similarly, several metrics associated with a hospital's “financial viability” are combined to create an overall weighted “financial viability” index or plot point. Each hospital is then mapped on the grid, using the indexes or plot points as the horizontal and vertical coordinates, with the horizontal axis representing “essentiality” and the vertical axis tracking “financial viability.” Based on the results of the analysis, each hospital was placed in one of the four quadrants on the framework shown in Figure 12.1.

Each quadrant in Figure 12.1 represents a different category of hospital and carries with it potentially differing policy implications for the State. Given the Commission's charge of ensuring that the State's supply of hospital and other health care services is best configured to appropriately respond to community needs, one policy

Figure 12.1:
Framework for Evaluating Hospitals



implication is that the State should focus its efforts and resources on those hospitals deemed essential (e.g. to the right of the mid-point on the horizontal axis). Another policy implication is that hospitals that are more financially viable (e.g., above the mid-point on the vertical axis) are less likely to need state support than those hospitals that are less financially viable. As a result, one could conclude that the major policy implication for the State is that it would be appropriate for the State to focus its efforts and resources on those supporting hospitals that are essential and financially distressed (e.g., in the lower right hand quadrant) while allowing market forces to prevail in the other quadrants.

In addition to classifying hospitals into one of the four categories, the approach provides an indication of their comparative degree of “essentiality” and “financial viability.” This feature is likely to be particularly helpful to the State if there are not sufficient funds to assist all hospitals judged to be “essential” and financially less viable.

The metrics on “essentiality” and “financial viability” used in this analytic framework are discussed later on in this chapter. An important factor to note is that the analytical framework developed to assist the State uses historical data and as such, represents the relative essentiality and financial viability of providers at a particular point in time. The framework has, however, been designed to be “dynamic” in that it can be repeated over time with updated data as it becomes available. In addition, it is highly likely that a hospital’s essentiality will change if one or more hospitals in a hospital market area cease to operate. Similarly, a hospital’s financial viability will change over time as it undertakes performance improvement initiatives or experiences continued erosion of its financial position. In addition, should a hospital merge with or be acquired by another hospital or join a hospital system, its financial viability could change. For these reasons, publishing a list of where individual hospitals lie on the grid would be of little value given that the list is certain

to change every year. It is important that the State update the analyses and recalibrate the essentiality and financial viability scores on a regular basis as it weighs options to support financially distressed hospitals. Software has been provided to the Governor's Office to facilitate up-to-date analysis.

II. Criteria for Identifying Essential Hospitals in New Jersey

As a starting point for identifying essential hospitals, the Commission reviewed a wide variety of sources, including the criteria used by New York's *Commission on Health Care Facilities in the 21st Century*. After extensive discussions and deliberation, the Commission

agreed on three major categories of criteria to identify essential hospitals:

1. Care for financially vulnerable populations,
2. Provision of essential services, and
3. Utilization.

With the exception of provision of essential services, each category includes several quantifiable criteria and metrics for identifying essential hospitals. These criteria, the relevant metric, and data sources are shown in Table 12.1.

One of the key operating premises of the Commission was that hospitals that devote significant resources to caring for financially vulnerable populations represent essential providers in the New Jersey hospital system.

Table 12.1:
Quantifiable Criteria and Metrics for Identifying Essential Hospitals

Criterion / Metric	Data Source
Care for Financially Vulnerable Populations	
Medicaid and Uninsured Discharges	2006 UB-92 Patient Discharge Data from New Jersey Department of Health and Senior Services
Medicaid and Uninsured ED Visits	2006 UB-92 Emergency Department Data from New Jersey Department of Health and Senior Services
For Medicare Disproportionate Share Hospitals, their ratio of patient days for Medicare dual eligible patients to total Medicare patient days¹³³	2006 Medicare Cost Reports, as available and 2005 Medicare Cost Reports otherwise
Provision of Essential Services	
Trauma Center Designation	New Jersey Department of Health and Senior Services
Utilization	
Percent of the Dartmouth Atlas-defined Hospital Service Area's Total ED Visits	Analysis of 2006 UB-92 Emergency Department Data from New Jersey Department of Health and Senior Services
Inpatient Occupancy	Analysis of Acute Care Maintained Beds and Patient Days from 2006 B2 Reports submitted by hospitals to the New Jersey Department of Health and Senior Services
Total Patient Days and ED Visits	2006 B2 Reports for Patient Days and 2006 UB-92 Emergency Department Data from New Jersey Department of Health and Senior Services for ED Visits

¹³³To qualify as a Medicare Disproportionate Share Hospital (DSH) and receive the Medicare DSH payment adjustment, a hospital's DSH patient percentage – the sum of the percentage of Medicare inpatient

days attributable to patients eligible for both Medicare and Medicaid and the percentage of total inpatient days attributable to Medicaid patients not also eligible for Medicare – must be at least 15 percent.

To measure a hospital's *care for financially vulnerable populations*, three separate metrics were used:

- Medicaid and uninsured discharges (which provide a measure of a hospital's role in caring for indigent patients on an inpatient basis).
- Medicaid and uninsured emergency department visits (which measure the role a hospital plays as a source of primary care for patients who do not have an ongoing relationship with a primary care physician).
- A Medicare disproportionate share hospital's ratio of inpatients days attributable to Medicare patients who are also eligible for Medicaid to total Medicare days (which measures a hospital's role in caring for poor Medicare patients).

The second criterion, *provision of essential services* as measured by trauma center designation, was selected because trauma centers are regional resources that provide a comprehensive array of specialized services that are not available at every hospital.

Utilization was selected as a criterion for identifying hospitals that are essential to maintaining access to care because it reflects the size of the hospital's patient care activity. The operating premise here was that a more heavily-utilized facility was more essential than a less heavily-utilized facility. Three metrics were identified to assess utilization:

- A hospital's emergency department visits as a percent of the Dartmouth Atlas-defined hospital service area's total emergency department visits (which measures a hospital's relative importance as a provider of emergency services in a geographic area).
- Inpatient occupancy rate on the number of maintained beds reported by hospitals (this measures a hospital's volume of inpatient care relative to its capacity).
- The sum of total patient days and emergency department visits (which is an overall indicator of the size of a hospital's patient care activity). While total outpatient visits may be the best

indicator of the size of a hospital's ambulatory care activity, in the absence of a standardized source of data that allows for meaningful comparison across hospitals, we are using emergency department visits as a proxy.

III. Criteria for Identifying Hospital Financial Viability

The criteria for evaluating hospitals' financial viability are a subset of the financial indicators reviewed in the overall assessment of the financial condition of the State's hospitals in Chapter 5 of this report. After analyzing a variety of financial indicators, the Commission selected, in consultation with staff of the New Jersey Health Care Facilities Financing Authority, three key measures of hospital financial viability¹³⁴— (1) profitability, (2) liquidity and (3) capital structure – and the metrics for each.

Operating margin (as a percent of net revenue) was selected as the measure of profitability because it is a clear indicator of the hospital's financial performance in its core business of patient care and does not reflect the way the hospital is financed or the hospital's non-patient care revenue, such as income from investments.

Days cash-on-hand was chosen as the measure of liquidity because it reflects the level of funds immediately available to maintain current operations.

Long-term debt to capitalization was selected as the capital structure metric because it provides a clear assessment of how highly leveraged a hospital is.

Table 12.2 presents the criteria and metrics for assessing hospital financial viability along with the 2006 statewide average for each metric.¹³⁵

¹³⁴The Commission considered using times interest earned ratios, but decided not to because these ratios do not add anything to the distinctions the Commission seeks to make among hospitals over and above the Long-term Debt to Capitalization ratio.

¹³⁵The 2006 statewide median values for these three metrics are as follows: 0.56% for operating margin; 114 days cash-on-hand; and 45.1% for long-term debt to capitalization.

Table 12.2:
Criteria and Metrics for Identifying Hospital Financial Viability

Criterion	Metric	2006 Statewide Average for Metric
Profitability	Operating Margin	- 0.9%
Liquidity	Days Cash-on-Hand	124
Capital Structure	Long-term Debt to Capitalization¹³⁶	51.2%

Hospitals' FY 2006 audited and unaudited financial statements provided by the New Jersey Health Care Facilities Financing Authority were used to calculate each of the three financial viability metrics for each hospital in the State. For hospitals that are members of hospital systems in which the system has financial responsibility for the individual hospitals, the hospital systems' value for each metric, calculated from the hospital systems' FY 2006 audited financial statements were used. The rationale for using hospital system financials is that when a system of hospitals jointly borrows under a master indenture as an obligated group, all the hospitals in the obligated group are financially bound together. In these cases it is the system's, rather than individual hospital members' financial indicators, that are the relevant measures for lenders and credit rating agencies and that the resources of the system are available to support individual hospitals in the system.

Each hospital was scored on these three financial viability metrics in the same way as the essential hospital metrics¹³⁷, except that all hospitals in the State were compared against the statewide average for the metric rather than against the average for the hospital market area in which the hospital is located. The reason for using the statewide average is to identify hospitals throughout the State that are in financial jeopardy, not necessarily to identify those facilities in each hospital

market area that have better or poorer financial performance relative to the others in the same market area. For example, if all hospitals in a hospital market area are performing better financially than the statewide average, it is unlikely that any of them should be eligible for State support or assistance, even those hospitals whose financial performance compares unfavorably to others in that hospital market area.

An analysis of hospitals' financial viability indicates that for 2006, 38 of the State's 80 acute care hospitals in operation in 2006 have financial viability scores below the statewide average. Nearly 60 percent of these financially troubled hospitals are located in two hospital market areas (Newark/Jersey City and Hackensack, Ridgewood and Paterson).

The next section of this chapter provides an explanation of how hospitals were categorized using the criteria and metrics for essentiality and financial viability.

IV. Method for Comparing Hospitals: Standardized Metrics

As previously noted in Tables 12.1 and 12.2, the various metrics for each hospital used in this analysis have different dimensions: some are percentages and some are numbers. Furthermore, each of these metrics has a different degree of dispersion of hospital values around the average. Both circumstances make it impossible to collapse such metrics meaningfully into an overall score of "essentiality" and "financial viability."

A widely applied solution to this problem is to "standardize" all of the metrics which, in effect, converts them to variables that have the same dimension

¹³⁶Several hospitals' Long-term Debt to Capitalization values were greater than 100 percent or were negative. We set these hospitals' Long-term Debt to Capitalization values at 100 percent for the financial viability analysis.

¹³⁷Since higher values of Long-term Debt to Capitalization put a hospital at greater risk, we inverted the score for that metric so that values above the average yield negative scores. Doing this allowed us to sum the scores to arrive at an overall score of each hospital's financial viability relative to other hospitals in the State.

and the same degree of dispersion. For each metric, each hospital's score is based on how far above or below the average it is for that metric. The methodology for standardizing variables is described more fully in Appendix 6.

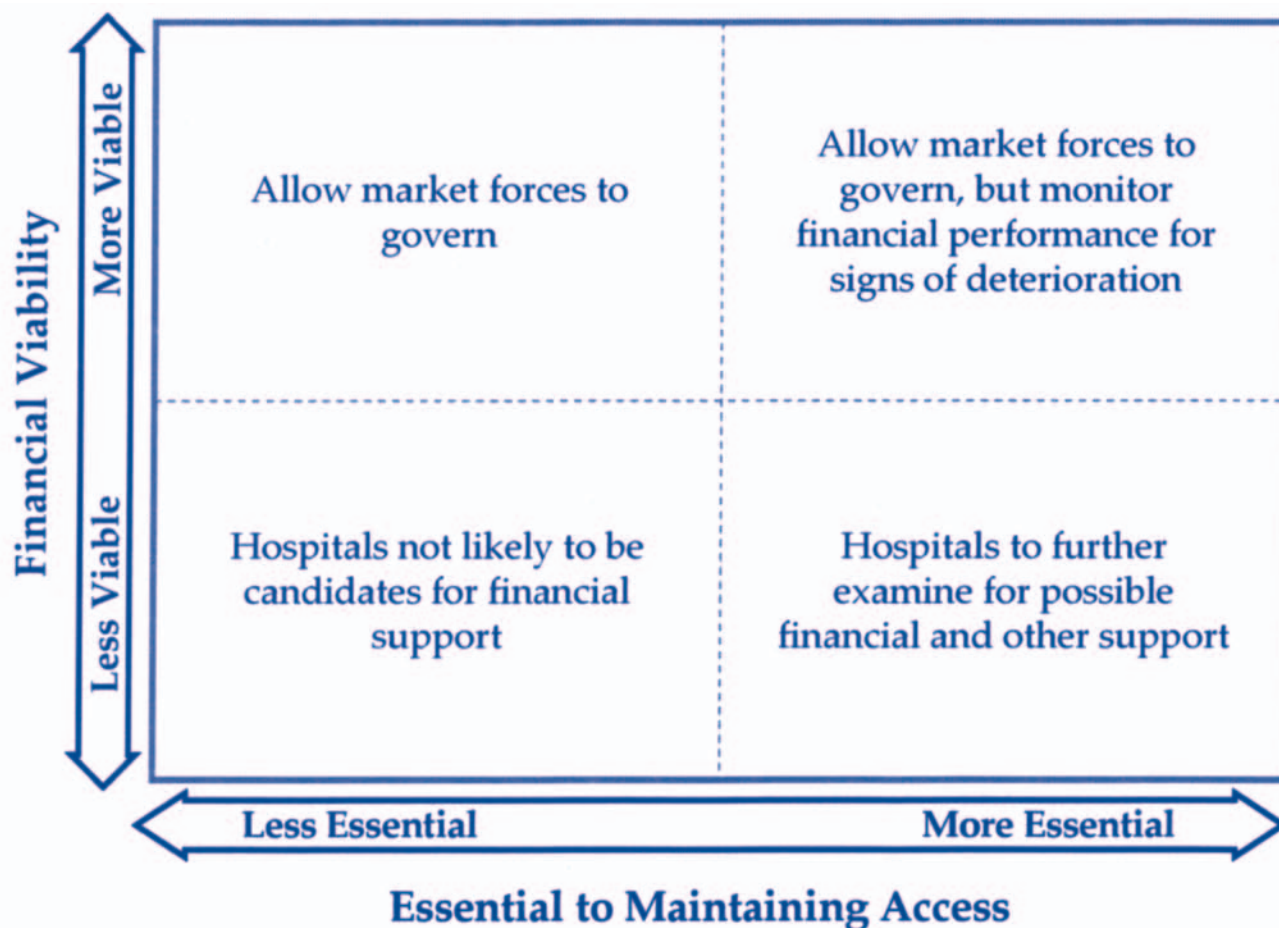
After standardizing each metric for "essentiality," the individual standardized scores were combined into an overall weighted score for "essentiality," assigning equal weights to all metrics. With this method, a positive score indicates a hospital is more essential than the average for all hospitals in the hospital market area and a negative score indicates a hospital is less essential than the average. Each hospital's overall essentiality score is relative only to the other hospitals in its hospital

market area. A similar approach was used to develop an overall weighted score for each hospital's financial viability.

V: Combining "Essentiality" and "Financial Viability"

Using the results of the essential hospital and financial viability analyses, each of the hospitals within a hospital market area can be categorized into one of the four quadrants illustrated in Figure 12.2. The mid-points on the horizontal and vertical axis represent the average "essentiality" score and the average "financial viability" score.

Figure 12.2:
Essentiality and Financial Viability Framework for Evaluating Hospitals



VI. Conclusion

This chapter provides an overview of the analytic approach to identifying which financially distressed hospitals in New Jersey are potential candidates for financial assistance from the State. It should be noted that the analytic framework represented by Figure 12.2 is based only on strictly quantifiable metrics. As such, it cannot possibly address all of the social, economic and geographic issues that must be examined by government in determining which financially distressed hospitals the State should support to maintain access to care. The quantitative analytic framework, therefore, must be supplemented by an assessment of non-quantifiable factors and input from policy analysts and policymakers regarding their knowledge of local conditions. In the end, mere numbers cannot take the place of sound judgment; they can only guide that judgment.

Among the non-quantitative issues that the Commission and State need to consider in determining which financially distressed hospitals are essential to maintaining access to hospital care, include but certainly are not limited to:

- Whether the services provided by a hospital are available and accessible elsewhere in the hospital market area;
- What the impact on residents would be in terms of travel time/distance to access hospital care in the event of a hospital's closure;
- Whether a hospital is part of a hospital system and the extent of the resources available to the system to support a financially distressed facility;
- What public transportation alterations or other transportation solutions are available or would be necessary to maintain access to care in the event of a hospital's closure;
- What quality of care and efficiency improvements are possible and necessary in financially distressed, essential hospitals;
- What potential access to care implications would be for particular medically underserved populations if a hospital were to close;
- What the potential impact on access to key ambulatory services would be if a hospital ceased operating as an inpatient facility;
- What the impact on employment in the hospital market area would be should a hospital close.



Chapter 13: Supporting Essential, Financially Distressed Hospitals

Key Points

- **Essential hospitals experiencing financial distress should receive financial support from the State. However, this support should not be unconditional.**
- **Essential hospitals receiving support should comply with conditions related to management and governance and undergo close monitoring of efficiency, quality and overall financial health.**
- **The Commission recommends adding supplemental payments to the Medicaid hospital payment rates to essential, financially distressed hospitals to take advantage of federal matching funds while better targeting public resources.**
- **The Commission proposes the creation of a Distressed Hospital Program to provide additional funding to essential, financially troubled hospitals. This program would include time-limited grants focused on improving operations as well as capital funds.**

One of the goals of the Commission's work is to strengthen the acute care hospital system in New Jersey. As discussed in previous chapters, the premise that underlies the Commission's framework for evaluating the hospitals' essentiality and financial viability is responsible allocation of the State's scarce resources for health care services. The State decision-making and action that the framework implies – directing State resources for helping financially troubled hospitals to those hospitals that provide essential services to their regions – is prudent and responsible State policy.

The converse implication of this policy is that the State will not provide support for non-essential hospitals that are not financially viable, and as a result, some of them will close. The State's policy of allowing some non-essential hospitals to close should help strengthen the remaining hospitals by consolidating patient volume and revenue in fewer hospitals and reducing excess capacity. As discussed in Chapter 4, analysis of supply and

demand for hospital services suggests that there is a surplus of hospital beds, and that the surplus is greatest in the areas of the State with the most financially distressed hospitals. Closure of some hospitals will consolidate existing patient volume in fewer hospitals, thus reducing the excess capacity. Moreover, the marginal cost of caring for closed hospitals' former patients is lower than the increased revenue remaining hospitals will receive for caring for them, thus providing a favorable margin.

To provide direct support to help essential, financially troubled hospitals improve their financial performance will require an increase in state funding combined with a reallocation of existing funding. This chapter provides the Commission's recommendations on how the State should provide this financial support. It also includes recommendations for conditions the State should impose on hospitals receiving such support.

I. Medicaid and Charity Care Payments

The first priority for states in providing financial support for hospitals and reducing their uncompensated care burden is to maximize the impact of their state expenditures by leveraging federal matching funds. States generally do this through:

- Medicaid hospital payment systems and
- Medicaid coverage expansion programs.

New Jersey has been very successful at leveraging federal funding in the past. However, it is increasingly difficult to access federal funds. Thus, it is important that the existing funding programs, to the extent possible, be aligned with the Commission's goal of supporting essential, financially troubled hospitals. Since there is no opportunity to claim federal match by increasing charity care subsidy payments to hospitals because, as discussed above, New Jersey has exceeded its federal DSH allotment for 2008, one way for the State to support essential, financially troubled hospitals is to revamp the way charity care subsidy payment are distributed. In addition, there is some opportunity, although limited, to leverage additional federal funding to increase Medicaid payments to provide increased payments to essential, financially troubled hospitals.

Recommendation:

The State should consider a supplemental add-on payment to the Medicaid fee-for-service base DRG rate for essential hospitals in financial distress.

In spite of the increasing difficulty in accessing federal funding, there is an opportunity for New Jersey to increase Medicaid fee-for-service funding targeted to essential hospitals through a new supplemental payment. For example, the Division of Medical Assistance and Health Service (DMAHS) could design an add-on payment for hospitals that are essential based on the Commission's criteria, plus other factors, as appropriate, and that have financial performance "scores" less than the statewide average in the prior year. The new add-on payments would require an increase in

state expenditures, but would be eligible for federal matching funds as long as they comply with the federally-defined upper payment limit (UPL) that governs Medicaid payments. Information provided to the Commission indicates that there is room under the private hospital UPL to increase Medicaid payments.¹³⁸

II. Distressed Hospital Program

Even with the benefit from closure of some hospitals and increased Medicaid and charity care funding as recommended in the previous section, state funding support will likely be necessary to help some or all essential, financially troubled hospitals improve their financial conditions.

Recommendation:

The Commission recommends that the State create a Distressed Hospital Program focused on providing financial support to financially distressed, essential hospitals. The program would be financed through an increase in the Ambulatory Assessment (which would be used to service debt financed by NJHCFFA backed bonds).

Increasing the Ambulatory Assessment to fund the Distressed Hospital Program is an effective way to generate necessary funds. In doing so, it also helps address issues raised earlier in the report regarding the competitive disadvantage of hospitals relative to free-standing ambulatory care facilities due to uneven regulatory requirements.

The Distressed Hospital Program would only distribute funds to eligible hospitals. Eligibility would be limited to those hospitals caring for a high percentage of patients from vulnerable populations, those experiencing substantial financial difficulties, and those located in an underserved area or providing an essential service that is otherwise unavailable within reasonable proximity.

¹³⁸In addition, a financially troubled, essential hospital could receive the DRG add-on payment only if it is not already being paid at its hospital-specific DSH limit, i.e., the hospital's Medicaid and charity care subsidy payments equal its cost of caring for Medicaid and uninsured patients. According to DMAHS, most hospitals' Medicaid and charity care subsidy payments are less than their hospital-specific DSH limits.

A. Eligibility

For a hospital to qualify for the state support to continue operations it must meet all of the following conditions:

Care for Vulnerable Populations (minimum thresholds)

- 10% Medicaid Discharges
- 10% Uninsured Discharges
- 10% Medicaid ED visits
- 20% Uninsured ED visits
- 25% Medicare DSH patient percentage

Financial

- Negative profit margin for the system for 2 consecutive years.
- Days Cash-on-Hand less than 50
- Current Ratio less than 1.5
- Long-term debt to capitalization greater than 75%
- Inpatient Occupancy rate greater than 50%

Geography and Services

- Located in a medically underserved area
- Travel time to nearest hospital must be greater than 15 minutes
- Designated Trauma Center
- Mental Health Services

B. Conditions of Participation in the Distressed Hospital Program

Following a hospital's approval to participate in the Distressed Hospital Program, the State would impose a number of requirements on the facility.

Immediately

- Arrange for a financial and operational audit – including a review of hospital management
- Provide a seat on the Hospital board
- Assess surrounding markets for strategic partnerships

Within 6 Months

- Reduce case mix adjusted length of stay by 10%
- Initiate program reductions based on results of audits
- Prepare a plan for sale of assets
- Implement staffing reductions as necessary

Within 1 year

- Reduce accounts receivable balances by 20%
- Reduce managed care denials by 25%
- Ensure charge master is updated

C. Types of Financial Support for Essential Hospitals from the Distressed Hospital Program

Recommendation:

The States should provide time-limited grants and/or zero-interest loans for operating and financial performance improvements to essential, financially distressed hospitals.

State-funded grants and zero-interest loans to essential, financially troubled hospitals could help address chronic barriers to financial viability. For example, hospitals could use the funds to retain consultants to help them develop and implement operations improvements and capital investment plans. As discussed in Chapter 15, a condition of the grants would be significant State oversight and involvement with the hospital's board and periodic reporting of progress and attainment of benchmark performance levels. Hospitals receiving grants should have to demonstrate improved and sustainable financial performance; for example, hospitals would have to attain financial performance levels necessary to qualify for FHA-insured loans for capital investment in physical plant and technology.

Recommendation:

The State should establish a capital grant program for hospital facility renovation and information technology investment to essential, financially distressed hospitals.

Some of New Jersey's essential, financially troubled hospitals do not currently meet the financial performance requirements for FHA-insured loans, which are generally below the levels for the lowest investment grade credit ratings. State-funded capital grants, similar to those the HEAL NY program provides, may be the only means for some of these hospitals to access capital financing to renovate their old physical plants and invest in information and medical technology.

III. Help in Accessing Low-Cost Financing

Many states assist financially distressed hospitals by facilitating the process of securing loans or capital from the sale of non-core assets and helping to obtain revolving lines of credit secured by accounts receivables to address working capital and temporary liquidity needs. In addition, many states offer hospitals financing and refinancing of capital projects through publicly offered and private placement tax-exempt bonds. The New Jersey Health Care Facilities Financing Authority (NJHCFFA) issues municipal bonds to provide not-for-profit hospitals and other health care organizations with access to low-cost capital. NJHCFFA can issue both federally tax-exempt and taxable bonds, and interest on all bonds issued by the Authority is exempt from New Jersey taxation.

Another way states can assist hospitals to access low cost financing is by helping them obtain U.S. Department of Housing and Urban Development Federal Housing Administration (FHA) Section 242 mortgage insurance. FHA-insurance enhances the creditworthiness of borrower hospitals, thereby enabling them to finance their debt at more affordable rates than they would otherwise be able to attain. To qualify for FHA insured loans, hospitals must have an average operating margin of zero or greater for the last three years, and an average debt service coverage ratio of at least 1.25 percent. In addition, eligible hospitals must be willing and able to grant an FHA insured lender a first lien on the property, plant and equipment that secure the mortgage.¹³⁹

The majority of the FHA 242 loans have been to hospitals in New York, but FHA has made efforts to broaden its mortgage insurance portfolio to hospitals in other states. In 2000, New York hospital mortgage balances comprised 89 percent of the FHA's total mortgage portfolio, but as March 2007, hospitals in other states comprised 45 percent of FHA's \$5.7 billion outstanding principal balance. Over 20 New Jersey hospitals have obtained FHA-insured loans since the program's inception.¹⁴⁰

¹³⁹U.S. Department of Housing and Urban Development.

¹⁴⁰U.S. Department of Housing and Urban Development. FHA Mortgage Insurance for Hospitals – Portfolio Data. (<http://www.hud.gov/offices/hsg/hosp/portdata.xls>)

IV. Conclusion

This chapter provided the Commission's recommendations for the type of support that should be made available to financially distressed, essential hospitals. However, the Commission notes again that funds distributed to support failing hospitals must be attached to conditions. Some of these conditions are outlined in this chapter and include a variety of management and governance issues along with efficiency goals.

The type of support the Commission recommends making available to failing, essential hospitals is supplemental Medicaid payments, charity care payments refocused on "needy" hospitals, and a newly created Distressed Hospital Program. Clinical quality and efficiency benchmarks that should be monitored and met as part of receiving support are presented in Chapter 15.

The Commission recognizes that one of the outcomes of our effort to ensure that the State has a rational distribution of financially viable acute care hospitals and services sufficient to meet the needs of its residents, is that some non-essential, financially distressed hospitals may close. In the next chapter, we discuss policies and procedures to minimize the impact of hospital closures and to ensure that the closure of financially distressed hospitals that are not essential is as orderly as possible.

Chapter 14: Facilitating the Closure of Non-Essential Hospitals

Key Points

- In an effort to strengthen the acute care hospital system, the Commission believes that non-essential hospitals should be allowed to close if they experience financial distress.
- A Certificate of Need (CN) application is necessary for a hospital closure, but, the current application process commences relatively late in the course of a hospital's period of distress. The CN process should be refocused on an orderly closure rather than the decision to close.
- The costs associated with closure are substantial – the State should develop a fund to partially support the closure process. Public funds should not be used to bailout bondholders who assumed a certain level of risk as investors. A top priority should be providing some economic protection for hospital employees.
- The State should help with the process of identifying alternative uses for closed hospitals.

The goal of the Commission's work is to strengthen the acute care hospital system in New Jersey, and allowing some non-essential hospitals to close should help strengthen the rest of the hospitals in the State by consolidating patient volume in fewer hospitals and reducing excess capacity. In this chapter, we discuss New Jersey's and other states' policies for facilitating the closure of hospitals, offer recommendations for New Jersey to consider in helping non-essential financially distressed hospitals in closing and evaluate potential alternative uses for closed hospitals' facilities.

I. Policies for Assisting Hospitals in Closing

This section of the chapter reviews the existing policies in New Jersey related to hospital closures and examines approaches used by other states to support hospital closings.

A. Current New Jersey Policies

New Jersey's principal policy governing hospital closure is the Certificate of Need (CON, or CN as it is known in New Jersey) program. Although New Jersey's CN

program focuses primarily on the approval of new and expanded hospital services, hospitals seeking to close must submit a CN application for termination/discontinuation of service and these applications are subject to full CN review.¹⁴¹ The CN process requires an applicant to justify the need for the proposed action, demonstrate that the action will not have an adverse impact on access to healthcare services in the region or statewide, and show that the action will contribute to the orderly development of adequate and effective health care services. In making determinations of need, the Department of Health and Senior Services takes into consideration criteria such as the availability of facilities or services which may serve as alternatives or substitutes, the need for special equipment and services in the area, and the adequacy of financial resources and revenues.

B. Other States' Policies

While states and local governments have assisted in hospital closures in a variety of mostly ad-hoc ways — including transitioning patients to other facilities,

¹⁴¹N.J.A.C. 8: 33-3.2

assisting employees in finding new employment, and facilitating property sales and debt repayment, as in New Jersey — the principal procedure other states use is the CN program. In addition to New Jersey, 34 other states and the District of Columbia have certificate of need statutes, and of these, nine others (Alabama, Connecticut, Hawaii, Illinois, Iowa, Kentucky, Maryland, Tennessee, and Vermont) also require hospitals to submit applications to close. In addition to these nine states, two states (Alaska and Arkansas) require a notification of closure, but not a formal CN application.

All CN states that require applications to close, except Hawaii, Illinois and Tennessee, require a hospital to complete the standard CN application, modifying responses in the application to reflect the reduction or closure of services, as opposed to the expansion of services. Illinois and Hawaii have specific requirements and review criteria for CN applications related to the discontinuation of services, as described in Table 14.1 below.

Table 14.1:
Additional CN Requirements/Review Criteria for Illinois and Hawaii

State	Additional Requirement/Review Criteria
Illinois	Applicants must provide the following: • Reason for discontinuation; • Other services or facilities in planning area that are available and willing to assume applicant's workload; • Closure plan indicating the process used to provide alternative services or facilities for patients prior to or upon discontinuation. Applications are reviewed to determine that: • Stated reasons for discontinuation are valid; • Discontinuation will not adversely affect the services needed by the planning area and will not have an adverse effect on the delivery system by creating demand for services that cannot be met by existing area facilities; • Discontinuation is in the public interest and will not cause planning area residents unnecessary hardship by limiting access to needed services for low-income persons, racial and ethnic minorities, women, handicapped persons, the elderly and other underserved groups.
Hawaii	In the case of elimination or relocation of a facility or service, applications are judged by: • The need that the population currently served has for the service; • The extent to which that need will be met adequately by the proposed relocation or by alternate arrangements; • The effect that the elimination or relocation of the service has on the ability of the elderly, low-income persons, racial and ethnic minorities, women, persons with disabilities and other underserved groups to obtain needed health care.

Beyond the CN process, two states – New York and Maryland – have other programs to support hospital closures. The Maryland Hospital Bond Indemnification Program, enacted in 1985 by the State’s General Assembly as part of overall legislation to reduce excess hospital capacity, helps pay costs associated with a hospital’s closure. A hospital that intends to close can apply to the program for payment of the principal and interest on non-insured public-body issued bonds and some costs for closing. In its application, a hospital must demonstrate how its closure will reduce the State’s excess hospital capacity. If the hospital’s application is accepted, the Maryland Health Services Cost Review Commission assesses a temporary fee on all other Maryland hospitals to pay off the obligations and closing costs. New Jersey’s version of a bond indemnification program is the Hospital Asset Transformation Program. However, the New Jersey Hospital Asset Transformation Program has never been funded.

New York has received an 1115 Research and Demonstration waiver from the United States Department of Health and Human Services to implement reform initiatives that will improve quality of care and result in long-term savings for both New York and the Federal government. Under this 1115 waiver, New York must invest \$3 billion over five-year period to receive up to \$1.5 billion in federal financial participation (FFP) over five years for designated state-funded health care programs that currently serve low-income and uninsured New Yorkers, and that are not otherwise eligible for federal matching funds. These federal funds are intended to “free up” state funds for New York to invest in its health care reform initiatives. As part of its agreement with the federal government, New York is required to generate \$3 billion in gross Medicaid savings (\$1.5 billion in federal savings) over the five-year demonstration period. Should the State not achieve these savings by the end of the demonstration, it

will be required to refund to the federal government the difference between the federal investment in the Federal-State Health Reform Partnership (F-SHRP) reforms and the federal savings generated.¹⁴²

New York has allocated \$550 million of the 1115 waiver funding for assisting hospitals and nursing homes in implementing the recommendations of its Commission on Health Care Facilities in the 21st Century in reshaping the health care market in the state. Hospitals and nursing homes have submitted grant request for financial assistance totaling \$2.5 billion and New York made the first grant award of \$17 million in late August for closure of St. Vincent’s Midtown Hospital in Manhattan.

It is important to reiterate that the federal government’s support to New York is contingent upon the State achieving specific savings targets, and to note that New York’s 1115 waiver includes major Medicaid and health system changes, such as an expansion of the State’s Medicaid managed care program. Thus, the breadth of New York’s demonstration project is well beyond the New Jersey’s Commission scope and a similar 1115 demonstration project waiver for New Jersey is likely not feasible.

II. Issues Associated with Hospital Closures

Closing any business presents a myriad of challenges and issues to the owners, employees, vendors, and consumers. Because hospitals are complex organizations with many constituencies, the issues associated with closing a hospital are particularly challenging. Table 14.2 identifies some of the major issues and considerations that must be addressed in closing a hospital.

¹⁴²Centers for Medicare and Medicaid Services, “New York Federal-State Health Reform Partnership Section 1115 Demonstration Fact Sheet,” (October 1, 2006). Available online: <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/New%20York%20FSHRP%20Fact%20Sheet.pdf>

Table 14.2:
Checklists of Issues and Considerations to Address in Closing a Hospital

- | | |
|---|---|
| ☐ Governance and Authority | ☐ Financial |
| ☐ Accreditation and Regulatory Requirements | ☐ Legal |
| ☐ Communications with Key Constituencies | ☐ Patients |
| ☐ Employees | ☐ Operations |
| ☐ Medical Staff | ☐ Asset Disposition |

We briefly discuss some of the major employee- and financial-related issues below. A more detailed discussion of these and the other issues listed in Table 14.2 are included in Appendix 7.

A. Employees

Because closure of a hospital directly and perhaps most significantly, affects its employees, issues related to a hospital's employees represent one of the more challenging considerations in closing a hospital. This can be especially true in markets in which unions have a substantial presence, such as in New Jersey. Among the many employee-related issues that must be addressed in a hospital closure are severance payments, termination of benefits, settlement of contracts, and notification requirements as specified in union contracts, the federal government's Worker Adjustment and Retraining Notification (WARN) Act which specifies timeframes for notifying employees of layoffs.

B. Financial

The financial issues associated with the closing of a hospital are numerous, highly complex and often unique to the specific hospital. In addition, the costs of closing a hospital are substantial. By way of example, in response to the recently released recommendations on realigning hospital resources by the New York Commission on Health Care Facilities, hospital executives released estimates of the costs to close their facilities, including an estimate of \$67.7 million to close St. Joseph Hospital (127 beds) and \$250 million to close Erie County Medical Center (406 beds).¹⁴³ On a per bed basis, the cost to close these facilities was estimated to be \$533,071 and \$615,764, respectively.

The key financial issues that must be addressed when closing a hospital are listed in Table 14.3.

¹⁴³Franczyk, Annemarie, "Closing hospitals will cost millions," *Buffalo Business Journal* (November 17, 2006). Available online: buffalo.bizjournals.com/buffalo/stories/2006/11/20/story1.html.

Table 14.3:
Checklist of Key Financial Issues to Address When Closing a Hospital

- | | |
|--|---|
| ☐ Operational cutoff date and coordination of final closing, cost report, audit, and tax returns | ☐ "Related organization" reimbursement issues |
| ☐ Notification of finance constituencies, including banks, service bureaus, system support (payroll, regulatory reporting), collection agencies, trustees of restricted funds, vendors, payers, IRS, insurers, etc. | ☐ Existing or remaining obligations under state regulations and effect of closure on such obligations. |
| ☐ Daily cash management | ☐ Preparation of termination notice to Medicare |
| ☐ Property inventory and disposition | ☐ Determination of Medicare payment rules following termination |
| ☐ Supply consolidation, control and security | ☐ Preparation of cost report covering period up to date of cessation (due no later than 45 days past, no exceptions) |
| ☐ Implement revised invoice aging policy | ☐ Evaluation of the sale of property for recapture rules under Medicare |
| ☐ Implement authorization of all disbursements by CFO/CEO | ☐ Insurance contracts, self-insurance trusts, etc. for general liability, auto, fire and casualty, professional liability, Workers' Compensation |
| ☐ Determine flow of funds for prepaid expenses, advances, escrowed funds | ☐ Determination of insurance needs for future operations or potential liability |
| ☐ Billing and collection of accounts outstanding | ☐ Notification of all insurance carriers of closing date to terminate or modify policies as appropriate |
| ☐ Preparation of necessary financial reporting required to support debt actions | ☐ Tail insurance for Directors and Officers (D&O) |
| ☐ Terms of all unapplied restricted gifts, donations or grants | ☐ Tail insurance options for malpractice insurance |
| ☐ Previous cost report controversies, appeals or reversals | |
| ☐ Pending rate appeals or amounts in controversy | |

Recommendations:

The State should develop and fund a program to help pay some of the costs of closing a hospital.

- The program should not pay for what is often the largest cost associated with closing a hospital, namely the hospital's debt obligations financed through bond issues. Bondholders assume risk when they purchase bonds, and default is clearly one of those risks and it is not the State's responsibility to provide a bailout for investors.
- Hospital employees should be provided appropriate economic protection and should receive severance pay for a similar duration as the hospital's executives.

Other hospitals will likely benefit from reduction in excess capacity resulting from hospital closures, so a potential source of funding for this program is a special temporary assessment on the rest of the hospitals in the closed hospital's market area proportional to their expected financial gain or a more long-run statewide fund supported by hospitals for such purposes.

The State should review the CN hospital closure process. It should be streamlined and refocused to permit a more rational closure and realignment process than results from markets forces and the bankruptcy process.

Currently, New Jersey's CN process handles an application to close a hospital in much the same way that it does for initiation of a new hospital service. New Jersey should retain a review process for closing hospitals, but should streamline it to make it timelier and change its focus to providing assistance in planning and executing orderly closure instead of reviewing the need for closure. Currently staff of the Department of Health and Senior Services (DHSS) expend significant time and effort in trying to ensure orderly closure of a hospital, however, their role is often reactive. DHSS staff should refocus their efforts by proactively assisting hospitals that intend to close with the planning and execution of their closure. This could include, for example, designating an office that would serve as a single point

of contact for hospitals planning to close and that would provide a resource clearinghouse and website of case studies, best practices and checklists related to the closure process. The CN closure process should also emphasize community notification and input and ensuring the provision of alternative sources of health services affected by closure. This includes access to reproductive health services that might be limited if surrounding institutions do not provide such services.

III. Alternative Uses for Non-Essential Acute Care Facilities

The process of converting a facility to another use, particularly one that is non-health care related, can be a difficult, time-consuming and expensive. While there are examples of hospitals that have been converted to other health care uses, and fewer examples of conversion to non-health care use, it is also common for closed hospital facilities to sit vacant for years, while buyers and sellers agree on terms, or while the sale is mired in legal issues or community disagreements over the facility's disposition. This section provides information about how closed hospital facilities can be re-used for other purposes and provides recommendations for the State's role in the re-use of closed hospital facilities.

A. Re-use of Closed Hospital Facilities – Health Care Re-use

Among the factors that influence the potential re-use of closed hospital facilities are location and demographics of the community, the age and size of the facility and campus acreage. Regulatory considerations such as zoning laws and legal restrictions and community/public opinion and preferences also influence the potential re-use of closed hospital facilities. Typically, a combination of several or all of these factors determines how a closed hospital's facility is re-used, and experience and research shows that virtually no situation is the same, as demonstrated by the examples outlined below. Nonetheless, some overarching findings emerged from a review of the re-use of closed hospitals around the country over the last several years. These findings include:

- Closed hospital facilities are most commonly used for health care services, but rarely for general acute care hospitals.
- Non-health care uses of closed hospitals are driven largely by the value of the land they occupy.

With respect to the first finding, a study conducted by the University of California at Berkeley provides a good summary of the predominant re-use of hospitals for health care related purposes. The study identified 23 facilities that were closed in California between 1995 and 2000.¹⁴⁴ However, the researchers were able to locate information about the current use of only eight of

those facilities and Table 14.4 outlines the re-use for those eight facilities. Five of the six closed hospital facilities that were being re-used for medical purposes were for outpatient services or non-acute care services. The Berkeley research also identified two closed hospitals' facilities that were for sale and, interestingly, one of the conditions of their sale was that they could not be used for medical purposes.

The information in the University of California at Berkeley study parallels the professional experience of consultants engaged by the Commission, research and anecdotal information, examples of which are shown in Table 14.5.

Table 14.4:
Re-uses of Some Closed Hospitals in California

Health Care Purposes
Rural health center operated by a city
Dialysis center operated by a private entity
Outpatient facility for a large managed care plan
Medical offices with a fitness center
Assisted living facility
Acute care hospital under new ownership
Non-Health Care Purpose
Multi-use senior center operated by local government
Administrative office for healthcare system while hospital was offered for sale

¹⁴⁴“California’s Closed Hospitals, 1995 – 2000.” April 2001.

Table 14.5:
Re-uses of Closed Hospitals in Other States

State	Closed Hospital	Re-use
Illinois	Mary Thompson Hospital	Residential and outpatient substance abuse treatment center for women and children
Kansas	Memorial Hospital	Prison hospital
Maryland	North Charles Hospital (Maryland)	HMO primary care center
New York	Butterfield Memorial Hospital	Outpatient center
	Brooklyn Hospital Center Caledonian Campus	Full service diagnostic and treatment center
	Columbus Community Healthcare	Diagnostic and treatment center
	Genesee Hospital	Outpatient services for a while, now only physician offices
	Interfaith Medical Center	Methadone maintenance treatment center
	Mohawk Valley General Hospital	Primary care extension clinics
	St. Mary's Hospital	Mental health and substance abuse services
	Samaritan Medical Center Stone St. Division	Diagnostic and treatment and dialysis center
	Staten Island University Hospital Concord Division	Urgent care center
	Union Hospital of the Bronx	Full service diagnostic and treatment center
Ohio	Columbus Community Hospital	Diagnostic and treatment center

The facilities of most of the hospitals in New Jersey that have closed since 2000 are being used for ambulatory

care purposes as shown in Table 14.6.

Table 14.6:
Re-uses of Closed Hospitals in New Jersey

Closed Hospital	Re-use
Irvington General Hospital	FQHC
South Jersey Hospital Millville	Ambulatory services
South Jersey Hospital Bridgeton	Emergency and outpatient services
West Hudson Hospital	Ambulatory services
Virtua West Jersey Hospital Camden	Emergency and outpatient services
Saint Francis Hospital (Jersey City)	St. Francis Rehabilitation Center

B. Re-use of Closed Hospital Facilities – Non-Health Care Re-use

The second theme related to re-use of existing hospitals is that in many cases, the land on which a closed hospital sits is more valuable than any health care re-use that can be made of its physical plant. For example, three former hospitals in Chicago were demolished and the land redeveloped for residential condominiums and town homes in the past twenty years, and all of them were in desirable, dense, mixed use areas in the City's near north and Lincoln Park neighborhoods. Additional examples in New Jersey include the University Medical Center at Princeton, which has sold its acute care hospital to a developer who plans to convert it to a mixed-use facility, and the recently announced development of a condominium complex on the site of the closed Hospital Center at Orange.

In addition to the examples cited above, there are several examples in which hospitals built replacement facilities and re-purposed the old facility for non-health care uses. The following case studies outline this alternative.

• Platte Valley Medical Center (Brighton, Colorado)

In July 2007, Platte Valley Medical Center in Brighton, Colorado, a city of more than 20,000 people located 20 miles from Denver, closed its 26-year old facility when its newly constructed hospital with more beds and space opened. The City of Brighton is purchasing the old facility. The City plans to convert the old building to an educational facility and is currently in discussions with local community colleges about their interest in using the facility for classes and programs.¹⁴⁵

• University Medical Center at Princeton

University Medical Center at Princeton is constructing a new hospital, which will consolidate its current two campuses – one with the acute care hospital and one with a long-term care facility – on a new site. To help finance the new hospital project, the Medical Center has sold the property where its 206-bed acute care hospital is located to a developer who will convert it for a mixed-use facility primarily for residential

¹⁴⁵Navigant Consulting, Inc. client project.

purposes. The property was attractive to developers not only because of its location in a desirable area, but also because of the size of the hospital. Renovating the hospital's 296,000 existing square feet of space, rather than constructing a new building, allows for a higher density project than would be allowed under zoning regulations for new construction. The hospital's existing parking structure was another attractive feature for developers. Princeton University has purchased the Medical Center's long-term care property.¹⁴⁶

• Salt Lake City Veterans Administration Hospital

The facility that opened as the Salt Lake City Veterans Administration Hospital in the 1930s was converted to Primary Children's Hospital in the 1960s. The Children's Hospital closed in 1990 when it was relocated to a new facility in a different location. The old building sat mostly vacant for more than 15 years until 2005 when construction of a luxury condominium complex began. The exterior of the old hospital was preserved, but the building's five floors and 80,000 square feet were gutted and 28 condominiums, ranging in price from \$500,000 to \$2.5 million, were constructed.¹⁴⁷

Recommendation:

The State should help facilitate re-use of closed hospital facilities for other purposes.

One of the many concerns associated with closure of a hospital is what will happen to its building and site. Historically, the State has encouraged and facilitated the reuse of closed hospital facilities for other health care services. Several former New Jersey hospital facilities, for example, are being used for non-acute health care services, such as primary care clinics. The State should continue to encourage and facilitate re-use of closed

hospital facilities for other health care purposes, as appropriate, by working with local officials to identify health care and community services organizations that could use the vacated facilities, expedite resolution of zoning issues, and perhaps provide low cost loans for renovations. When re-use for health care services is not appropriate or feasible, the State could collaborate with local economic development officials to create a package of incentives to attract proposals from private developers. These incentives could include expedited planning review process, zoning exceptions or assistance and property tax breaks.

IV. Conclusion

The Commission recognizes that one of the outcomes of its efforts to ensure that the State has a rational distribution of financially viable acute care hospitals and services sufficient to meet the needs of its residents is that some non-essential, financially-distressed hospitals may close. As such, it is important that the State not only support essential, financially distressed hospitals, but also has in place policies and procedures to ensure that the closure of financially distressed hospitals that are not essential is as orderly as possible.

Most often closed hospital facilities are used as non-inpatient health care centers. Non-health care commercial re-uses are also possible if a closed hospital's land is more valuable than any potential health care reuse of its physical plant. However, the opportunities for non-health care commercial re-use or redevelopment are highly dependent on the demographics of the area and its economic conditions. As a result, given the challenging demographic and economic conditions of several of the areas in New Jersey with the most financially distressed hospitals, it is likely that many of the non-essential hospitals that close will be used to provide non-inpatient health care services because they cannot be re-used or redeveloped in the foreseeable future.

¹⁴⁶Navigant Consulting, Inc. client project.

¹⁴⁷Hilton, D., "Old hospital evolving into luxury condos." *Deseret Morning News*. October, 5, 2005.

Chapter 15: Improving State Oversight to Provide Greater Accountability for State Resources

Key Points

- **Greater accountability is needed for hospitals receiving state support.**
- **The Commission recommends the creation of a “Hospital Performance Dashboard” to monitor quality and efficiency of facilities. These measures would be particularly important as a monitoring tool for essential hospitals receiving state support to ensure the efficient provision of high quality clinical services.**
- **The Commission recommends the creation of an “Early Warning System” that would focus on monitoring hospital finances to detect early negative financial trends that signal erosion of financial viability.**
- **When the “Early Warning System” triggers are tripped, the Department of Health and Senior Services would intervene at the level of hospital governance and management in a graduated fashion based on severity of financial problems and responsiveness of management.**

One of the underlying tenets of the Commission’s work is that there are certain hospitals that are essential resources for their regions and, as such, those hospitals should be eligible to receive State support should they become financially distressed. An important caveat to this tenet is that the State does not have unlimited resources to support even this important group of hospitals and therefore, must allocate its resources judiciously and ensure that those resources are used appropriately. This requires an enhanced monitoring process to identify hospitals that are showing signs of deteriorating financial performance as early as possible and a structured process to monitor how any resources the State provides to an essential, financially distressed hospital are used.

This chapter provides a summary of New Jersey’s current oversight practices and offers ways for the State to enhance its oversight of hospitals to provide greater accountability for State resources committed to supporting essential hospitals in attaining financial viability. This overview of current practices is followed

by recommendations by the Commission to create a “Hospital Performance Dashboard” to regularly monitor hospital performance on quality and efficiency metrics as well as an “Early Warning System” to detect negative financial trends that signal potential problems with an essential hospital’s financial viability. These systems achieve two goals. First, they help ensure that state resources are not going to inefficient and poor performing hospitals without a plan to remedy such deficiencies. Second, they provide a mechanism for state intervention at a much earlier stage to address the declining fiscal health of an essential hospital before bankruptcy is imminent.

I. Current State Oversight Practices

The New Jersey Health Care Facilities Financing Authority (NJHCFFA) and the Department of Health and Senior Services (DHSS) currently monitor hospitals’ financial performance. By DHSS regulation, all hospitals must submit quarterly financial statements

to DHSS, and all hospitals with debt issued through NJHCFFA must report their quarterly financial statements to NJHCFFA in accordance with their bond covenants. DHSS and NJHCFFA have combined their hospital financial statement data collection efforts with NJHCFFA serving as DHSS' data collection contractor.

NJHCFFA regularly monitors the financial performance of all the State's hospitals, irrespective of whether they have debt placed through NJHCFFA. Each quarter, NJHCFFA analyzes the financial statements that all hospitals submit and seeks to identify those facilities with deteriorating trends in financial performance. NJHCFFA particularly focuses on hospitals' liquidity and operating margins. Based on this analysis, NJHCFFA selects hospitals to review more closely and prepares a report for DHSS that provides an assessment of the hospitals' financial performance along with appropriate recommendations. Typically, the recommendations are for DHSS representatives to meet with hospital management to discuss the deteriorating financial trends and to hear management's strategy for reversing them. However, if the hospital does not have debt placed through NJHCFFA, the hospital is under no legal obligation to meet with the DHSS, and DHSS has little leverage in influencing the hospital's management or board to take action to improve performance. If the hospital has debt placed through NJHCFFA, the hospital has obligations to its bondholders or bond insurer, as discussed below.

As part of its role as an issuer of bonds, NJHCFFA monitors borrower hospitals' compliance with bond covenants. These covenants specify the timetable for reporting financial statements following the close of each quarter and the financial performance standards that borrower hospitals must maintain. NJHCFFA reviews the accuracy of the financial ratio calculations that borrower hospitals submit and certify each quarter to verify that the hospitals' financial performance is in compliance with levels specified in their bond covenants. Failure to submit quarterly financial information on time constitutes technical default. However, failure to meet a particular financial performance standard does not necessarily constitute a technical default as long as the hospital responds in accordance with the provisions delineated in its bond covenants. For example, when a borrower hospital fails to meet all the required financial performance standards,

it must institute corrective action by retaining an external consulting firm to develop an improvement plan. NJHCFFA monitors the hospital's action plan to ensure that it hires a consulting firm in a timely manner and that the consultants prepare their report within the timeframes established in the bond covenants.

In addition, depending on the seriousness of the hospital's financial condition, NJHCFFA representatives may attend meetings of the hospital's board and the board's finance committee to monitor the hospital's progress in implementing its performance improvement plan. Moreover, when a borrower hospital's financial condition is precarious, NJHCFFA monitors its financial reports monthly and its cash position weekly. NJHCFFA, representing the bondholders, tries to work closely with the borrower hospital's management and board to avoid default, but it is the bondholders or bond insurers who are ultimately at risk and who seek to hold the hospital's management and board accountable.

II. Monitoring Performance – Quality & Efficiency

Since the Institute of Medicine's landmark reports, *To Err Is Human* (2000)¹⁴⁸ and *Crossing the Quality Chasm* (2001)¹⁴⁹, revealed widespread incidence of medical errors and substandard care in U.S. hospitals, there has been a great deal of attention to quality of care. Much of this initial attention has focused on the measurement and reporting of quality. Only recently have compensation programs tied to clinical performance begun to emerge.

Nationally, some progress has been made in developing quality indicators and risk-adjustment mechanisms to compare quality across institutions. Over the last few years, Congress has announced a number of quality initiatives, calling for increased transparency of quality delivered to Americans within our health care system.

¹⁴⁸Institute of Medicine. *To Err is Human: Building a Safer Health Care System*. Washington, DC: National Academies Press, 2000.

¹⁴⁹Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press, 2001.

To that end, hospitals have been voluntarily reporting on a number of disease-based quality-process measures on a website called Hospital Compare.¹⁵⁰ While these measures are a beginning, there still is much that needs to be done to achieve transparency in the quality of medical care delivered to Americans. In New Jersey, the need to increase transparency of quality in our hospitals is no different. The widespread variability in clinical practices across New Jersey hospitals documented in the Dartmouth Atlas Project and reported elsewhere in this report further calls attention to the need for better monitoring and reporting.

Variations in utilization and efficiency patterns within hospitals in New Jersey calls for the need to implement quality and efficiency metrics that can be applied uniformly across hospitals. In New Jersey, the need to define metrics to compare hospitals is even more paramount, especially given the large percentage of hospitals needing state financial assistance. To that end, the Commission created a subcommittee on benchmarking efficiency and quality to develop benchmarks in which to compare hospitals. The development of these benchmarks is needed to ensure that public funds are used to support efficient and high quality health care facilities.

Recommendation:

The Commission recommends that the State create a “Hospital Performance Dashboard” to monitor the quality of care rendered by facilities and the efficiency with which it is produced and delivered. These metrics would be particularly important as a monitoring tool for essential hospitals that receive State support, to ensure the efficient provision of high quality clinical services by these hospitals.

¹⁵⁰<http://www.hospitalcompare.hhs.gov/Hospital/Search/SearchCriteria.asp?version=default&browser=Firefox%7C2%7CMacOSX&language=English&defaultstatus=0&pagelist=Home>

A. Measure Selection

The Commission, guided by the subcommittee on benchmarking efficiency and quality, selected a wide range of measures, which could be used to evaluate hospital performance if a subsidy was provided by the State. The following criteria were used to guide measure selection:

- Clear data definitions of the measures to ensure comparability across hospitals;
- Data currently available to minimize additional data collection burdens by hospitals;
- Measures representing a broad range of areas including clinical quality, outcomes, financial performance and operating indicators;
- Transparent measures so calculation methods and data sources are available and clearly specified;
- Recognition that measures may differ depending on area of specializations offered by different hospitals.

Based on these criteria, a wide range of quality and efficiency measures were selected for consideration. There was general agreement that the Commission needed to create a broad dashboard to accurately reflect hospital performance. While a number of measures provided useful information about hospital operations, the measures chosen were constrained to measures that are widely available for all New Jersey hospitals. Hospitals requesting subsidies might be asked to provide additional data.

B. Quality Measures

The quality measures endorsed by the Commission are based on a wide range of data sources and types of quality including consumer satisfaction, mortality and clinical process measures. The measures chosen are based on readily available metrics and should not increase burden on hospitals for additional data collection. In addition, the measures are generally collected already by the Department of Health and Senior Services.

Recommendation:

The Commission endorsed a set of quality measures for the development of a “Hospital Performance Dashboard” - these measures are summarized below and in Table 15.1.

Perfect Case Scores

- Reflect how well a hospital provides all the correct care to a patient with a heart attack, pneumonia, congestive heart failure or a surgery patient.
- Can be calculated based on the New Jersey Annual Hospital Performance Report.

Hospital-Consumer Assessment of Healthcare Providers and Systems (H-CAHPS)

- Standardized survey to measure patients’ perspectives on hospital care within the following composites: Doctor Communication, Nurse Communication, Responsiveness of Hospital Staff, Cleanliness and Quiet Environment, Pain Management, Communication about Medicines and Discharge Information.
- Can be obtained via CMS Hospital Compare and New Jersey Performance web sites.

Mortality-Risk Adjusted for Top 10 Volume DRGs

- Reflects mortality rates of hospitals for the top 10 DRGs.
- Can be calculated using hospital discharge data at the DHSS, using All Patient Refined (APR)-risk adjustment methodology.

Agency for Healthcare Research and Quality (AHRQ) Inpatient Quality Indicators (IQI) for Mortality

- Reflects mortality rates for patients who died as a result of pneumonia, congestive heart failure (CHF), acute myocardial infarction (AMI) and stroke.
- Can be calculated using hospital discharge data and applying methodology developed by AHRQ software and APR-DRG risk adjustment.

Thirty Day Readmission Rates for Top 10 Volume DRGs

- Defines readmission rates to hospital within 30 days of discharge.
- Can be calculated using hospital discharge data at the DHSS.

Average Length-of-Stay (ALOS) for Top 10 DRGs

- Defines the average length of stay of patients admitted to the hospital.
- Can be calculated using hospital discharge data at the DHSS, using APR-risk adjustment methodology.

In addition, the Department of Health and Senior Services will be collecting and publicly reporting on nosocomial infection rates. The Department will determine the specifics of such measures through the advice of the Quality Improvement Advisory Committee at the Department.

Other indicators may be required of hospitals when requesting for a subsidy, including information on pediatric care, obstetrical care, and emergency care.

Table 15.1:
Quality Measures Endorsed by Commission for Inclusion in a “Hospital Performance Dashboard”

Indicators	Available for All Hospitals*	Source
Perfect Care Scores: AMI, pneumonia, CHF, SCIP	Yes	DHSS based on information collected for Hospital Performance Report
Nosocomial Infection Rates	Yes in 2009	DHSS will phase-in based on hospital reports
Hospital CAHPS	Yes in 2008	CMS
Mortality-Risk Adjusted for top 10 DRGs	Yes	DHSS based on APR-DRGs
AHRQ IQI Mortality: ■ Pneumonia ■ CHF ■ AMI ■ Stroke	Yes	DHSS calculates using AHRQ software and APR-DRGs
30 day Readmission Rates for top 10 DRGs	Yes	DHSS based on APR-DRGs
ALOS-Risk Adjusted for top 10 DRGs	Yes	DHSS based on APR-DRGs
Accreditation Status	Yes	Joint Commission

* Indicates that the measure may be calculated based on existing data.

C. Efficiency Measures

The efficiency measures endorsed by the Commission assess a hospital's costs, resource use, patient utilization review, staffing, and revenue cycle management. Similar to the quality measures, these measures are generally already collected and maintained in existing databases by the Department of Health and Senior Services.

Recommendation:

The Commission endorsed a set of efficiency measures for the development of a “Hospital Performance Dashboard”- these measures are summarized below and in Table 15.2.

Full-time Equivalent Staffing per Adjusted Occupied Bed

- Calculates the full-time equivalent staffing provided per actual bed occupied, versus a static bed capacity number

- Can be calculated in Hospital Costs Report provided to DHSS, and UB-92 admissions data, adjusting for volume (using gross revenue) and case mix/severity

Labor/Non-labor/Total Expense per Adjusted Admission

- Calculates the labor, non-labor and total expense involved per admission
- Can be calculated in Hospital Costs Report provided to DHSS, and UB-92 admissions data, adjusting for volume (using gross revenue) and case mix/severity

Case Mix Adjusted Length of Stay (ALOS)

- Included as an indicator of management's ability to control utilization, and hence, costs, at the hospital
- Can be calculated using hospital discharge data at the DHSS, using APR-risk adjustment methodology

Occupancy (% of Maintained Beds)

- Reflects hospital management's ability to utilize beds within hospital, with low rates indicated hospital incurring costs to keep unneeded beds available
- Can be calculated using DHSS B-2 forms

bills and paying vendors with the resulting cash flow

- Can be calculated from hospital data reported to DHSS and New Jersey Health Care Facilities Financing Authority (NJHCFFA) financial database

Days in Accounts Receivable and Average Payment Period

- Reflects hospital's ability to effectively manage the process of generating and collecting patient

Denial Rate

- Measure of revenue cycle management
- Self-reported by hospitals

Table 15.2:

Efficiency Measures Endorsed by Commission for Inclusion in a "Hospital Performance Dashboard"

Indicators	Available For All Hospitals*	Source	Comments
FTE per adjusted occupied bed	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Non-labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Total expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Case mix adjusted ALOS	Yes	DHSS B-2 Forms and UB-92 data	Use APR-DRGs to calculate case mix index
Occupancy (maintained beds)	Yes	DHSS B-2 Forms	Licensed beds are fixed in short run but maintained beds can be adjusted.
Days in accounts receivable	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Average payment period	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Denial rate	No	Voluntary reporting from hospitals	Will not calculate statewide benchmark but will use as additional information to evaluate revenue cycle management

*Indicates that the measures may be calculated based on existing data.

D. Overall Key Recommendations for the Hospital Performance “Dashboard”

- The Quality and Efficiency metrics should be part of the evaluation process when determining whether a hospital meets criteria to receive a state subsidy.
- The Quality and Efficiency metrics should become available to the public.
- The measures selected are largely based on what can be applied uniformly across all New Jersey hospitals and current data collected by the State.
- Additional data collection efforts should be considered by the State in the future as a long-term strategy. These include Institute of Healthcare Improvement (IHI) safety measures, medical staff qualifications, and infrastructure in health information technology.
- Decisions on support by the State must also consider whether the hospital has funds to create an infrastructure to monitor quality performance.

III. Early Warning System for Hospital Financial Distress

There has, of late, been a great deal of discussion regarding the appropriate level of State involvement in

ensuring that hospitals in New Jersey are operating with reasonable financial efficiency. Other than a few State, county or municipally run hospitals¹⁵¹, New Jersey hospitals consist almost entirely of not-for-profit corporations¹⁵², which are, except for licensing and limited governmental funding, completely independent from any state or local governmental entity. Up until recently, out of respect for this independence and the belief market forces would lead to appropriate funding levels, the State has taken a relatively hands-off approach with regard to oversight of an individual hospital’s finances, choosing rather to allow each hospital’s management and governing body to exercise its business judgment in operating its facilities.

Several recent developments make a compelling case for the State to take a more proactive approach to hospital finances. First, five New Jersey hospitals have filed for bankruptcy since July of 2006.¹⁵³ Second, four hospitals have closed or announced their intention to close since 2006.¹⁵⁴ Third, within the last year several hospitals have been sold or are in the process of being sold.¹⁵⁵ Fourth, New Jersey hospitals have experienced a significant downward financial trend over the last several years, despite a generally upward financial trend

¹⁵¹The University of Medicine and Dentistry of New Jersey, a State entity, owns University Hospital in Newark. The County of Bergen owns Bergen Regional Medical Center in Paramus. The City of Hoboken recently acquired, through the new statutory creation of a municipal hospital authority (N.J.S.A. 30:9-23.15 *et seq.*), the hospital formerly known as St. Mary Hospital and renamed it Hoboken University Medical Center.

¹⁵²Of the non-profit hospitals in the State, thirty (30) are single site hospitals unaffiliated with any system (three of which are owned by governmental entities as described in note 2 above). Three (3) are affiliated with out-of-state based, multi-state, not-for-profit hospital systems. Forty-two (42) hospitals are affiliated with in-state, not-for-profit systems, which range in size from two to six hospitals.

¹⁵³The five hospitals to declare bankruptcy since July 10, 2006 are (i) Barnert Hospital in Paterson, (ii) Bayonne Medical Center in Bayonne, (iii) Pascack Valley Hospital in Westwood, (iv) PBI Regional Medical Center in Passaic, and (v) William B. Kessler Memorial Hospital in Hammonton. It should be noted that these bankruptcies prove quite costly to the hospital, the creditors of the hospital and the suppliers to the hospital, not to mention the toll bankruptcy takes on a hospital’s employees, patients and community. In situations such as these, the State is also sometimes asked to provide advances of charity care and hospital relief funds payments or to provide loans, grants or other extraordinary aid.

¹⁵⁴The four hospitals that have closed since 2006 or are planning to close are (i) Saint Mary’s Medical Center, which closed its inpatient acute

care services at its original location after it acquired PBI Regional Medical Center (it intends to close and sell its original facility once it moves the behavioral health and other services still offered there into its newly acquired facility), (ii) Union Hospital in Union, which was closed by its parent, Saint Barnabas Health Care System, and sold to Overlook Hospital (part of the Atlantic Health System), which will operate it as a satellite emergency department; (iii) Irvington General Hospital in Irvington, which was closed by its parent Saint Barnabas Health Care System; and (iv) Greenville Hospital in Jersey City, which is subject to a pending certificate of need to close by its parent Liberty Health System. New Jersey had nine additional hospitals close between 2000 and 2004 and nine more hospitals close between 1988 and 1999, for a total of 22 hospital closures in the last twenty years. Source, Records maintained by the New Jersey Health Care Facilities Financing Authority as well as the New Jersey Hospital Association (http://www.njha.com/advocacy/pdf/Hospital_Closures_Next.pdf).

¹⁵⁵In addition to the bankruptcy sales currently in process for Barnert Hospital, Bayonne Medical Center and Pascack Valley Hospital, (i) PBI Regional Medical Center was sold through a bankruptcy auction to St. Mary’s Medical Center in Passaic, (ii) Union Hospital was sold to Overlook Hospital (part of Atlantic Health System), (iii) Mountinside Hospital was sold to the multi-state, for-profit Merit Health System, (iv) Saint Clare’s Health Services is currently in the process of being acquired by the multi-state, not-for-profit Catholic Health Initiatives, and (v) Solaris Health System announced on November 16, 2007 that it was seeking a purchaser for its Muhlenberg Regional Medical Center in Plainfield.

for hospitals elsewhere in the country.¹⁵⁶ Finally, over the last three years New Jersey has significantly increased its payments to hospitals for uncompensated care through programs such as Medicaid, Charity Care and Hospital Relief. Despite these funding increases, hospitals have increasingly been requesting advances under these programs and, in some cases, sought loans, grants or other extraordinary additional funding.

In response to recent requests from hospitals for advances, loans, grants and other extraordinary funding, the State has taken a more proactive role. In a somewhat ad hoc but reasonable fashion, the State has implemented a form of State monitoring of the requesting hospital and required it to take steps to remedy the problems with its financial operations.

A more proactive, structured and formal approach, which identifies appropriate Early Warning System triggers of financial distress and leads to specific and progressive steps toward remedying the financial distress, would be the appropriately limited but rational response to the need for State oversight of hospital finances. It would also add a level of predictability for both the State and its hospital constituency. The Early Warning System can be used proactively by the State to begin a monitoring process that could prevent further financial deterioration of a hospital before it resorts to making an emergency request for an advance, loan, grant or other extraordinary funding. The progressive steps to remedy the financial distress can be designed to reverse any financial deterioration and return the hospital to sound financial footing.

A. Authority for the State to Intervene

The State, by itself or through the Department of Health and Senior Services and the Department of Human Services, has a wide range of authority it could cite to impose the requirements suggested herein on hospitals. For instance, the State could enact specific legislation to accomplish its goal of supervising hospital finances. Alternatively, rules or regulations could be enacted or amended to require hospitals to permit State monitoring

and intervention, under identified circumstances, as a condition to receiving or maintaining the licenses or Certificates of Need issued to them by the Department of Health and Senior Services or the Department of Human Services. Finally, funding from sources such as Medicaid, Charity Care, Hospital Relief Fund, or any other State-controlled funding source could be conditioned, by statute, rule or regulation, to hospital compliance with the State's demand for financial monitoring or intervention.

Recommendation:

The Department of Health and Senior Services should implement an Early Warning System focused on monitoring the financial health of hospitals and intervening in a graduated fashion based on the severity of financial difficulties and the response of management.

B. Early Warning System

The concept of an Early Warning System "trigger," in this instance, is meant to alert the State to the potential for financial distress at a particular hospital. The purpose is to allow the State to determine whether additional monitoring or some intervention may be required. Because the State frequently becomes aware of a hospital's financial distress relatively late, and often too late to take any meaningful action, the Early Warning System should be able to identify not only sudden and drastic changes in the financial condition of a hospital, but should also identify subtle changes or trends over time that may indicate future financial difficulties. Therefore, just as remedies should be progressive, the Early Warning System should reflect the degree of financial distress, which can then guide the State to the appropriate starting point on the monitoring or intervention spectrum.

The State currently requires all hospitals to provide quarterly unaudited financial information and annual audited financial statements. In order to determine when triggers in the Early Warning System have been reached, it will be necessary for the State to continue to collect this information from hospitals. In fact, failure to deliver these reports in a timely fashion, in and of itself, should be a trigger in the Early Warning System.

¹⁵⁶See e.g. Standard & Poor's report entitled "What's Ailing New Jersey's Not-For-Profit Hospitals: The Reasons Why They Lag the Strong National Credit Trend" released in March of 2007.

Based on the anecdotal experience of the staff at the New Jersey Health Care Facilities Financing Authority and its historical observation and calculation of statewide medians of the key financial indicators for hospitals, the following triggers are suggested.

Stage 1 Triggers

The first step toward righting a hospital's financial ship is referred to as "Monitoring" in the section entitled "Remedies" below. The State should impose "Monitoring" when any of the following occurs at a hospital: (i) its Days Cash-on-Hand¹⁵⁷ falls below 50 days; (ii) its Cushion Ratio¹⁵⁸ falls below 6.0; (iii) its Days in Accounts Receivable¹⁵⁹ is above 60; (iv) its Average Payment Period¹⁶⁰ is above 70 days; (v) its Total Margin¹⁶¹ falls to 0 or below; or (vi) its Earnings Before Depreciation¹⁶² falls below 4%.

Additionally, the "Monitoring" remedy should be imposed if a hospital experiences: (i) a decline in Days Cash-on-Hand of any of the following (a) 30% over 2 years, (b) 25% in one year, or (c) 20% in one quarter; (ii) a decline in the Cushion Ratio of any of the following (a) 30% over 2 years, (b) 25% in one year, or (c) 20% in one quarter; (iii) a 25% increase in Days Accounts Receivable over 2 years; (iv) a 25% increase in the Average Payment Period over 2 years; (v) a decline in the Total Margin in two consecutive years; or (vi) a decline in Earnings Before Depreciation in two consecutive years.

Finally, the imposition of "Monitoring" should be strongly considered if, based on an analysis of all six of the key statistics identified above, the hospital is in the bottom 25% compared to other hospitals in the State.

¹⁵⁷The state-wide median as of June 30, 2007 for Days Cash on Hand is 68.48 days. This statistic measures how many days a hospital could continue to operate solely from cash on hand assuming it had no income. It tests a hospital's ability to meet unexpected expenses and implement strategic plans.

¹⁵⁸The statewide median as of June 30, 2007 for Cushion Ratio is 7.22. This statistic measures cash reserves in relation to annual the debt service.

¹⁵⁹The statewide median as of June 30, 2007 for Days in Accounts Receivable is 48.89 days. This statistic measures average time it takes the hospital to collect its accounts receivable and is an indication of the hospital's ability to manage revenue cycle, which, if long, is a potential indicator of cash flow problems.

Stage 2 Triggers

The second step toward righting a hospital's financial ship is referred to as "Intervention" in the section entitled "Remedies" below. The State should impose "Intervention" when any of the following occurs at a hospital: (i) Days Cash-on-Hand falls below 30 days; (ii) the Cushion Ratio falls below 2.0; (iii) Days in Accounts Receivable is above 75; (iv) the Average Payment Period is above 90 days; (v) the Total Margin falls below (3.00); or (vi) Earnings Before Depreciation falls below 0%.

Additionally, the "Intervention" remedy should be strongly considered if, based on a comparison of all six of the key statistics identified above, the hospital is in the bottom 10% of hospitals in the State.

C. Remedies

Remedies should be progressive in nature based on the potential for financial distress or, if already distressed, the degree of financial distress. For instance, if the potential for financial distress is remote, the level of State involvement should start out as the least intrusive. However, if within a reasonable period the least intrusive means of State involvement does not result in measurable improvements, progressively more intrusive means are called for until financial improvements result. Conversely, if the level of financial distress at a particular hospital is high when the State discovers it, a more intrusive level of State involvement is justified from the outset. Thus, if a hospital has more than one of the key indicators in the Stage 1 Trigger range or if a hospital is approaching a Stage 2 Trigger in one or more of the key indicators, the State should be given the discretion to begin the "Monitoring" remedy discussed below at either Level 2 or Level 3.¹⁶³

¹⁶⁰The statewide median as of June 30, 2007 for Average Payment Period is 63.44 days. This statistic measures the timeliness of a hospital's payments to vendors and, if long, is a potential indicator of cash flow problems.

¹⁶¹The statewide median as of June 30, 2007 for Total Margin is 1.62%. This statistic measures a hospital's profitability, including interest earnings and non-operating revenue and expenses.

¹⁶²The statewide median as of June 30, 2007 for Earnings Before Depreciation is 5.70%. This statistic provides a rough indicator of cash flow by adding back depreciation.

¹⁶³In the interest of consistency and to avoid possible claims of unequal, unfair or arbitrary treatment, it may be advisable to further divide the Early Warning Triggers so that it is readily discernable (and thus less discretionary) at which level the Monitoring of a hospital will begin.

D. Monitoring

Level 1 – Upon tripping a Stage 1 Trigger the State should appoint a Monitor¹⁶⁴ for a hospital. The Monitor should be authorized to attend all hospital board meetings, executive committee meetings, finance committee meetings and steering committee and/or turnaround committee meetings.¹⁶⁵ The Monitor at Level 1 shall have no voting power, but shall receive the same notice and preparatory materials distributed to board members for the above-mentioned meetings.¹⁶⁶ At the Monitor's request, he or she shall be able to meet separately with any one or more key employee(s) or board member(s). Within thirty (30) days of the imposition of the Monitor, the management of the hospital and its governing body should be required to prepare a Management Action Plan which should be adopted by the governing body. The Management Action Plan should identify areas for improvement and a plan for the implementation of those improvements. The Monitor should meet monthly with the hospital's management and key members of the governing body to discuss the progress of the implementation of the Management Action Plan and its results. If after three months, the key indicators have not materially improved as a result of the Management Action Plan, the State should impose Level 2 Monitoring.

Level 2 – Under this level of monitoring the Monitor shall have full voting power at the board meetings, executive committee meetings, finance committee meetings and steering committee and/or turnaround committee meetings. The Monitor shall hold biweekly meetings with the hospital's management and key members of the governing body to discuss the progress of the implementation of the Management Action Plan and its results. If a total of six months have elapsed since the time within which the Management Action Plan was to have been adopted and the key indicators have not materially improved, the State should impose Level 3 Monitoring.

Level 3 - Under this level of monitoring the Monitor shall have full voting power as well as veto power over actions at the board meetings, executive committee meetings, finance committee meetings and steering committee and/or turnaround committee meetings, which concern the fiscal health of the organization. The Monitor shall hold weekly meetings with the hospital's management and key members of the governing body to discuss the progress of the implementation of the Management Action Plan and its results. If a total of nine months have elapsed since the time within which the Management Action Plan was to have been adopted and the key indicators have not materially improved, the State should impose Intervention.

E. Intervention

Throughout the Intervention levels identified below, the hospital shall continue to be subject to a Monitor empowered in accordance with Monitoring Level 3 above, to the extent not inconsistent with the Intervention remedies.

Level 1 – The hospital shall be required to engage an independent consultant within one month to prepare a thorough report with recommendations, deliverable within two months, that analyzes the effectiveness of any or all of the following, at the discretion of the Monitor: the hospital's operations, management and governance. Once the consultant's report is completed, the hospital shall be required to implement the recommendations of the report, or, if the report so indicates and the Monitor concurs, engage a consultant to implement the recommendations of the consultant's report.¹⁶⁷ Meetings with the consultant, management and key board members will be held weekly or biweekly, at the discretion of the Monitor, to assess the progress of the implementation of the consultant's recommendations.

¹⁶⁴Any action taken by any State appointed Monitor should be taken only after consultation with and approval by the Commissioner of the Department of Health and Senior Services or his or her designee or designees.

¹⁶⁵If not already doing so, the board and each of these committees should be required to meet at least monthly.

¹⁶⁶Certain information and discussions that would normally be exempted from being made public under New Jersey's Open Public Meetings Act or Open Public Records Act may be exempted from the Level 1 monitoring requirement.

¹⁶⁷Should the consultant's recommendations include replacement of management or change in the governing body, and the Monitor concurs, the State may require replacement of management or changes in the governing body at this level of intervention.

Level 2 – If key indicators have not significantly improved after six (6) months of implementing the consultant’s recommendations, or if at any time during the implementation process the Monitor concludes that any member of the hospital’s management or the governing body has interfered with the implementation to the detriment of the hospital, the State may ask the hospital to replace any member or members of the management team or of the governing body with a manager(s) or board member(s) not unacceptable to the State.

Level 3 – If after twelve (12) months the hospital is not well on its way to financial recovery, the State may replace the hospital’s entire management team or its entire governing body or direct the hospital to seek a strategic partner, sale or closure.

F. Funding for Monitoring and Intervention

There will be substantial costs for providing the Monitoring and Intervention recommended herein. Monitors can either come from (i) a new special division of the Department of Health and Senior Services which could maintain a pool of employees trained and experienced in hospital finance or (ii) consultants hired ad hoc by the Department as needed. In either case the State will need to find a way to pay for these additional costs. One funding source for this additional cost could be an increase in the Hospital Assessment which is currently .53% of a hospital’s net patient revenue. Other sources could include increases in assessments on ambulatory surgery centers or health insurance providers. Any combination of increases in these three assessments may also be appropriate.

Arguably, the cost of Intervention may be more appropriately paid directly by the individual hospital requiring Intervention. However, because the hospital is in clearly in financial distress at this stage, it would be wise for the State to pay the costs of Intervention, possibly through an increase of the assessments on hospitals, ambulatory surgery centers or health insurance providers similar to that identified above.

The increases in any or all of the above-mentioned assessments may also be leveraged to create a large pool of funds through the issuance of bonds backed by the income created by those increases, which would need to

be pledged to secure the bonds. The resulting pool of bond proceeds could be used not only to pay for Monitoring and Intervention, but also for the costs associated with the wind down of operations of a hospital slated to close or alternatively to fund the continuation of operations at a hospital slated for sale, after a purchaser has been identified but before the acquisition can be consummated due to pending statutory and regulatory approvals.

G. Preventive Measures

Good governance and management practices can go a long way toward preventing or mitigating financial distress of hospitals. The Commission’s recommendations regarding governance were presented at length in Chapter 10 and will not be repeated here. It should be noted that legislation enacted by the State on April 30, 2007 mandating training for members of hospital boards¹⁶⁸ is a significant step toward better governance. Properly provided, this training can provide hospital board members with an overview of issues effecting hospitals and help board members understand their supervisory and fiduciary duties. Development of the curriculum for board training is currently pending. Great care should be taken to ensure this training is thorough and meaningful. Finally, the Commission urges the State to mandate its recommended governance requirements rather than merely recommend them.

IV. Conclusion

It is well known that many New Jersey hospitals are currently experiencing financial distress or are on the verge of financial distress. Performing worse on a whole than other hospitals in the country, this dismal reality is likely to persist whether or not the increases in Federal and State funding suggested by many are appropriate or forthcoming. Plainly stated, funding increases, if enacted, may resolve the financial struggles of many hospitals, but are simply not a panacea to the epidemic of financially struggling hospitals. In addition to the arguably insufficient governmental funding, hospitals have been negatively affected by changes in

¹⁶⁸N.J.S.A. 26:2H-12.34.

health care practice patterns, pricing pressures from managed care companies and competition for well paying patients from ambulatory surgery centers, imaging centers and diagnostic and treatment centers.

The recent increase in hospital bankruptcies and closures is graphic and disturbing anecdotal evidence of the deterioration of the financial health of New Jersey's hospitals. The State's past reluctance to insinuate itself into a hospital's finances management, in favor of relying on the business judgment and timely response of the hospital's management or governing body, has proven to be ineffective. Based solely on the increasing amount of taxpayer dollars provided to hospitals, the

State would be irresponsible to continue its practice of not intervening to prevent further deterioration of the financial health of hospitals in New Jersey. This chapter identified rational benchmarks through an "Early Warning System" for when it is appropriate for the State to intervene and what reasonably tailored forms the State's intervention should take. In addition, the chapter described the Commission's recommendation for the development of a "Hospital Performance Dashboard" that would provide for regular monitoring of quality and efficiency standards. These publicly reported metrics would increase transparency of the health care system and ensure standards are met when hospitals receive state support.

Section V:

A Vision for a 21st Century Health Care System



Chapter 16:

An Information Infrastructure for New Jersey Health Care

Key Points

- **The health care system severely lacks pertinent data and information needed to guide decision-making and to create incentives for provider accountability. A visionary information infrastructure is needed to overcome these barriers and realize the potential of a 21st century health care system.**
- **An information infrastructure is a key element of efforts to improve quality, address unjustified variations in clinical practice, and to measure and monitor hospitals' costs relative to efficiency benchmarks.**
- **Health information systems possess many of the characteristics of a public good – meaning the private sector will tend to under-invest in such a system. Public subsidies and mandatory participation are needed to develop and support sustainable information systems.**
- **Developing and sustaining a health information system is a very difficult task but one that holds great potential to improve health system performance. The State should form a commission charged with developing the framework and policies around the development of a regional health information system. Such a commission needs to engage many key stakeholders to overcome these challenges.**
- **To maximize effectiveness, a future health information system should be standardized, transparent, and easily accessible and should be managed by a public-private organization.**

It is fair to state that health care in New Jersey, in the United States and virtually everywhere in the world is rendered in a fog. People in that fog may be trying to do the best they believe can be done, but collectively they fall far short of the best that would be achievable with a lifting of that fog.

The fog in question is the lack of pertinent information that can, at once, guide decision making in health care, but also hold the participants in the health care sector accountable for their actions. It is also fair to state that, relative to other sectors in modern economies – e.g., the financial sector, the travel industry, and the retail industry, to mention but a few – the health sector tends to be a unique underachiever in this regard. It devotes relatively fewer resources to information systems than do other industries and, for the resources it does deploy,

achieves less. Much of the waste, fraud and abuse said to be part of modern health systems and considerable human suffering – in the midst of much succor and miraculous cures – can be traced to this lack of an adequate information system.

The persistent fog surrounding the delivery of health care is particularly disturbing in the face of current attempts to convert what hitherto had been known as “patients” into “consumers” who are expected to shop around smartly for cost effective care under so-called *Consumer Directed Health Care*. Unless strident efforts are made at long last to lift that fog through more widespread application of modern IT in health care, these “consumers” will resemble nothing so much as blindfolded shoppers thrust into department stores, there to shop smartly for wanted or needed items.

This chapter briefly explores the reasons for the lack of adequate information systems in health care, sketches the vision of a 21st Century health-care information system, examines how much of that vision has been achieved by now in New Jersey or is actively being pursued, and finally offers some recommendation to move New Jersey health care toward an information platform that adequately serves the state's people.

I. The Imperative of a Health System Information Infrastructure

At the core of an efficiently functioning health-care system is an information infrastructure that enables the various decision makers in health care — patients, physicians and nurses, the executives of health care facilities, insurance companies and government officials -- to make decisions that result in timely and cost-effective health care. Remarkably, relative to other sectors in the economy, the health sector has been uniquely lagging in its use of available information technology (IT). In exploring the reasons why this is so, it will be helpful to divide the sector into its supply side and its demand side.

The Supply Side: As a general rule, suppliers in any economic sector will actively seek the information that helps them achieve their own goals, but otherwise will shun the transparency that might expose them to the brunt of full-fledged competition on price and quality as well as public accountability for the use they make of resources.

That penchant is not evil. It is normal and perfectly human. Therefore, the supply side in health care cannot be expected to develop the information infrastructure required for cost-effective, high-quality health care and full accountability unless those who pay for health care mandate it to do so.

The Demand Side: Remarkably, in health care the demand side of the sector has been and continues to be largely asleep at the switch. Patients and those who chiefly pay for health care (government and private

insurers) so far have been remarkably tolerant of a high variance in both the cost and quality of the health care they procure, where “high variance” is technical jargon for the phenomenon that excellent and shoddy quality and wasteful as well as cost-effective health care are permitted to exist side-by-side within the same health-care system – e.g., that of a single state or even a single community. Instead, the demand side of the sector has simply trusted the providers of health care to do the right thing and have been content to procure health care in the fog alluded to above.

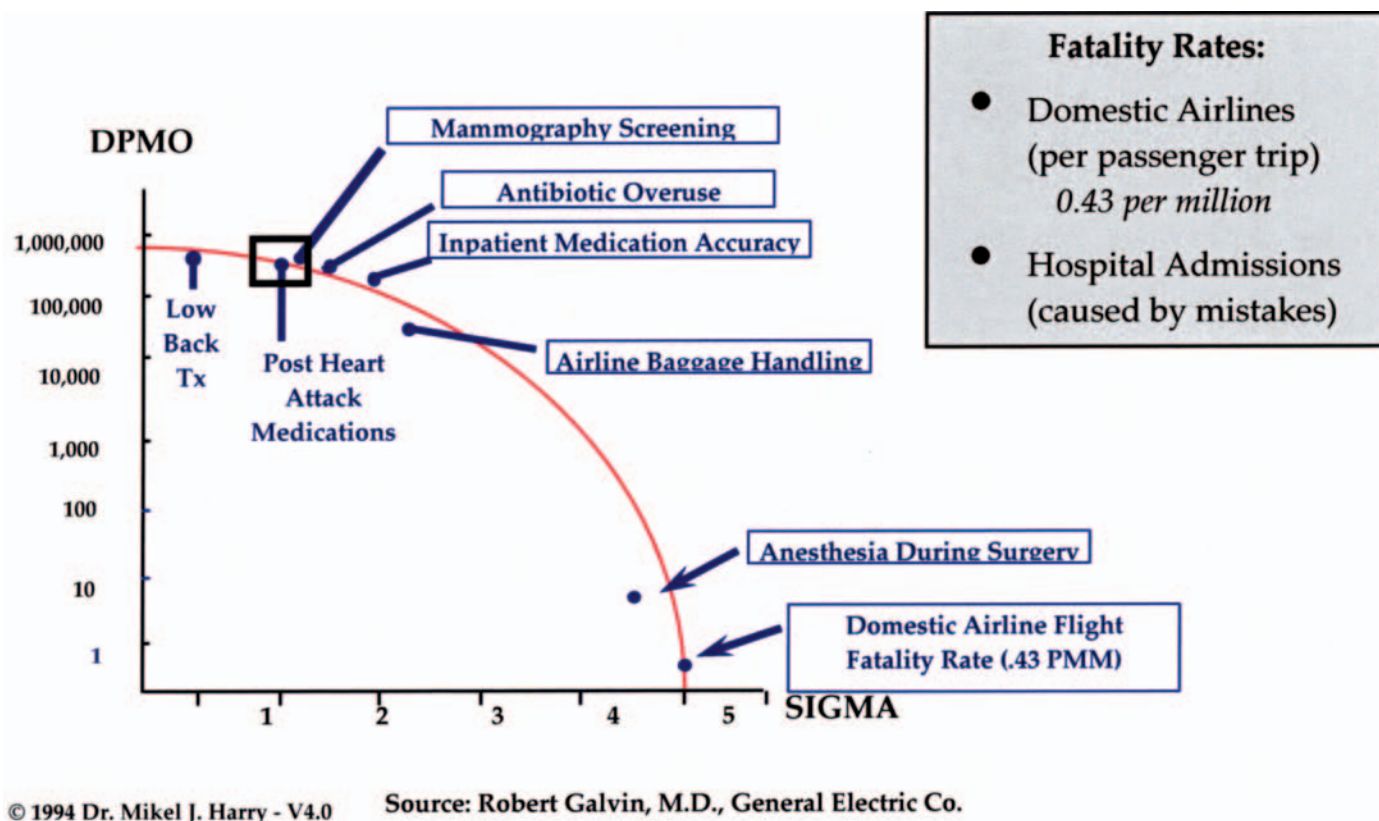
One can understand why patients, who usually are well-insured from the cost of health care, would not show much concern over the total cost of their care, as long as their out-of-pocket costs are tolerable. The patients' manifest indifference toward variations in the *quality* in health care, however, is nothing short of remarkable. The only sensible explanation is that so far patients have been kept ignorant of that variance, which has long been known to health policy analysts and at least some policy makers in the private and public sectors.

Why both public and private insurers have been so passive on this score, however, remains a mystery. It can flatly be stated that they could have served society better, but the economics of American health care have never compelled them to do so.

A. High Variance in the Quality and Cost of Health Care

In the mid-1990s, for example, employee benefit managers at the General Electric Co. popularized the six-sigma chart shown below, indicating for a number of activities the number of defects per million opportunity for defect (DPMO), a metric used in six-sigma quality control. The chart indicated that more errors occurred in a number of medical treatments than in baggage handling by airlines, a notoriously error-prone activity. It is a quite stunning statement on the quality of U.S. health care, especially because Americans so often boast that theirs is “the best health system in the world.”

Figure 16.1:
The Quality Imperative: The General Electric View



At the end of the decade, in 1999, the prestigious Institute of Medicine (IOM) of the National Academy of Sciences published its landmark study *To Err Is Human: Building a Safer Health System*, in which the Institute's panel of experts estimated that somewhere between 44,000 to 98,000 Americans died prematurely in hospitals as a result of avoidable medical errors, very frequently errors in the administration of drugs. Earlier in the decade, Lucien L. Leape, M.D. of Harvard University had likened these premature deaths due to medical errors in a seminal article published in the *Journal of the American Medical Association* to "the equivalent of three jumbo-jet crashes every 2 days."¹⁶⁹

The IOM's 1995 report was followed, in 2001, by the Institute's *Crossing the Quality Chasm: A New Health System for the 21st Century*. A passage in the Executive Summary is instructive for present purposes:

¹⁶⁹Lucien L. Leape, "Errors in Medicine," *Journal of the American Medical Association*, 272(23) (December 21, 1994): 1851-58.

The health care system as currently structured does not, as a whole, make the best use of its resources. ... A highly fragmented delivery system that largely lacks even rudimentary clinical information capabilities results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services – services for which the potential risk of harm outweighs the potential benefits. What is perhaps most disturbing is the absence of any real progress toward restructuring health care systems to address both quality and cost concerns, or toward applying information technology to improve administrative and clinical processes (p. 3; *Italics added*).

Apparently, there has not been much progress since 2001 either. In a paper entitled "The End of the Beginning: Patient Safety Five Years After 'To Err is Human'," Robert Wachter observes that

Table 16.1:
Blue Cross Blue Shield Outcomes Study for Tertiary Centers

	Blue Distinction Centers		All Other Centers	
	Mean	Maximum	Mean	Maximum
Short-term Major Complications from Bariatric Surgery	5%	8%	7%	37%
Heart Transplant Patient One-Year Mortality Rate	11%	30%	19%	57%
Inpatient Mortality (Heart Attack)	7%	15%	9%	40%

Source: Data provided by Nat Kongtahworn, Director, Network Strategies, Office of Clinical Affairs, Blue Cross Blue Shield Association.

Since 1999, there has been progress, but it has been insufficient. Stronger regulation has helped, as have some improvements in information technology and in workforce organizations and training. Error-reporting systems have had little impact, and scant progress has been made in improving accountability. Five years after the report's publication, we appear to be at "the end of the beginning."¹⁷⁰

Shown above are data on clinical outcomes from three standard procedures in tertiary centers, broken down into those declared by the Blue Cross Blue Shield Association to be Centers of Distinction and all other centers in the study. The data exhibit a remarkable variance in clinical outcomes, especially in the mortality rate associated with heart transplantation. These data raise two questions. First, what factors drive this high variance in clinical outcomes? Second, why do patients continue to be referred to centers with high mortality

rates, and why do private insurers pay for procedures performed in such centers?

Ignorance of these facts is likely to be the major explanation. While targeted studies can identify such variances, such data are not routinely collected, organized and publicized by insurers. Government's casual attitude towards these variances in mortality in the hospital sector stands in stark contrast to the stringent patient-safety standards government imposes on the pharmaceutical and medical device industries through the Food and Drug Administration (FDA). Why should an avoidable, premature death in a hospital be taken more lightly than a death from a problematic prescription drug or medical device? The Commission makes note that New Jersey's various health report cards indicate significant and steady improvements in the quality of care at the State's hospitals. This evidence further confirms that the availability and transparency of health care data improves quality.

¹⁷⁰Robert M. Wachter, "The End of the Beginning: Patient Safety Five Years after 'To Err is Human'," *Health Affairs Web Exclusive* (30 November, 2004): W4-534-45.

Finally, results from a recently published study in *The New England Journal of Medicine* suggest that, on average, children in the study received 46.5% of the indicated care¹⁷¹, a finding that parallels an earlier, similar study for adults published in the same journal.¹⁷²

In sum, then, uneven quality of health care remains a significant feature of the American health care system, and New Jersey's health system, while improving, is not an exception to this finding. It would be puzzling indeed why patients accept this state of affairs with such equanimity – why they would opt to receive care at hospitals in which their chance of dying from low-quality care is higher than elsewhere -- were it not for the fact that patients have absolutely no idea that such quality differentials exist. Instead of transparency on so important a matter, patients have been lulled into complacency by the much-mouthed mantra that the American health system is the best in the world, a mantra actually contradicted by a growing body of evidence. As a recent cross-national study by the Commonwealth Fund concludes:

Despite having the most costly health system in the world, the United States consistently underperforms on most dimensions of performance, relative to other countries. This report—an update to two earlier editions—includes data from surveys of patients, as well as information from primary care physicians about their medical practices and views of their countries' health systems. Compared with five other nations—Australia, Canada, Germany, New Zealand, the United Kingdom—the U.S. health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives. The U.S. is the only country in the study

without universal health insurance coverage, partly accounting for its poor performance on access, equity, and health outcomes. The inclusion of physician survey data also shows the U.S. lagging in adoption of information technology and use of nurses to improve care coordination for the chronically ill.¹⁷³

B. Information on the Cost of Hospital Care

In the context of health care the word “cost” has two meanings. It could mean the *payment* the patient's insurer makes for a hospital service. A better term for it would be the “price” the insurer pays for the service. Or it could mean the cost the hospital (or doctor) incurs to deliver the treatment, that is, the cash providers pay for the inputs they use in the treatment of patients. Not much is known publicly about the payments hospitals receive from different payers for the same service. Almost nothing is known about the input costs different hospitals incur for different services or medical cases.

Payments to Hospitals: As was noted earlier in this report (see Chapter 6), the price hospitals receive from insurers for a standard service varies significantly from private insurer to insurer, usually in inverse proportion to the insurer's market power. That price is different again for Medicaid and different once again for Medicare. Finally, because they have virtually no market power vis a vis hospitals, uninsured patients tend to be charged the highest prices, unless they are outright charity cases. In the end, however, what low-income uninsured and non-charity patients actually pay hospitals tends to be just a fraction of the prices they were charged.

All of these varied prices for the same service have virtually no systematic relationship with the cost of providing these services, whatever they may be. Furthermore, with the exception of prices paid by Medicare and Medicaid, all prices paid hospitals from the various parties are kept a tightly guarded trade secret. Although, in principle, uninsured patients or

¹⁷¹Rita Mangione-Smith, M.D., M.P.H., Alison H. DeCristofaro, M.P.H., Claude M. Setodji, Ph.D., Joan Keeseey, B.A., David J. Klein, M.S., John L. Adams, Ph.D., Mark A. Schuster, M.D., Ph.D., and Elizabeth A. McGlynn, Ph.D., “The Quality of Ambulatory Care Delivered to Children in the United States,” *The New England Journal of Medicine*, 272(15) (October 11, 2007): 1515-23.

¹⁷²McGlynn, E.A., Asch, S.M., Adams, J., Keeseey, J. Hicks, J., DeCristofaro, A., & Kerr, E.A. *Steven M. Asch, M.D., M.P.H., Eve A. Kerr, M.D., M.P.H., Joan Keeseey, B.A., John L. Adams, Ph.D., Claude M. Setodji, Ph.D., Shaista Malik, M.D., M.P.H., and Elizabeth A. McGlynn, Ph.D.*, Quality of health care delivered to adults in the United States. *New England Journal of Medicine*, 2003; 348: 2635-45.

¹⁷³Karen Davis, Ph.D., Cathy Schoen, M.S., Stephen C. Schoenbaum, M.D., M.P.H., Michelle M. Doty, Ph.D., M.P.H., Alyssa L. Holmgren, M.P.A., Jennifer L. Kriss, and Katherine K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care* (May 16, 2007), available at www.cmf.org.

those with high deductible health insurance ought to have information on the prices hospitals might charge them, as a rule there does not exist an information base to provide that information.

As was noted in Chapter 6 (see Table 6.4) as well, there is great variation in the volume of services for which New Jersey hospitals bill Medicare for roughly similar patients. Although the medical cases represented by these patients were not 100% identical, so that differences in patients might explain some of this variation, it is hard to believe that genuine differences in acuity could have accounted for such vast differences in health-care utilization.

It was recommended in Chapter 6 that the State explore information technology capable of tracking every order entry by every affiliated physicians for every input used in the treatment of every hospital case. To be sure, the administrators of some hospitals may routinely assemble resource-use data by individual physician affiliated with the hospital, but such data are unlikely to provide adequate leverage in dealing with physicians on whose goodwill and referrals the hospital must rely for its revenue flow. After all, it is not usually the hospital patient but the referring physician who effectively is the hospital's customer. The question the Governor and State legislators must explore is whether the information should also be available to them to assess the efficiency with which a hospital is run before deciding whether or not a hospital warrants state subsidies of any sort.

The Input-Cost of Hospital Services: The hospital industry regularly laments that Medicare and Medicaid pay hospitals less than 100% of the full cost of treating Medicare and Medicaid patients in hospitals. It is a plausible argument, but it leaves open the question whether the "costs" to which the payers' payment rates are compared are invariably justified. To say that Medicaid pays only about 70% of a hospital's costs may be misleading if the hospital's costs are 120% of a reasonable benchmark of what efficiently produced health care in hospitals should cost.

Here, too, New Jersey lacks a sophisticated information system that can routinely inform government on how a particular hospital's costs compare to reasonable benchmark costs.

C. The Potential Role of State Government in Health Information Systems

The troublesome circumstances described in the preceding subsections lead to the question of what role State government has in financing and constructing an information infrastructure designed to drive the entire health system – patients, insurers and providers alike – towards higher levels of performance. Alternatively put, the question is whether Americans can rely on the private sector to develop that infrastructure, given that sector's undistinguished history in this regard.

So far, neither the federal nor the state governments have done much to force greater transparency on the activities of the providers of health care whose revenues depend heavily on government financing. Only in the past few years have governments begun to address this important task seriously. Although private employers and their agents (private health insurers) equally had every opportunity in the past several decades to hold the providers of health care more rigorously accountable for the cost and quality of the services paid for by private insurers, and to provide the insured public with greater transparency on the cost and quality of health care delivered by health care providers, for the most part they, too, have failed to do so and are only now making timid steps in that direction.

If the State's government wishes to drive the State's health system more rapidly towards high performance, in terms of both cost and quality, government probably will have to intervene rather heavily to guide the invisible and timid hand of the private market place. To illustrate, a good faith cooperative effort is currently under way by Horizon Blue Cross Blue Shield of New Jersey and the New Jersey Hospital Association to develop a so-called regional health information

organization (RHIO) that would facilitate the sharing of clinical information on patients across providers. Participation in any such effort, however, would be *voluntary* and thereby makes it difficult to develop a business model for the system from the individual hospital's perspective. Recent research on RHIOs elsewhere in the nation strongly suggest that RHIOs based on strictly voluntary efforts are prone to fail.¹⁷⁴

Recommendation:

In view of the decade-long failure of the private sector to develop such an information infrastructure – e.g., Regional Health Information Organizations (RHIOs) – the State should take a leading role in the development of such a system, financing both the research and the development efforts to establish such a system. Participation in such a system should be mandatory upon health care providers.

A strong business case for such an infrastructure could be provided if government mandated participation in the RHIO which, in turn, probably would require sustained financial support of the venture by government. That support could easily be defended on economic grounds, as a RHIO has a strong dimension of a public good. Economists make the case that, left to its own devices, the private sector will always under-supply public goods, unless their production is subsidized explicitly by government.

Recommendation

To maximize its effectiveness, a future health information system should be standardized, transparent, and easily accessible. It should be managed by a public-private organization that is chartered by the State and, in view of the public-goods nature of the enterprise, supported by State funds.

¹⁷⁴See Julia Adler-Milstein, Andrew P. McAfee, David W. Bates, and Ashish K. Jha, "The State Of Regional Health Information Organizations: Current Activities And Financing," *Health Affairs Web Exclusive*, December 11, 2007; http://content.healthaffairs.org/cgi/search?ck=nck&andorexactfull-text=and&resourcetype=1&disp_type=&author1=&fulltext=RHIO&pubdate_year=&volume=&firstpage=.

II. A Full-Fledged 21st Century Health Information System

A full-fledged, state-of-the art health-care information system already being developed in several parts of this country and, sometimes even more rapidly, in other nations would serve the following distinct objectives.

1. It would allow physicians and other providers of care throughout the state carefully authorized access to each patient's complete medical record.
2. It would endow patients with a personal electronic health record that would help them better to manage their health and their use of health care.
3. It would offer the providers of health care and those who pay for it (mainly third-party payers) adequate information to facilitate the business transactions surrounding health care smoothly and more cost-effectively than is now the case.
4. It would routinely provide data required especially by government (which pays for close to 50% of all health care in the U.S.) and communities to hold the providers of health care accountable for their use of real health care resources in the treatment of patients.
5. In particular, it would yield the data to hold physicians routinely accountable for their use of their own and their affiliated hospital's real resources in the treatment of patients. Thus one could explore, for example, the huge variations in resource-use and hold the individual physicians driving these variances formally accountable for them.

A. Different Records in a Health Information System

It would not make sense to develop one giant electronic record that could serve all of these diverse objectives at once. Instead, there should be a common master file – sometimes called the “spine” – that would contain data used in raw form or transformed by several or all of a set of electronic records customized and enriched with yet other data to serve the narrower objectives listed above. These various electronic records may be described as follows.

Electronic Health Record (EHR): An electronic record is any combination of text, graphics, data, audio, pictorial, or other information representation in digital form that is created, modified, maintained, archived, retrieved, or distributed by a computer system. An EHR is a larger concept in that the electronic information is more than the clinical information; it includes demographic information and sometimes payment codes, such as IDC and CPT codes. The electronic information is shared within a larger organization or with a second outside health care entity and follows federally recognized standards such as HL7 and X12. EHR can and should be certified by the CCHIT. The master “spine” might consist of such EHRs.

Electronic Medical Record (EMR): The purpose of the EMR is designed to be an electronic interface among clinicians. It would allow any physician authorized to do so by the patient or the patient’s guardian to access that patient’s full medical record, or authorized parts of it, which would include a medical history, the patient’s current drug regimen, all tests previously done and observations recorded by other physicians. The EMR would be kept in the clinical language understood by clinicians. This objective could be accomplished either by a smart card carried by the patient or by what is known as the VISA system, that is, a card carried by patients that permits authorized access to a central storage location for the patient’s file. The EMR would meet the first of the objectives listed above.

Personal Electronic Health Record (PEHR): The second objective listed above is met in various locations around the world by a PEHR, which is a multipurpose record written in language lay people can understand and allowing patients to see their most recent test results, graphical or tabular histories of test scores for particular metrics (e.g., blood pressure), their current and past prescription-drug regimen and so on. There would be electronic links from test results to explanations of these results and further links to the relevant literature, perhaps ordered by level of difficulty. Patients would also find on this record relevant treatment options for particular medical conditions, and guidance for proper health maintenance, including nutrition. Ideally, such a file should also provide links to reliable information on sundry dimensions of the quality

of care rendered by individual providers of health care and, to the extent that it is relevant to patients, information on their share of the cost for procuring health care from particular providers of care. Finally, patients could make appointments with physicians via this record, or communicate directly with individual physicians.

All of these desiderata may appear as too much of a load for a PEHR to carry. The fact is, however, that such records are already in use here and abroad and are spreading rapidly. Here it must be noted that the establishment and maintenance of a PEHR requires a sponsor who both finances and manages it. One alternative is to lodge that responsibility with third-party payers, who could recover their costs through premiums or user fees levied on the insured. Another alternative would be to lodge that responsibility with the patient’s “medical home,” that is, the patient’s primary-care physician, who would be explicitly paid for that service by third-party payers (or strictly by government). The model of the “medical home,” now still mainly a concept on the drawing board, has captured the imagination of health policy makers around the world.

One could imagine entrepreneurial companies to establish medical homes, replete with sizeable computer systems and staff to support it, should physicians in their medical practices shun this task. These entrepreneurial companies could contract with both private and public insurance systems.

The other objectives listed above would similarly be met by customized electronic records all of which, however, would share a common, standard nomenclature, to permit easy transmission and comparability of the data. History suggests that the development and adoption of such a nomenclature would require the guiding hand of government, along with at least some public financing.

Of particular note here would be a data system tailored to meet the 5th objective listed above, namely, a system capable of tracking the hospital resource use of individual, affiliated physicians by medical case and by input, to facilitate holding physicians accountable for the health-care costs they authorize over their signature.

B. The Financing of a Health Information System

As noted in passing earlier, a state's or nation's health information system has dimensions of a public good. In economic analysis a public good is one whose consumption or use by one person does not detract from any other person's use of that good. A second, less important dimension of a pure public good is that it is non-excludable, which means that everyone can enjoy its use.¹⁷⁵

The information produced by scientific research is a pure public good – e.g., Einstein's famous equation $E = MC^2$ or the Pythagorean theorem – is a pure public good, as is the security provided by national defense and homeland security. Clearly, a common database, once it is established, has this feature. Economic theory shows that such goods would be under produced by the private sector unless the production were collectively financed, typically by mandatory levies such as taxes.

Even goods that appear basically private consumption goods exhibit so-called “positive ties” that represent public-good dimensions. Telephone networks, for example, are such goods, because the value of a privately owned telephone increases with the number of other privately owned phones to which each telephone connects. When one person buys a telephone, all other telephone owners benefit. Economic theory suggests that the production or purchase of such goods should receive public subsidies as well if society wishes them to be produced in sufficient quantity.

The upshot of these reflections is that, because of its connectedness across the health system, a healthcare information infrastructure has dimensions of a public good and thus ought to be supported with public subsidies. The development and maintenance of the system's common data base (its “spine”) in particular should be heavily government funded, even if the actual development and maintenance is delegated to a private entity. Early experiences with regional health information systems have demonstrated the importance

of sustained public sector support – many systems elsewhere have failed by relying on private sector funding which often is inadequate over the long run.¹⁷⁶ Furthermore, to reap the full benefit of a health information infrastructure, participation in it by individual providers of health care should be mandatory.

C. Progress to Date in New Jersey

Legislation has been proposed that would create a central repository under the authority of the Department of Banking and Insurance. Under the proposal the initial source data for populating the repository would be the electronic claims data processed and maintained by health insurers, including the New Jersey Medicaid program.

In addition to that information, the proposed repository could also be populated with health data maintained by State agencies including the following:

- NJ Hospital Discharges (UB-92)
- Cardiac Utilization
- Quality Reporting
- Patient Safety Reporting
- Cancer Registry
- Childhood Immunization Health Registries
- Medicaid/NJ FamilyCare Claims
- Annual Hospital Cost Reports
- Annual Hospital Financial Statements
- Unaudited Quarterly Financial and Utilization Reports

As referenced earlier, the New Jersey Hospital Association and New Jersey Blue Cross/Blue Shield formed the EMR/EHR taskforce to develop Regional Health Information Organizations (RHIOs) around the state. Data collected through these organizations could also be used to populate the repository.

¹⁷⁵Sometimes an intrinsically public good is artificially made excludable through law – e.g., by patent protection.

¹⁷⁶Adler-Milstein, J., McAfee, A.P., Bates, D.W., and Jha, A.K. The state of regional health information organizations: current activities and financing. *Health Affairs*, 2008; 27(1): w60-w69.

Recommendation

Developing and sustaining a health information system is a very difficult task, but one that holds great potential to improve health system performance. Therefore, the Commission recommends that the State should form a commission charged with developing the framework and policies around the development of a regional health information system, drawing where appropriate on similar efforts elsewhere in the United States and abroad. Such a commission needs to engage many key stakeholders to overcome these challenges.

New Jersey's health care system and the population it serves would greatly benefit from the development of a clearinghouse for electronic health data that can be accessed by all interested parties. In essence, it is envisioned that the clearinghouse would function as a spine from which users would be able to extract and utilize data to suit their particular needs. While it is anticipated the development of such a system will take several years and occur in incremental steps, there are basic guiding principles that must be followed.

1. Public/Private Partnership – the sensitivity of the data mandates that security is paramount. Therefore the oversight and control must ultimately reside with government but the operation and output should include and reflect private sector concerns.
2. Standardization – As with any system the consistency of the terminology is critical.
3. Transparency – the system's basic functionality and data elements must be available at little to no cost and be understood by the general public.
4. Routine Outcome/Health Status Reporting – there should be regular periodic publications that summarize and report key utilization and health indicators.

5. Information already available in payer data warehouses must be used to begin populating the database with historical information that already exists.
6. Hospitals and individual practitioners must have an easy-to-use, one stop repository that can be accessed securely over the internet without forcing the adoption of another unique hardware/software configuration.
7. Laboratories, imaging and radiological facilities should file test results, reports and digitized images with the EHR Custodian for use by providers.
8. Pharmacy Benefit Managers should be required to supply filed prescription information with the EHR Custodian. Steps should be taken to remind consumers to follow recommended medication usage especially in chronic disease management.
9. Durable Medical Equipment Providers and other health care support providers should file reports with the EHR Custodian.

In view of the decade-long failure, to this day, of the private sector to develop such an information infrastructure – e.g., Regional Health Information Organizations (RHIOs) – the State should take a leading role in the development of such a system, financing both the research and the development efforts to establish such a system.

To maximize its effectiveness, a future health information system should be standardized, transparent, and easily accessible. It should be managed by a public-private organization that is chartered by the State and, in view of the public-goods nature of the enterprise, supported by State funds.

III. Conclusion

Transparency is a critical step toward improving the performance and accountability of the health care system to “lift the fog” that is currently hindering progress toward high quality, cost-effective care. An information infrastructure is necessary to address the unjustified variances in clinical practice across the state and the nation as a whole. Government must play

an important role in the creation of a 21st Century health information system. The characteristics of such a system resemble that of a public good, which firmly calls for a government role. The absence of such a role will lead to chronic underinvestment in this important area and a failure to maximize value from the health care system.



New Jersey Commission on Rationalizing Health Care Resources



Appendices for Final Report

January 24, 2008



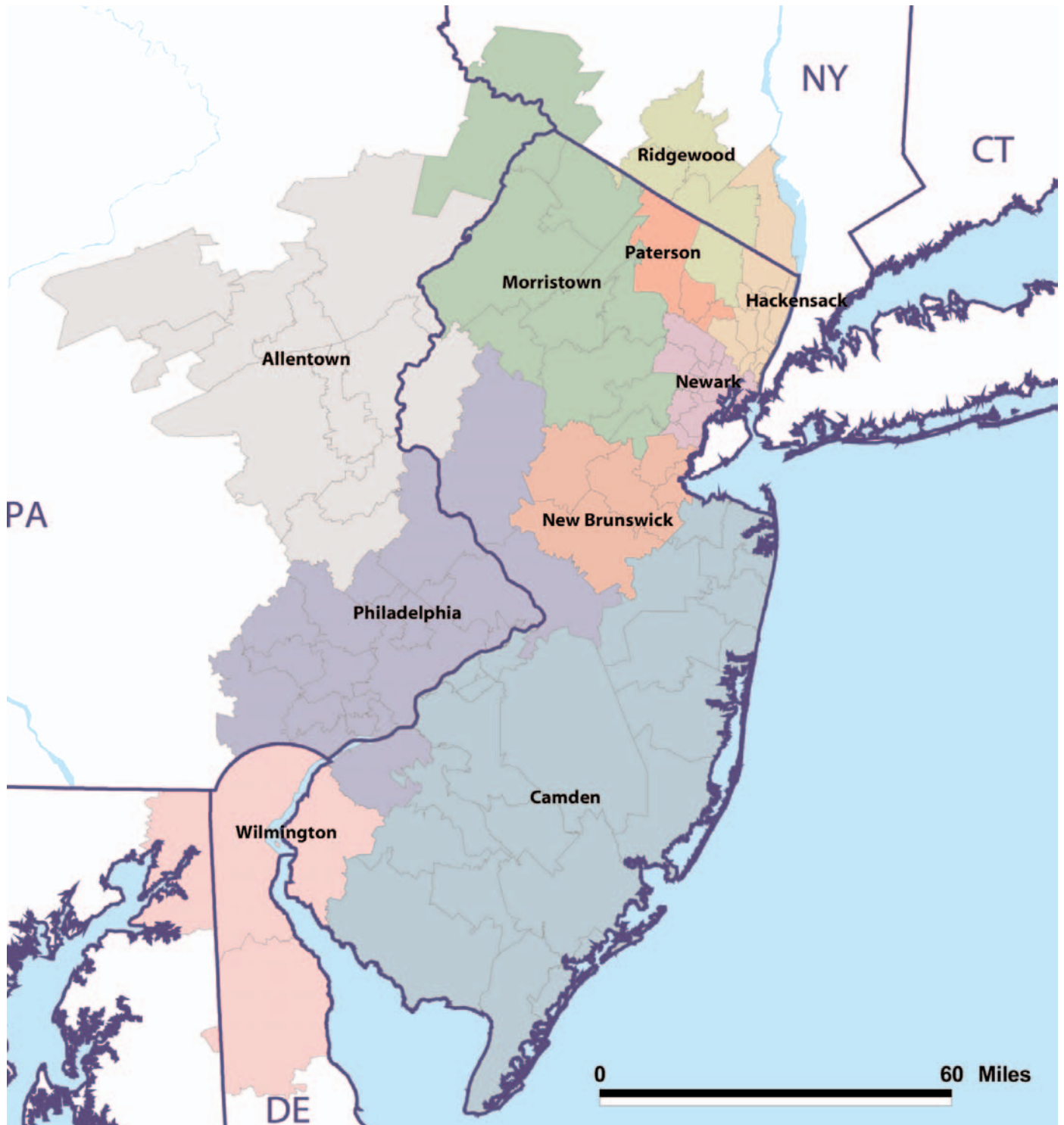
Jon S. Corzine
Governor

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Appendix 1: DARTMOUTH ATLAS-DEFINED HOSPITAL REFERRAL REGIONS FOR NEW JERSEY AREA





Appendix 2: ADJUSTMENTS TO DARTMOUTH ATLAS-DEFINED HOSPITAL REFERRAL REGIONS TO FORM NEW JERSEY HOSPITAL MARKET AREAS

Dartmouth Atlas-defined Hospital Service Area	Dartmouth Atlas-defined Hospital Referral Region	Adjustments
Phillipsburg	Allentown, Pennsylvania	Reassigned from Allentown to Morristown Hospital Referral Region
Flemington	Philadelphia, Pennsylvania	Reassigned from Philadelphia to New Brunswick Hospital Referral Region
Trenton	Philadelphia, Pennsylvania	Treated as its own hospital market area
Twenty Hospital Service Areas in central and southern New Jersey	Camden, New Jersey	Divided into three market areas: • Toms River • Atlantic City • Camden
Woodbury	Philadelphia, Pennsylvania	Reassigned from Philadelphia to Camden market area
Salem	Wilmington, Delaware	Reassigned from Wilmington to the Atlantic City market area
Ridgewood	Ridgewood, New Jersey	Combined with Hackensack and Paterson Hospital Referral Regions
Paterson	Paterson, New Jersey	Combined with Hackensack and Ridgewood Hospital Referral Regions
Newark	Newark, New Jersey	None



Appendix 3: NEW JERSEY ACUTE CARE HOSPITALS BY HOSPITAL MARKET AREA

Hospital	Hospital Market Area
Bayonne Medical Center	Newark/Jersey City
Christ Hospital	Newark/Jersey City
Clara Maass Medical Center	Newark/Jersey City
Columbus Hospital	Newark/Jersey City
East Orange General Hospital	Newark/Jersey City
Greenville Hospital	Newark/Jersey City
Jersey City Medical Center	Newark/Jersey City
Mountainside Hospital	Newark/Jersey City
Newark Beth Israel Medical Center	Newark/Jersey City
RWJU at Rahway	Newark/Jersey City
Saint Barnabas Medical Center	Newark/Jersey City
Saint James Hospital	Newark/Jersey City
Saint Michael's Medical Center	Newark/Jersey City
Trinitas Hospital - Williamson Street Campus	Newark/Jersey City
UMDNJ-University Hospital	Newark/Jersey City
Union Hospital	Newark/Jersey City
Barnert Hospital	Hackensack, Ridgewood and Paterson
Bergen Regional Medical Center	Hackensack, Ridgewood and Paterson
Chilton Memorial Hospital	Hackensack, Ridgewood and Paterson
Englewood Hospital and Medical Center	Hackensack, Ridgewood and Paterson
Hackensack University Medical Center	Hackensack, Ridgewood and Paterson
Holy Name Hospital	Hackensack, Ridgewood and Paterson
Meadowlands Hospital Medical Center	Hackensack, Ridgewood and Paterson
Palisades Medical Center of New York	Hackensack, Ridgewood and Paterson
Pascack Valley Hospital	Hackensack, Ridgewood and Paterson
PBI Regional Medical Center	Hackensack, Ridgewood and Paterson
St. Joseph's Hospital and Medical Center	Hackensack, Ridgewood and Paterson
St. Joseph's Wayne Hospital	Hackensack, Ridgewood and Paterson
Hoboken University Medical Center	Hackensack, Ridgewood and Paterson

Hospital	Hospital Market Area
St. Mary's Hospital	Hackensack, Ridgewood and Paterson
The Valley Hospital	Hackensack, Ridgewood and Paterson
Hackettstown Regional Medical Center	Morristown
Morristown Memorial Hospital	Morristown
Muhlenberg Regional Medical Center, Inc.	Morristown
Newton Memorial Hospital	Morristown
Overlook Hospital	Morristown
Saint Clare's Hospital/Denville Campus	Morristown
Saint Clare's Hospital/Dover General	Morristown
Saint Clare's Hospital/Sussex	Morristown
Warren Hospital	Morristown
Hunterdon Medical Center	New Brunswick
JFK Medical Center	New Brunswick
Raritan Bay Medical Center - Old Bridge Division	New Brunswick
Raritan Bay Medical Center - Perth Amboy Division	New Brunswick
Robert Wood Johnson University Hospital	New Brunswick
Saint Peter's University Hospital	New Brunswick
Somerset Medical Center	New Brunswick
University Medical Center at Princeton	New Brunswick
Bayshore Community Hospital	Toms River
CentraState Medical Center	Toms River
Community Medical Center	Toms River
Jersey Shore University Medical Center	Toms River
Kimball Medical Center	Toms River
Monmouth Medical Center	Toms River
Ocean Medical Center	Toms River
Riverview Medical Center	Toms River
Capital Health System at Fuld	Trenton
Capital Health System at Mercer	Trenton
Robert Wood Johnson University Hospital at Hamilton	Trenton
St. Francis Medical Center	Trenton
Cooper Hospital/University Medical Center	Camden

Hospital	Hospital Market Area
Kennedy Memorial Hospitals-University Medical Center, Cherry Hill	Camden
Kennedy Memorial Hospitals-University Medical Center, Stratford	Camden
Kennedy Memorial Hospitals-University Medical Center, Turnersville	Camden
Lourdes Medical Center of Burlington County	Camden
Our Lady of Lourdes Medical Center	Camden
Underwood-Memorial Hospital	Camden
Virtua-Memorial Hospital of Burlington County, Inc.	Camden
Virtua-West Jersey Hospital Berlin	Camden
Virtua-West Jersey Hospital Marlton	Camden
Virtua-West Jersey Hospital Voorhees	Camden
AtlantiCare Regional Medical Center, Inc.	Atlantic City
AtlantiCare Regional Medical Center, Inc.	Atlantic City
Burdette Tomlin Memorial Hospital, Inc.	Atlantic City
Shore Memorial Hospital	Atlantic City
South Jersey Healthcare Regional Medical Center	Atlantic City
South Jersey Hospital - Elmer	Atlantic City
Southern Ocean County Hospital	Atlantic City
The Memorial Hospital of Salem County	Atlantic City
William B. Kessler Memorial Hospital, Inc.	Atlantic City



Appendix 4: NEW JERSEY POPULATION AND INPATIENT HOSPITAL VOLUME PROJECTIONS – ADDITIONAL INFORMATION

In this Appendix, population projections are provided for New Jersey at the State level and at the individual market area level. Inpatient volume projections are also provided at the individual market level.

Figure 1 below compares New Jersey's 2005 population and population projections for 2010 and 2015 by age

composition to the U.S. as a whole. The Figure illustrates that New Jersey's proportion of population age 18 to 44 is projected to be slightly smaller and its population age 45 to 64 slightly larger than the nation as a whole in 2015.

Figure 1
New Jersey and U.S. Population Age Composition
(2005 and Projected 2010 and 2015)

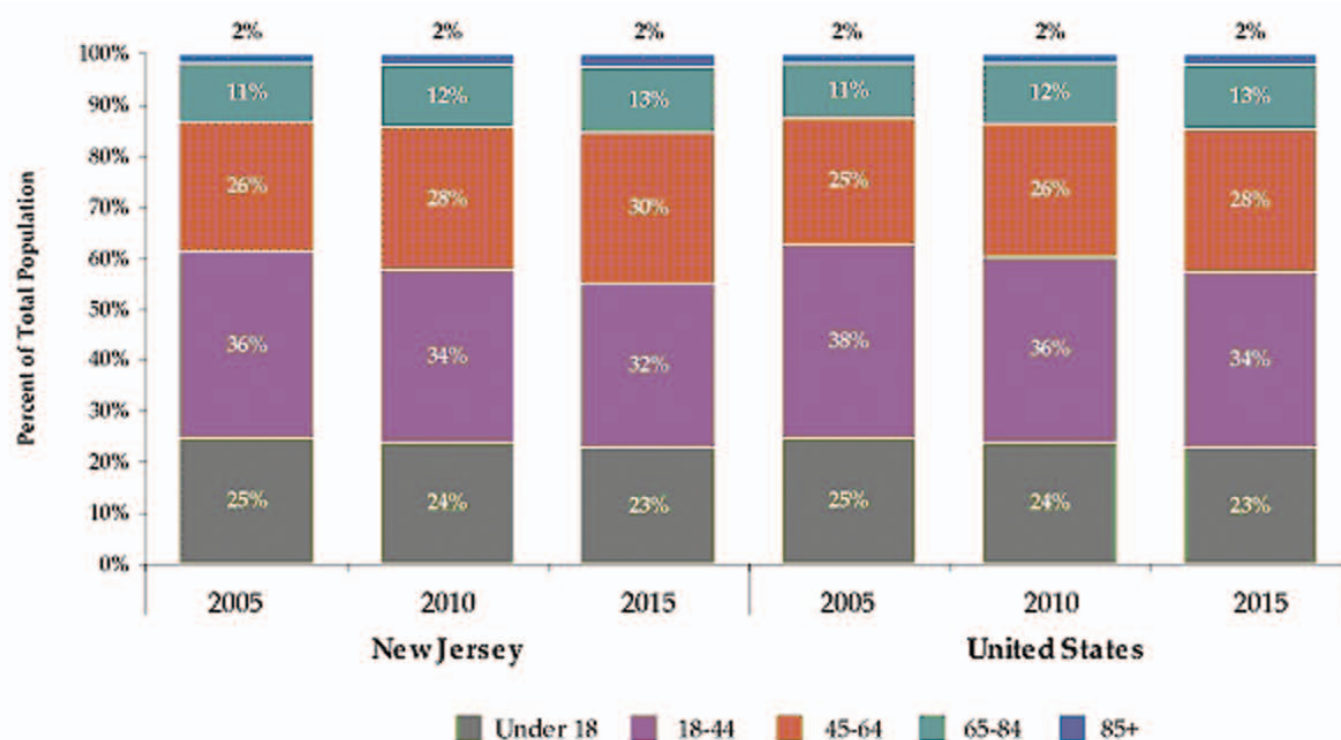


Figure 2 on the following page shows that there is variation in the 2005 and projected 2015 population age composition across the eight New Jersey market areas. In 2005, the Toms River and Atlantic City areas had the highest proportions of population in the 65 and over age group. By 2015, the 65 and over age group is projected to comprise 19 percent of the Toms River area's and 16 percent of the Atlantic City area's and Hackensack, Ridgewood and Paterson areas' total population.

As described in Chapter 4, to remove the effect of age composition and mix of services variations across market areas, we compared use rates and ALOS across market areas for 10 high volume DRGs for the 45 to 64 age group. Exhibits 1 and 2 illustrate the variation in use rates and ALOS for the 10 high volume DRGs across the eight market areas.

Figure 2
Age Composition of Population by Market Area (2005, and Projected 2010 and 2015)

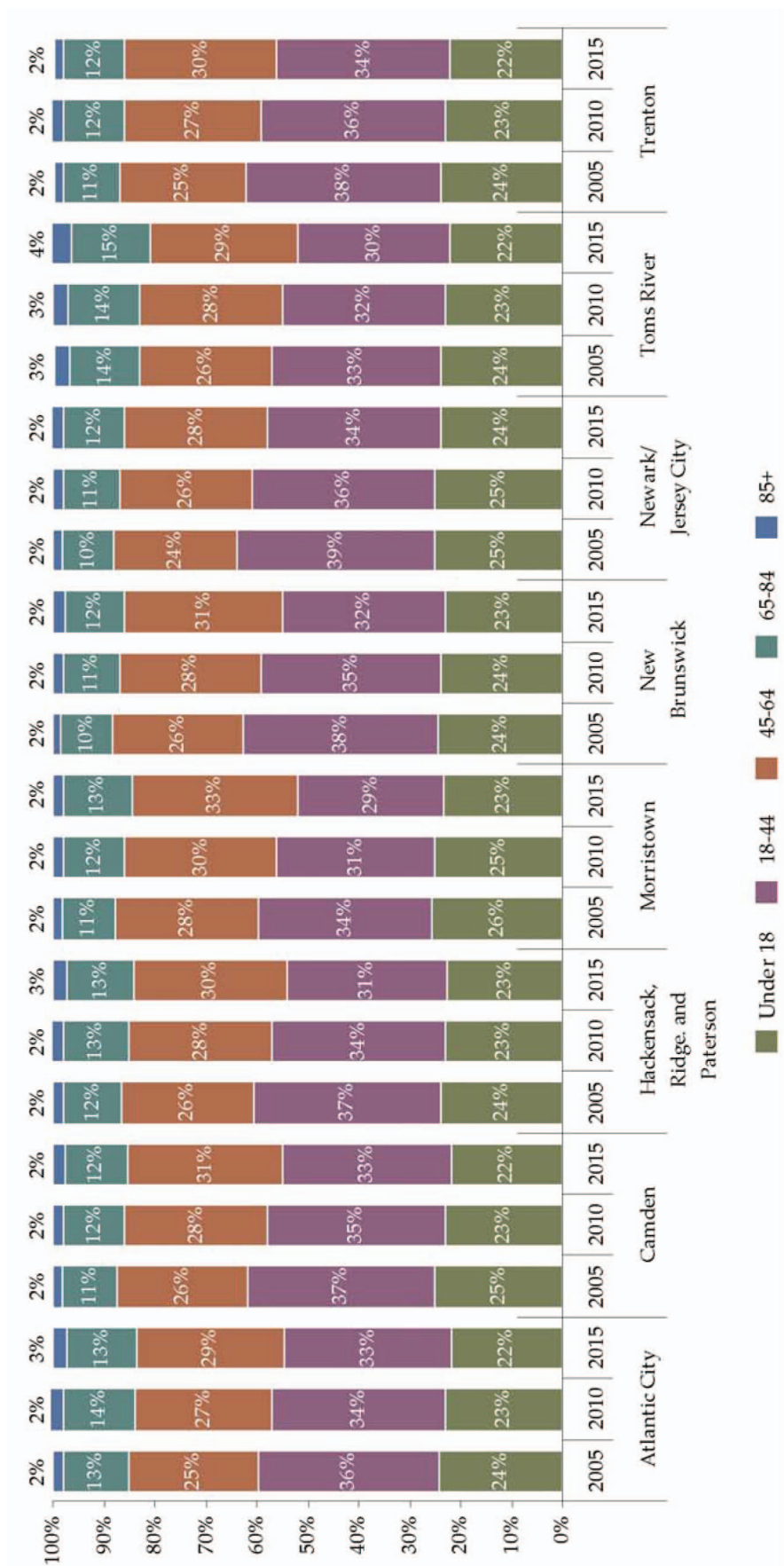


Exhibit 1
Use Rate (Discharge per 1,000 Population) in 10 High Volume DRGs for New Jersey Residents' Age 45 - 64 by Market Area of Residence (2005)

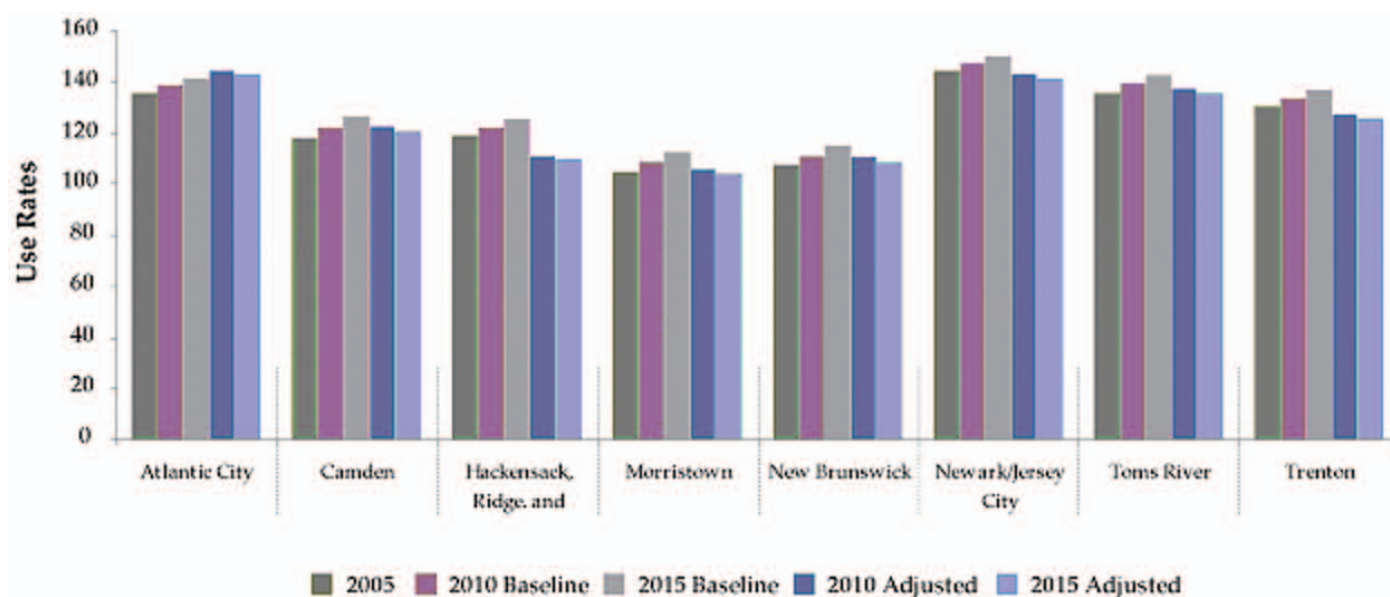
DRG	Description	Atlantic City	Camden	Hackensack, Ridge. and Paterson	Morristown	New Brunswick	Newark	Toms River	Trenton	Entire State
14	Stroke with Infarction	1.10	0.99	0.79	0.49	0.76	1.35	0.81	1.33	0.91
88	Chronic Obstructive Pulmonary Disease	2.91	2.51	1.72	1.29	1.34	3.01	2.22	3.28	2.14
89	Simple Pneumonia and Pleurisy Age above 17 with Complications and Comorbidities	2.11	1.62	1.26	1.28	1.21	2.03	1.41	2.21	1.55
541	Respiratory Disorder Except Infections, Bronchitis, Asthma with Major Complications and Comorbidities	1.71	1.15	0.84	0.79	0.89	1.51	1.50	1.19	1.16
127	Heart Failure and Shock	2.32	1.80	1.39	0.90	1.01	4.42	1.49	3.13	1.98
143	Chest Pain	7.79	8.07	4.40	3.78	4.66	6.98	4.90	6.46	5.68
544	Congestive Heart Failure and Cardiac Arrhythmia with Major Complications and Comorbidities	1.10	0.58	0.49	0.30	0.55	1.45	0.77	0.95	0.74
854	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without Acute Myocardial Infarction	2.13	2.12	2.47	2.09	2.63	3.33	2.91	1.82	2.54
359	Uterine and Adnexa Procedures for Cancer In situ and Non-Malignancy without Complications and Comorbidities	3.86	3.53	3.37	3.53	3.80	4.25	3.76	3.99	3.73
430	Psychoses	4.23	3.32	4.72	3.82	1.98	6.32	5.07	3.53	4.27

Exhibit 2
ALOS in 10 High Volume DRGs for New Jersey Residents' Age 45-64 by Market Area of Residence (2005)

DRG	Description	Atlantic City	Camden	Hackensack, Ridge, and Paterson	Morristown	New Brunswick	Newark	Toms River	Trenton	Entire State
14	Stroke with Infarction	5.4	4.9	5.6	5.2	5.6	5.5	4.6	5.6	5.3
88	Chronic Obstructive Pulmonary Disease	4.2	4.2	4.9	4.7	5.6	5.2	4.7	4.4	4.8
89	Simple Pneumonia and Pleurisy Age above 17 with Complications and Comorbidities	5.0	4.9	5.6	4.7	5.3	5.7	5.1	5.4	5.3
541	Respiratory Disorder Except Infections, Bronchitis, Asthma with Major Complications and Comorbidities	7.0	6.9	8.6	7.7	8.3	8.8	7.7	7.0	7.9
127	Heart Failure and Shock	4.4	4.1	5.1	4.3	4.7	5.0	4.4	4.6	4.7
143	Chest Pain	1.9	1.7	1.8	1.5	1.8	2.2	1.9	2.1	1.9
544	Congestive Heart Failure and Cardiac Arrhythmia with Major Complications and Comorbidities	7.4	7.3	8.4	7.3	10.5	8.6	8.1	8.6	8.3
854	Percutaneous Cardiovascular Procedure with Drug-Eluting Stent without Acute Myocardial Infarction	2.0	1.9	1.7	1.5	1.5	1.8	1.4	1.5	1.7
359	Uterine and Adnexa Procedures for Cancer In situ and Non-Malignancy without Complications and Comorbidities	2.3	2.2	2.4	2.2	2.2	2.4	2.1	2.2	2.3
430	Psychoses	6.7	8.0	12.5	8.9	9.1	10.4	8.8	10.0	9.8

Figure 3 illustrates 2005 use rates compared to projected 2010 and 2015 use rates under the two projection scenarios.

Figure 3
Use Rates for New Jersey Residents by Market Area
(2005 and projected 2010 and 2015)





Appendix 5: FINANCIAL DATA SOURCES AND CONSIDERATIONS

The Commission used two primary data sources to provide current and historical financial data: the Medicare Cost Report (Worksheet G), and audited financial statements.

The Medicare Cost Report is an annual report submitted to the Centers for Medicare and Medicaid Services (CMS) by all Medicare providers (any hospital that receives federal Medicare/Medicaid funds). The report is comprehensive – hospitals report total costs, not just Medicare costs – and requires information on administrative structure, staffing and utilization of services, as well as financial data. Medicare Cost Reports are maintained in the Healthcare Cost Report Information System (HCRIS), a national data reporting system. Currently, the most recent data available for all hospitals is for FY 2005.

The New Jersey Health Care Facilities Financing Authority (NJHCFFA), the State's primary issuer of municipal bonds for New Jersey's health care organizations, provided hospitals and hospital systems' audited financial statements. During its 35-year history, the NJHCFFA has issued more than \$13 billion in bonds on behalf of over 140 health care organizations throughout the State. New Jersey hospitals submit audited financial statements to NJHCFFA for review and inclusion in a database used for on-going monitoring and analysis. Although FY 2005 is the most current year for which NJHCFFA has a complete set of audited reports, as of November 2007, all but 11 hospitals have submitted their FY 2006 audited financial data to NJHCFFA.

The Medicare Cost Reports have the advantage of providing a national database, collected through a standardized form, which allows for state-by-state comparisons. However, an independent party does not

review the reports. Further, inconsistent or incomplete reporting of certain financial elements limits the ability to calculate key financial ratios. For example, reporting non-operating gains and losses is not consistent across hospitals, which limits the ability to compare operating and total margins from facility to facility. In addition, this will cause the operating margin to be equal to or greater than the total margin. As another example, the Medicare Cost Report does not include a line item for board-designated funds; without this element, days cash-on-hand as conventionally defined cannot be calculated.

Audited financial statements are reviewed by an independent third party. Further, the requirement that the statements be prepared in accordance with Generally Accepted Accounting Principles (GAAP) reduces the inconsistency in reporting of financial elements from hospital to hospital. However, with few exceptions, it is difficult to get state-by-state data based on audited financial statements.

The primary value of unaudited statements is that they are usually available within 45 to 60 days from the end of a period. In contrast, audited financial statements are not usually available until 120 to 150 days after the fiscal year ends; cost reports are usually not available until six or more months after the year ends. Thus, unaudited statements will typically provide the most current picture of a hospital's financial condition. The primary disadvantage of unaudited statements is that they have not been reviewed by an independent outside party. In some cases, there may be material differences between the unaudited and audited statements based on the findings of that outside review. Therefore, unaudited statements should be analyzed with caution.



Appendix 6: METHODOLOGY FOR COMPARING HOSPITALS

The methodology for comparing hospitals is based on the average for each metric for all hospitals in the hospital's market area.

A score is established equal to the number of standard deviations away from the average for each hospital. A positive score indicates a hospital is more essential than the average for all hospitals in the area and a negative score indicates a hospital is less essential than the average.

The formula used for converting a hospital's metric on a certain variable (e.g., number of Medicaid and uninsured discharges and ER visits, occupancy rate, etc.) into its equivalent standardized value is as follows:

Standardized Score =

$$\frac{(\text{Individual Hospital Metric Value} - \text{Average for All Hospitals in the Market Area})}{\text{Standard Deviation of the Metric for the Area}}$$

By subtracting the average of the metric for the relevant hospital market area from the observed value of the metric for a given hospital and then by dividing it by that metric's dispersion (standard deviation) across hospitals in that area, one arrives at a new variable whose average across the area must, by construction, be 0 and whose measure of dispersion (standard deviation) is 1.

If this is done for every metric, then, regardless of the size and dimension of each metric, all standardized metrics will have an across-market-area average of 0 and a dispersion (standard deviation) of 1. Because these standardized variables are now similar, one can add them up, by weighting each, to arrive at an overall weighted average score that may reflect many distinct metrics.

On the following pages in Tables 1 and 2, examples are provided of this method for standardizing two of the essentiality metrics, one that is numbers (number of Medicaid and uninsured ER visits) and one that is percentages (occupancy rate).

Table 1
Method for Standardizing Metrics Example:
Medicaid and Uninsured ED Visits

Hospital	Observed Value for Number of Medicaid and Uninsured ER Visits	Average Number of Medicaid and Uninsured ER Visits for Market Area	Observed Value less Average	Standard Deviation	Standardized Score
	A	B	C = A - B	D	E = C/D
A	5,562	13,827	-8,265	9,935	-0.83
B	5,732	13,827	-8,095	9,935	-0.81
C	6,231	13,827	-7,596	9,935	-0.76
D	6,281	13,827	-7,546	9,935	-0.76
E	7,951	13,827	-5,876	9,935	-0.59
D	9,159	13,827	-4,668	9,935	-0.47
F	11,484	13,827	-2,343	9,935	-0.24
G	12,028	13,827	-1,799	9,935	-0.18
H	15,333	13,827	1,507	9,935	0.15
I	20,500	13,827	6,674	9,935	0.67
J	31,550	13,827	17,724	9,935	1.78
K	34,107	13,827	20,281	9,935	2.04
Average	13,827				0.00
Standard Dev.	9,935				1.00

Table 2
Method for Standardizing Metrics Example:
Inpatient Occupancy Rates

Hospital	Observed Value for Occupancy Rate	Average Occupancy Rate	Observed Value less Average	Standard Deviation	Standardized Score
	A	B	C = A - B	D	E = C/D
A	47%	72%	-25%	11%	-2.33
B	59%	72%	-13%	11%	-1.25
C	68%	72%	-4%	11%	-0.39
D	70%	72%	-2%	11%	-0.19
E	70%	72%	-2%	11%	-0.15
D	74%	72%	2%	11%	0.19
F	76%	72%	4%	11%	0.36
G	78%	72%	6%	11%	0.59
H	79%	72%	7%	11%	0.67
I	82%	72%	10%	11%	0.95
J	82%	72%	10%	11%	0.96
K	83%	72%	11%	11%	1.03
Average	72%				0.00
Standard Dev.	11%				1.00

As these two example show, the variation in the observed values is very different for the two metrics: for the number of Medicaid and uninsured ER visits, the dispersion (standard deviation) is 9,935, while the dispersion for occupancy rates is 11%. However, the standardized scores in Column E account for these different dispersions in the observed values for the metrics. For example, Hospital I has 6,674 more Medicaid and uninsured ER visits than the average for all the hospitals in the market area and this yields a standardized score of .67. For the occupancy rate metric, Hospital H's occupancy rate is 7 percent greater than the average occupancy rate for all hospitals in the market area, and its standardized score is also .67. In standardized terms, both Hospital I and Hospital K are 0.67 above the average for these two different metrics. Standardizing allows for hospitals' observed values to become "unit free", thus enabling them to be added across all the essentiality metrics.

Under this method, each hospital's overall essentiality score is relative only to the other hospitals in its market area; it is not valid to compare hospitals' essentiality scores across different market areas.

The Commission used the same methodology for scoring each hospital on the three financial viability metrics, except that it compared all hospitals in the State against the statewide average for the metric rather than against the average for the market area. Since higher values of Long-term Debt to Capitalization put a hospital at greater risk, the score was inverted for that metric so that values above the average yield negative scores. Doing this allowed us to sum the scores to arrive at an overall score of each hospital's financial viability relative to other hospitals in the State.

Appendix 7: ISSUES TO ADDRESS IN CLOSING A HOSPITAL

Issue	Description		
Governance and Authority	Determine who will oversee the closure process (<i>the hospital's board, a special committee or task force?</i>) and the scope of authority that group and management will have to make decisions related to the closing in terms of authorizing resolutions/restrictions/limitations.		
Accreditation and Regulatory Requirements	Accreditation and regulatory issues associated with closing a hospital, include, but are not limited to: • Preparation of the CN • Notification of the State Health Department, NJHCFFA, and JCAHO • Providing required notification of termination for all healthcare licenses (e.g., pharmacy, lab, blood bank, DEA) • Notification of appropriate federal agencies (e.g., Department of Health and Human Services, Social Security Administration, CMS, Internal Revenue Services, Environmental Protection Agency) • Notification of appropriate State agencies (State Department of Licensing and Regulation, Worker's Compensation, Employment Security Bureau, Planning Commission)		
Communications with Key Constituencies	Given that hospitals have a multitude of constituencies, communication with these various groups and individuals throughout the closure process is critical. It is essential that the hospital identify the necessary communications resources, assign responsibility for communications, develop a consistent message regarding the reasons for and process of closure and provide ongoing updates and information to groups including, but not limited to those identified below <table border="0"> <tr> <td> • Board and other governing bodies • Vendors and suppliers • Medical staff • Licensing authorities • Employees • Payers • Patients/families </td> <td> • Donors • Community organizations/neighbors • Volunteers/auxiliary • Elected officials • Lenders/bond trustees • Other providers • Ambulance companies </td> </tr> </table>	• Board and other governing bodies • Vendors and suppliers • Medical staff • Licensing authorities • Employees • Payers • Patients/families	• Donors • Community organizations/neighbors • Volunteers/auxiliary • Elected officials • Lenders/bond trustees • Other providers • Ambulance companies
• Board and other governing bodies • Vendors and suppliers • Medical staff • Licensing authorities • Employees • Payers • Patients/families	• Donors • Community organizations/neighbors • Volunteers/auxiliary • Elected officials • Lenders/bond trustees • Other providers • Ambulance companies		

Issue	Description
Employees	Employee-related issues that must be addressed in a hospital closure are the following: • Notification requirements including provisions in union contracts and the federal government's Worker Adjustment and Retraining Notification (WARN) Act, which specifies regulations regarding notification of the termination of employment. This act entails notifying both employers and local governments when mass layoffs occur. The specific regulations include provisions regarding the timeframe for notice depending on the size of an organization. • Identification and settlement of vacation, termination, sick leave, early retirement, outplacement, life insurance and tuition reimbursement benefits due to employees • Determination of prior liabilities related to Worker's Compensation, EEO, arbitration awards, 401K, etc. • Notification for Social Security withdrawal • Termination of 401K plan, including notification to employees and payment of match • COBRA eligibility information and benefits • Identification and negotiation/settlement of special employment contracts • Employee reduction plan to coincide with the ramping down/cessation of operations
Financial	While the cost of closing a hospital will vary from one hospital to another, there are typically a number of obligations that must be met, including: • Vendor or trade debt • Commercial lease financing • Corporate debt • Tax exempt bonds or leases • Wages, pensions and benefits • Malpractice and other insurance • Taxes In addition to these obligations, it is important to note that equipment leases generally include penalties for early cancellation. If the hospital has land and building leases, these also generally have early cancellation penalties. Likewise, vendor service agreements often have penalties for early cancellation, as do physician contracts.
Medical Staff	Some of the major medical staff issues resulting from a hospital's closure include: • Determination of assistance to be provided to physicians (e.g., facilitate expedited credentialing at other facilities) • Physician contract review, notification and settlement • Continuing Medical Education (CME) credit reporting • Specialist coverage (e.g., anesthesia, E.R., radiology, pathology, etc.) through transition/closure • Medical records completion

Issue	Description
Legal	Legal issues surrounding the closure of a hospital permeate virtually all of the considerations in closing a hospital. Other legal considerations associated with the closing of a hospital include: • Loan agreements, supply contracts, deeds, contracts and option to purchase land, leases and sub-leases, contracts with related organizations, guarantees, installment sales agreements, third-party managed care organizations, physician groups, HMOs, PPOs • Settlement of contracts, including physician contracts, loan agreements, supply contracts, service contracts, deeds, leases (real estate and equipment) guarantees, installment sales agreements, bond documents • Litigation and risk exposure, including insurance claims, threatened proceedings, consent decrees, fraud and abuse claims, etc.
Patients	Issues affecting patients and their families relate primarily to redirecting patients to other facilities and providers once the hospital ceases operations. Key patient- and family-related components of a hospital's closure plans should include, for example: • A schedule for patient clinical care wind-down, based on State Department of Health and Senior Services requirements and financial constraints • A plan for phase-out of acute care inpatient services, ED operations, ambulatory care services and transfer of remaining patients • A patient/family communication plan
Operations	Operational considerations are a key aspect, as the hospital must continue to operate as it goes through the process of ceasing operations. Some of the operational considerations related to closing a hospital include: • Security plan for asset preservation • Facility upkeep • Supply control • Handling of confidential material, including retention and retrieval of medical records, pharmacy records, employee records, legal documents, financial records, x-rays, medical staff records, etc.
Asset Disposition	Examples of assets at the hospital that will need to be disposed of when closing include: • Real estate – can be sold and the proceeds used to meet some of the hospital's financial obligations. • Owned equipment – can be offered for sale to physicians or other hospitals. Alternatively, the hospital can solicit bids from a firm to purchase the equipment in its entirety. • Supplies and drugs – explore the potential for returns to vendors, offer to sell them to other hospitals, clinics, or physicians, and/or arrange for overseas donation of certain items.



Appendix 8.1: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 1:

Access and Equity for the Medically Underserved

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I. Subcommittee Charge

The Subcommittee on Access and Equity for the Medically Underserved was charged with developing recommendations to address the breadth of needs of low-income and medically underserved New Jersey residents. More particularly, this subcommittee examined the systemic gaps and other access barriers that now exist, which often interfere with the availability and provision of quality primary, specialty and inpatient care, including inpatient and outpatient mental health and substance abuse care. In the context of the full Commission's final report, and in the environment of increasing numbers of hospital closures, the Subcommittee's work focused on identifying potential solutions and alternative approaches to the provision of healthcare.

The gaps and access barriers identified by the Subcommittee included the following: over-reliance and/or inappropriate use of hospital emergency rooms, in the absence of other appropriate venues for the delivery of healthcare services; disparate and/or disconnected local health planning, in connection and in cooperation with community-based partnerships; a dearth of primary and specialty healthcare providers (doctors, nurses, nurse practitioners, physician assistants, dentists and other oral healthcare practitioners) and related workforce availability issues; transportation; cultural and communication barriers, including access for individuals who have mobility impairments, or are deaf, hard of hearing, blind or

visually impaired; access issues for persons for whom English is not a primary language; medical and dental care needs for individuals with developmental disabilities; availability of healthcare insurance; and historically low Medicaid reimbursement rates.

II. Overview of Subcommittee Process

The Commission members and State agency staff conducted two planning meetings prior to convening the full subcommittee, in order to identify data that would be helpful to subcommittee members during their deliberations, including maps and charts that identify the location of hospitals, federally qualified health centers, mental health, and other state and federally funded agencies located in medically underserved areas. This data was made available through the New Jersey Department of Human Services.

The Subcommittee held three meetings with the full membership: July 25, August 8, and August 30, 2007. A final meeting with Commission members and State agency staff was then held on September 6, 2007.

During the first full meeting, the Subcommittee was initially divided into subgroups and tasked with answering two fundamental questions:

- (1) What are the basic and essential health services that should be available for New Jersey residents?
- (2) Who constitutes the "medically underserved"?

For the purposes of this initial discussion, the subgroups intentionally operated under some very artificial assumptions: that insurance coverage, costs of providing such services, financial viability of neighborhood hospitals, access to transportation, and availability of primary and specialty care were issues of no consequence. Instead, the task was more narrowly focused on the services themselves in order to identify essential core services.

III. General Approach to the Issue

After much discussion regarding services to which New Jersey residents must have access, the Subcommittee decided that basic and essential services could, for the purposes of this report, be defined as those services covered by Medicaid Plan A, with some caveats. These services, while not entirely all encompassing, covered the broadest range of needs, and included specialty care populations such as individuals with developmental disabilities.

The Subcommittee also grappled with defining the medically underserved population. Was one “medically underserved”, for example, if one needed to travel a significant distance in the state for a mammogram? Or for bariatric surgery? After much deliberation, the Subcommittee agreed to use the definition of “Medically Underserved Areas” as used by the U.S. Department of Health and Human Services when it determines areas for funding programs and services for medically underserved populations: <http://bhpr.hrsa.gov/shortage/mauguide.htm>. This geographic narrowing appeared to satisfy concern that a particular healthcare service, while essential to some, may not necessarily be readily available to all New Jersey residents.

As the Subcommittee delved more deeply into its charge, it became apparent that barriers to care can be broadly categorized as either economic or environmental, or both, in nature. Economic barriers included access to health insurance, hospital finances and Medicaid reimbursement rates. Environmental barriers included geographic proximity to some other locus of care as a viable alternative to a hospital emergency room, transportation availability, language and other cultural or communication difficulties, physical access barriers for individuals with mobility impairments, well-established behavior (one may be

accustomed to accessing care through a hospital emergency room), and traditional focus on and funding of acute versus preventative care. In addition, three points of agreement emerged as a backdrop against which the group’s work took shape:

- (1) Most fundamentally, the relationship between the community and its hospitals was recognized as complex. A lack of services within a community, for example, often results in inappropriate or over-reliance on a given hospital, which strains the hospital’s finances and overall capacity. Conversely, hospital closures frequently strain community services and negatively impact capacity. What would ideally be a symbiotic relationship is often fraught with tension. The proliferation of ambulatory care centers across the state, which are arguably better able than hospitals to control payer mix, additionally strains hospital resources. It should be noted that while the Subcommittee did discuss this issue, it will be explored at greater length in the Commission’s full report.
- (2) Recognition was paid to the fact that health disparities associated with income, race, ethnicity and disability are closely intertwined with the issue of health access and quality. Indeed, barriers to accessing quality health care are at least a contributing factor to the grim reality that death rates from heart disease are more than 40 percent higher for African Americans than for whites and that Hispanics are nearly twice as likely as non-Hispanic whites to die from complications of diabetes.
- (3) Last, but certainly not least, there was an acknowledgment that one of the most significant predictors of access to health services and treatment is health insurance coverage. As the solutions to this factor are entangled with political, financial and philosophical differences, and therefore exceedingly complex, the Subcommittee did not devote any time to solutions concerning this topic.

IV. Key Findings and Recommendations

A. There is an over-reliance and/or inappropriate utilization of hospital emergency rooms

Hospitals are in trouble, at least in part, because they are inappropriately serving patients. Hospitals in low-income areas all too often report a large volume of cases

that come to their emergency departments with late stage illnesses such as cancer and kidney failure or come repeatedly for chronic conditions such as asthma, diabetes, and congestive heart failure. Indeed, a September 2007 Rutgers Center for State Health Policy report (Rutgers Study) noted that emergency department visits are on the rise in New Jersey and that a significant percentage of the visits might have been avoided through better access to primary care.

Recommendation:

Successful patient case management models should be supported and replicated in order to address the large volume of ambulatory care sensitive utilization. For example, certain case study hospitals included in the September 2007 Rutgers Study have developed “fast track” systems to separate emergent from other cases in the emergency department. Under this model, patients are routinely referred to outpatient clinics for non-emergent care. Other hospitals are having success as a result of developing elaborate case management and chronic disease management systems within the emergency department itself. While this is a clear departure from the traditional role of the emergency department, these facilities have decided that community need and patient preference have made the departure necessary. (This report can be accessed in full at: <http://www.cshp.rutgers.edu/Downloads/7510.pdf>).

Additionally, New Jersey should seek to replicate and implement emergency room (ER) diversion programs. Under such programs, hospitals employ a nurse to care manage patients after their ER visit. For Medicaid clients enrolled in an HMO, after the ER visit, the care manager works with the patient and the HMO in order to ensure that the proper follow-up care is coordinated with the patient’s medical home and primary care physician. In cases of Medicaid fee-for-service, the care manager connects the patient with the FQHC, as it will become the patient’s medical home. The purpose is to provide primary care as part of the continuum of care needed to prevent increased acute episodes.

B. Local health planning is disparate and/or disconnected from community-based partnerships

B1. FQHC/Community-Based Clinic Issues

Through a network of ninety-six satellite sites located statewide, New Jersey’s nineteen Federally Qualified Health Centers (FQHCs) provide high quality

preventive, primary, and acute care medical services for its medically underserved population. In addition, community-based health centers, such as Volunteers in Medicine, family planning centers, and the like provide similarly necessary services.

While the FQHCs and community health clinics are models for providing high quality primary and preventive care services, most of these sites are not equipped to provide specialty care services for a wide range of specialty care needs of their patient population. At present, for example, most FQHCs provide specialty care services through referrals to specialists affiliated with local hospitals or specialty care clinics as needed. Only a handful of these health centers have on-site specialty care services for selected specialties.

Since many of the medically underserved areas also suffer from severe shortages in health care providers, in many instances, the current referral system fails to provide timely treatment for the health center patients often resulting in harmful health effects, high number of emergency department visits, and costly hospitalizations. (For a fuller discussion of recommendations related to the FQHCs’ role in New Jersey, go to: <http://www.njpc.org/Medical%20Home%20Document.pdf>). It should be noted that support for Federal legislation increasing the number of FQHCs across the country would provide meaningful impact on the medically underserved community.

Recommendation:

Increase the primary care infrastructure and supply of specialty care to patients served by FQHCs and community-based clinics.

It is important to note that the Subcommittee generally agreed that community-based health clinics and FQHCs were equally critical to providing primary and specialty care. One solution proffered to accomplish the above recommendation was to encourage the New Jersey Primary Care Association (NJPCA), in collaboration with the Medical Society of New Jersey (MSNJ) and New Jersey Hospital Association (NJHA), to work to establish an expanded network of specialty care providers and hospitals to provide additional specialty care support for the health centers. By negotiating letters of agreement with specialists and participating specialty care clinics and hospitals, health centers could refer their patients as needed.

A related solution would encourage FQHCs and other clinics to focus primarily on providing on-site specialty care. The NJPCA has identified three approaches to providing on-site specialty care. Since case overload is a major reason for backlog in the existing system of specialty networks, the first approach would be to recruit retired specialists to provide volunteer specialty care services on-site at the health centers.

Costs associated with this approach include the cost of maintaining a valid license for retired physicians, the cost of registration for Continuing Medical Education (CME) credits and the cost of malpractice liability coverage for retired specialists. Legislative support at the national level is also needed to extend medical malpractice liability protections to volunteer physicians at community health centers. (H.R. 1313, the “Community Health Center Volunteer Physician Protection Act of 2005” was introduced in November 2005 to amend the existing Public Health Service Act to provide liability protections for volunteer practitioners at health centers.) A New Jersey alternative to this Federal legislation was introduced in 2003. While these bills would act as a catalyst to help bolster the infrastructure of physicians who volunteer service, both have been stalled in the process.

A second option would be to hire retired specialty care physicians on a part-time basis at the health care centers. Once employed, these physicians would be eligible for malpractice coverage under the Federal Tort Claims Act of 1992.

Under a third approach, health centers would contract with practicing specialists to provide on-site services for a few hours each week in high priority specialty areas. A related recommendation in this area was to encourage FQHC and community clinic physicians to join the medical staff of a single local hospital in order to encourage patient care through a team approach.

B2. Mental Health and Substance Abuse Services

Local hospitals are an integral part of the community mental health and substance abuse systems with much of the emphasis on meeting the most acute, serious needs of these populations. Many hospitals offer a continuum of psychiatric and substance abuse services, which function as acute care diversion services, as well as step down options from more intensive services. As they are

embedded in the community, these hospitals are critical in responding to the needs of the community members. When hospitals close, it is imperative that these critical services remain available to the community at the same level of accessibility and clinical intensity.

While hospitals serve as an important part of the mental health and substance abuse treatment system, some patients seeking emergency room treatment present signs of mental health or substance abuse treatment needs. According to the 2007 Rutgers Study, New Jersey hospitals have increasingly become providers of care for mental health and substance abuse patients, particularly through the emergency department. A number of emergency department physicians have attributed this rise to a decrease in the number of psychiatric beds and detoxification services and insufficient funding for community-based mental health and substance abuse care. Many admissions to emergency rooms are often related to drug or alcohol misuse. Best practice indicates that substance abuse-related emergency room visits represent an opportune moment for screening, brief intervention, and referral to treatment services. Currently, this practice is not widely implemented.

Additionally, the Subcommittee noted that the continuum of preventative, non-acute care provided by community-based and hospital providers is less expensive, effective, and preferable to costly emergency-based care. Available services and funding sources from hospital closures could be transitioned to replacement community or hospital-based services, and when possible, to more wellness and recovery-oriented services.

Recommendation:

State health policy should expand mental health and substance abuse capacity in the community, prioritize funding for mental health and substance abuse services, and insist on tailoring services to patients’ wellness and recovery needs. In addition, it is also critical that acute psychiatric and detoxification services, emergency and acute hospital inpatient care continue to be available in a hospital setting. As noted above, this could be funded through a reallocation of resources available once a hospital closes. Similar resource shifts should likewise occur for substance abuse services, now available on an inpatient basis in only limited parts of the State.

B3. Disconnect between community needs and the Certificate of Need process

The Subcommittee noted that the existing Certificate of Need (CN) process, which, in relevant part, examines availability and continuity of community resources when a hospital is considering closure, is ripe for examination and can be strengthened.

Recommendation:

Institute a community-based health planning process that encourages partnerships and includes community resources so that access to basic and essential healthcare services is a proactive, rather than a reactive endeavor. To that end, the Subcommittee is recommending that four regional focus groups be convened over the next year to ensure that input into health system redesign is focused on a consumer-driven system of care. If a hospital must ultimately close, county-based planning can buttress the Department of Health and Senior Services' monitoring of the availability of sustained, alternate resource development.

C. There exists a dearth of primary and specialty healthcare providers (doctors, nurses, nurse practitioners, physician assistants, dentists and other oral healthcare practitioners) and related workforce availability issues.

C1. Historically low Medicaid reimbursement rates

New Jersey's historically low provider reimbursement rates for Medicaid are well documented, and have been directly associated with adversely impacting access to a variety of healthcare services. Indeed, the abysmally low reimbursement rates have so severely impacted the availability of healthcare professionals who are willing and/or financially able to offer services to Medicaid patients in some cases, that meaningful access can be compromised by any reasonable level of geographic proximity to clients for care or may result in wholly inaccurate listings of practitioners willing to participate in such care.

Recommendation:

To improve the availability of quality care, the Subcommittee recommended that New Jersey should set provider reimbursement rates for Medicaid and other state-funded health care services at 75% or more of current Medicare reimbursement rates. The Subcommittee did note that Governor Corzine's 2008 Budget Initiative to include \$5 million (a \$20 million figure once annualized and matched with federal dollars) to increase Medicaid rates for services to children was a first and meaningful step to address this long-standing concern.

C2. Workforce issues and Graduate Medical and Dental Education

According to the New Jersey Council of Teaching Hospitals, New Jersey's teaching hospitals provide 70 percent of the medical care to the uninsured and underinsured. Faculty medical staff and physician residents are key care providers to New Jersey's medically underserved. New Jersey ranks 18th in the nation as to the number of physicians in training relative to the State's population. Furthermore, New Jersey has a particularly high percentage (39.7%) of practicing physicians who are International Medical Graduates (IMG), ranking us 2nd in the nation.

According to the Medical Society of New Jersey, our State is currently experiencing a shortage of physicians in the fields of obstetrics and gynecology, pediatric subspecialties, neurosurgery, anesthesiology, family practice, and general surgery. There is a similar shortage of dentists and other oral health practitioners. A September 2000 GAO report, "Factors Contributing to Low Use of Dental Services by Low-Income Populations" (<http://www.gao.gov/archive/2000/he00149.pdf>), discusses not only the low Medicaid reimbursement rates for dentists but also the short supply of dentists in many areas.

Recommendations:

- Loan forgiveness and scholarships. New Jersey should provide loan forgiveness and scholarships for professionals willing to serve in medically underserved areas or in professional specialties experiencing workforce shortages. Targeting incen-

tives to areas of greatest need is important for making health care services available where they are needed most. For example, Medicaid could focus its Graduate Medical Education (GME) funding to the specialties experiencing the greatest workforce shortages. Advocacy is also needed on the federal level to increase annual awards to physicians by the National Service Corps to encourage more doctors and dentists to practice in under-served areas while addressing rising medical/dental student debt.

- Boost class sizes in existing medical schools and establish new medical schools.
- Advocate increasing the number of residency training positions funded by Medicare to accommodate additional medical/dental school graduates.
- Minority recruitment and training. The percentage of minority enrollees in medical schools remained essentially unchanged between 1970 and 1996, and continued at a rate lower than minority representation in the general population. Addressing this trend is important because minority physicians most often serve in minority communities and under-served areas. State policy should establish goals to encourage the recruitment and training of health care providers whose race, ethnicity, and language reflect the composition of the state and communities in need.
- Telemedicine for remote areas. Telemedicine approaches enable the transfer of medical information – including medical images, two-way audio and videoconferences, patient records, and data from medical devices – for diagnosis, therapy and education. New Jersey should make use of currently available technology to develop and support telemedicine systems that provide medical expertise to underserved geographic areas of the state. Specifically, New Jersey could explore exercising Medicaid options for reimbursing telemedicine services and protect patients by requiring out-of-state physicians to be licensed to provide telemedicine services.

D. Lack of practical transportation options hinders access to care.

For those individuals who are not Medicaid eligible, transportation was noted as a significant barrier to accessing healthcare – especially in rural communities and other areas where a robust transportation infrastructure for seniors and those with disabilities is unavailable. In addition, the lack of coordination among existing systems that serve special populations creates duplication and increased costs.

Recommendation:

- The Subcommittee noted that transportation needs are best resolved through local planning and should figure prominently in the community and regional planning noted above. The federal government has initiated a “United We Ride” initiative that requires states to enhance access to transportation to improve mobility, employment opportunities, and access to community services for persons who are transportation-disadvantaged, including seniors, individuals with disabilities, and low income households. (New Jersey’s Department of Human Services manages this initiative.)
- When available, transportation for persons who are Medicaid eligible may be coordinated with existing county Paratransit trips. This will increase cost efficiency and reduce duplication of trips routing.
- The federal regulations that govern the United We Ride initiative require that each state develop a local planning process whereby the needs of the target populations are examined and addressed. Localities who fail to develop transportation plans risk losing Federal Transportation Administration (FTA) funding.
- The United We Ride initiative offers the health care community an opportunity to incorporate the transportation needs of the medically underserved into the local planning process. Since the planning process is ongoing, the health care community should verify that a member from their community is participating on the local transportation steering committee. This will ensure that, as transportation needs of the population change, they are identified on the plan updates.

E. Cultural and communication barriers exist for a number of special needs populations, including access for individuals with disabilities, including persons who are deaf, hard of hearing, blind, or visually impaired, or those for whom English is not a primary language.

E1. Special Needs Populations

E1a. Individuals who are Deaf or Hard of Hearing:

Generally speaking, the healthcare access needs for this population are similarly affected by the access and equity issues noted above. One obvious complication, however, is the ability of healthcare professionals to meaningfully communicate with persons who are deaf or hard of hearing, so that the quality of care rendered is not compromised. A 2005 study published in the Journal of General Internal Medicine examined healthcare system accessibility issues of deaf people found communication to be pervasive healthcare access problem. This report can be found at: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1828091>

Technological advancements are increasingly available, as are traditional resources such as American Sign Language interpreters, although in diminishing supply. These resources can readily provide meaningful communication for those with special needs, as appropriate. Access remains largely dependent, however, upon a healthcare facility's investment in and commitment to ensuring adequate availability of human or technological resources for those who require such assistance.

E1b. Individuals who are Blind or Visually Impaired:

Sensitivity and transportation issues permeate the access and equity issues for blind and visually impaired individuals. The ability to access health care is often dependent on the ability to complete health forms. Lack of alternative media for medical forms and the availability of staff to read forms creates a major barrier for sight impaired individuals. A 2007 study conducted by the National Council on Disability points to the importance of providing health care forms and information in alternative formats for those with visual impairments. As with other populations, accessing barrier free transportation is also an important issue. A

full copy of the National Council on Disability report can be found at: http://www.ncd.gov/newsroom/publications/2007/implementation_07-26-07.htm

E1c. Individuals with Physical Disabilities:

Generally speaking, the healthcare needs of individuals with physical disabilities are similarly affected by the access and equity issues noted above. Two complications, however, are barrier-free access to the locus of care and meaningful access to transportation. The above mentioned National Council on Disability report identified access to transportation as a significant barrier to accessing healthcare. One example of an important healthcare issue for this population is the lack of availability of accessible examination tables for persons who are non-ambulatory.

E1d. Individuals with Developmental Disabilities:

The medical needs of individuals with developmental disabilities range enormously in their complexity. A 2002 publication by the Surgeon General titled "Closing the Gap: A National Blueprint to Improve the Health of Persons with Disabilities" (<http://www.surgeongeneral.gov/topics/mentalretardation/retardation.pdf>) underscores the challenges in obtaining these services.

For those whose disability is mild to moderate, access to traditional hospital venues and/or community care clinics may suffice for routine medical or dental needs. For those with significant developmental disabilities, however, access to specialty medical and dental care, as well as mental health care (if needed) is critical. Additional behavioral supports may be required for consumers with challenging behaviors in order to facilitate the exam and treatment provided by the physician or dentist. A 2005 report by the Special Olympics highlights the gaps in health care for those with developmental disabilities. This report can be accessed via the Special Olympics website, www.specialolympics.org, and visiting their research link. The issue of transportation, akin to that which was noted for individuals with physical disabilities, is also a barrier to accessing health care services. The Subcommittee also noted that the recently-enacted Danielle's Law has imposed some unintended stressors upon hospital emergency rooms, as the frequency of such visits has increased.

Recommendations:

While it is difficult to generalize the accessibility concerns of special needs populations, basic accommodations such as communication support, barrier-free access, and specialized care are not always costly and should be prioritized. One example of an important and low-cost effort towards effective communication is the Communication Picture Board, prepared through a collaboration of the New Jersey Department of Health and Senior Services/Office of Minority and Multicultural Health and the New Jersey Hospital Association. This board utilizes a variety of pictures to enhance one's expression of needs, and is designed for use by emergency service personnel and frontline intake staff to better enable effective communication with the public.

For individuals with developmental disabilities, the dearth of medical and dental specialists is particularly acute. Articles at <http://rtc.umn.edu/nhis/> and <http://www.Pubmedcentral.nih.gov/picrender.fcgi?tool=pmcentrez&artid=1783697&blobtype=pdf> cite accessibility and communication as barriers to medical and dental services. As such, the establishment of Centers of Excellence for medical, mental health and dental care for individuals with developmental disabilities should be explored. Finally, the recruitment and retention issues noted above for medical and dental professionals exist as well for those individuals with developmental disabilities.

E2. Language

The increase in immigrant groups in New Jersey, coupled with higher incidence of chronic health care conditions requiring regular health care monitoring, argues strongly for health care services that can adequately serve linguistically, ethnically and culturally diverse families.

Recommendation:

To provide better access to healthcare and prevent unnecessary complications due to language and cultural barriers, New Jersey should provide translation and outreach and educational materials in the language of the patient populations. This can best be achieved by local planning efforts, outlined above.



Appendix 8.2: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 2: **Benchmarking for Efficiency and Quality**

A. Overview

The Commission on Rationalizing Health Care Resources was established to advise the Governor on a strategy for supporting a system of high quality, affordable, cost effective and accessible care. On a national level, changes in health care delivery have resulted in changes in health care finances. This has resulted in financial problems for many New Jersey hospitals and requests for state financial subsidies. In response, the Governor established the Commission to evaluate health care delivery issues and to recommend a rational way to evaluate requests for financial assistance.

In its June 2007 Interim Report, the Commission proposed specific criteria to determine whether a hospital was essential to ensure the provision of the full scope of health care services for all regions of the state but not financially viable. In addition, the Commission wanted to ensure that state determinations about essential hospitals and financial distress also considered quality of care and efficiency. It is not reasonable to provide financial subsidies to a poor quality hospital or an inefficient organization.

Subcommittee Charge:

Therefore, the Commission established the Subcommittee on Benchmarking and Quality in fulfillment of Executive Order #39 to “Recommend the development of State policy to support essential general acute care hospitals that are financially distressed, including the development of performance and operational benchmarks for such hospitals,” and in order to ensure that:

- public funds are used to support efficient and high quality health care facilities, and
- decisions about whether a facility is essential should consider both quality and efficiency in addition to community need and financial performance.

Overview of Subcommittee Process:

The Subcommittee was formed in May 2007 and was composed of thirteen members representing health system management, medical and financial leadership as well as academic and consumer representatives (Appendix 8.2A). Two members of the Commission on Rationalizing Health Care Resources (David Hunter and JoAnn Pietro) served as Subcommittee members in order to ensure consistency with overall Commission needs and approach. Mr. Hunter and Robert Jacobs M.D. served as Subcommittee co-chairs. The Subcommittee met five times between June and August 2007 to review a general approach, to choose both quality and efficiency measures and to develop a strategy for responding to hospitals which request a subsidy. The goal was to ensure development of a high quality and financially secure health care system, through the use of quality and efficiency measures that serve as performance and operational benchmarks.

There was active discussion among Subcommittee members on all issues considering both theoretical and practical perspectives. Subcommittee members are actively involved in managing hospitals and dealing with financially troubled institutions and brought that experience to the discussion. There was substantial agreement among Subcommittee members on the criteria for choosing measures, the quality and efficiency measures selected and the ways to use those metrics. The Subcommittee developed an approach to reviewing hospitals in financial distress, developing agreements with those hospitals and monitoring performance.

The Subcommittee focused on the use of quality and efficiency measures but noted that issues being considered by other Commission Subcommittees (e.g., health care infrastructure including electronic medical records and physician practice patterns) were significant determinants of hospital operations and performance.

B. Measure Selection: General Approach to the Issue

The Subcommittee's strategy was to select a wide range of measures which could be used to evaluate hospital performance and to determine whether operational changes were necessary. This dashboard for quality and efficiency could also be used to monitor hospital performance if a subsidy was provided by the State. The following criteria were used to guide measure selection:

- Clear data definitions of the measures must be available to ensure comparability across hospitals.
- Data must be currently available so that hospitals will not face additional data collection burdens.
- Measures should represent a broad range of areas including clinical quality, outcomes, financial performance and operating indicators, etc.
- Measures must be transparent so that calculation methods and data sources are specified and available.
- Different measures could be important for different hospitals because of areas of specialization.

Subcommittee members proposed a wide range of quality and efficiency measures for consideration. There was general agreement that the Subcommittee needed to create a broad dashboard to accurately reflect hospital performance. The Subcommittee evaluated those measures using the agreed-upon criteria.

When several measures covering the same area were recommended, one measure was chosen. Since measures need to be widely available for all NJ hospitals, a number of worthwhile measures were not included. There was also the recognition that while some proprietary systems could provide highly useful information about hospital operations, these systems could not be included since publicly available data was necessary.

There was general agreement that a hospital that applied for a subsidy might be asked to provide additional information to describe performance. These measures would be important to understand and evaluate a hospital's performance but consistent statewide data may be unavailable.

C. Key Findings - Quality and Efficiency Measures

Based on these criteria, a dashboard of quality and efficiency measures was developed to give a broad picture of a hospital's operations. The Subcommittee recommended that these measures be used to evaluate a hospital that applies for a special subsidy. For many of these measures, it will be possible to calculate both state and national medians to be used when evaluating individual hospitals. Whenever possible, a hospital will also be evaluated in terms of its percentile on each measure.

Recommended Quality Measures:

The recommended quality measures are presented in Table 1. These measures are based on a wide range of data sources and types of quality including consumer satisfaction, mortality and clinical process measures. The measures are largely based on information already collected by the Department of Health and Senior Services (DHSS):

- The perfect care scores can be calculated based on the patient level data already submitted for the New Jersey Annual Hospital Performance Report. The perfect care measures reflect how well a hospital provides all the correct care to a patient with a heart attack, pneumonia, congestive heart failure or a surgery patient.
- Mortality, readmission rates and average length of stay (ALOS) can be calculated using the hospital discharge data collected by the Department. The APR-DRG risk adjustment will be used when appropriate.
- H-CAHPS (Hospital-Consumer Assessment of Healthcare Providers and Systems) is a standardized survey to measure patients' perspectives on hospital care within the following composites: Doctor Communication, Nurse Communication, Responsiveness of Hospital Staff, Cleanliness and Quiet Environment, Pain Management, Communication about Medicines and Discharge information. HCAHPs measures will be available on the CMS Hospital Compare and NJ Hospital Performance web sites.

- The Department will be collecting and publicly reporting on nosocomial infection rates as required by proposed legislation. Specific nosocomial infection measures will be defined by the Department through the regulatory process with the advice of the Department's Quality Improvement Advisory Committee (QIAC).
- The Agency for Healthcare Research and Quality (AHRQ) has developed the Inpatient Quality Indicators (IQIs) which are a set of quality indicators which reflect mortality, utilization and volume based on hospital discharge data using the APR-DRGs.

When a hospital needs a subsidy, other issues would be addressed such as Board of Trustees involvement in quality oversight, inappropriate resource utilization, clinical efficiency and hospital resources allocated to quality improvement. The hospital might also be asked to provide information on pediatric care, obstetrical care and emergency care. These indicators are not part of the dashboard but could be considered for individual hospitals which apply for a subsidy.

Recommended Efficiency Measures:

The recommended efficiency measures are presented in Table 2. These measures assess a hospital's costs, resource use, patient utilization review, staffing and revenue cycle management. All measures, except for the Denial Rate, can be calculated with information readily available from existing data bases maintained by DHSS:

- Data on full-time equivalent staffing, labor expenses and non-labor expenses are provided in the Hospital Cost Reports provided to the DHSS annually. The Subcommittee considered calculating the cost measures on a per admission or per-patient day basis; the Subcommittee chose per-admission because a hospital's cost per day could be acceptable but the average length of stay too high. Admissions are adjusted for outpatient activity (using gross revenue figures from the Cost Reports) and case mix and severity (using APR-DRGs as applied to UB-92 admissions data). The CMI will include an adjustment for severity as well as to improve the consistency of these measures across hospitals.

- Already listed as a quality measure, average length of stay (ALOS) is included as an efficiency measure as well. The Subcommittee believes it is an indicator of the management's ability to control utilization, and hence, costs, at the hospital. Data to calculate ALOS is included in the B-2 Reports provided quarterly to the DHSS. Like the cost measures, ALOS should be adjusted for case mix to ensure comparability across hospitals. The Subcommittee noted that the unique utilization patterns associated with obstetric and psychiatric services could make cross-hospital comparison misleading for facilities with large programs in these specialties.
- Although a hospital's capital structure is essentially fixed in the short run, occupancy based on maintained beds is under management's control in the short run. Low occupancy rates on maintained beds could be an indicator that the hospital is incurring costs to keep unneeded beds available. This measure can be calculated from data included in the quarterly B-2 Reports provided to the DHSS.
- Days in accounts receivable and average payment period can be calculated from data collected on a quarterly basis for the DHSS/NJ Health Care Facilities Financing Authority (HCFFA) financial data base. The Subcommittee considered other financial ratios (e.g., operating margin, debt service coverage ratio, days' cash-on-hand). The Subcommittee felt that those measures could be significantly affected by factors and issues outside management's control (e.g. payer mix) and therefore would not be good measures of efficiency. In contrast, days in accounts receivable and average payment period reflect the ability to effectively manage the process of generating and collecting patient bills and paying vendors with the resulting cash flow.

The denial rate is included as an efficiency measure although there is no consistent source for this indicator. Subcommittee members felt that it is another important measure of revenue cycle management and should be provided by hospitals seeking additional financial support.

D. Key Findings - Response to Hospitals in Financial Distress

The Subcommittee recommends that the following approach be used when a hospital requests a subsidy or some form of financial support:

• **Evaluation/Decision on Subsidy**

If a hospital requests a subsidy or some form of financial assistance, the hospital is evaluated based on the criteria for financial distress and essential hospitals established by the Commission in order to determine whether a hospital is eligible for a subsidy. The final determination of a subsidy and the agreement between the hospital and DHSS is based on examining the hospital's performance on the quality/efficiency dashboard. That review would consider the hospital requesting a subsidy as well as other hospitals in the area. The statewide benchmark would be viewed as a comparison but not the determining factor. The hospital could be asked to provide additional information based on areas of specialization (e.g., pediatric care) or to review areas (e.g., denial rates) where consistent statewide data are not available. The Department should also review administrative overhead expenses to ensure that expenditures are reasonable.

The decision on whether to provide a subsidy and the amount of that subsidy will depend on this evaluation and the amount of funds available considering other hospitals requesting assistance.

• **Development of an Agreement**

If a decision is made to provide a subsidy, the Department and the hospital will form an agreement to ensure that public funds are appropriately spent. That agreement will involve one or more of the following components:

- DHSS and the hospital will agree on an action plan to resolve the issues identified in the DHSS review or issues identified by the hospital. This may be developed by the hospital's management and may require a consultant or some new executive leadership.
- The hospital may be required to retain new executive leadership.

- The hospital agrees to meet specified targets on the quality/efficiency dashboard. Those targets will be developed based on state and/or national performance norms and the hospital's current performance. Other financial indicators may also be included in the agreement as described above.
- The hospital might be required to contract with a management consultant in order to evaluate and improve its operations.
- The hospital may be required to add specific members to its Board of Trustees and/or Finance Committee in order to support changes in policy/operations. These members would be chosen to provide the appropriate skills based on the operating/financial issues and/or clinical identified during the evaluation process. These members would convey the DHSS position to the Board and provide relevant information to the Department.
- The hospital may be required to form a specified relationship with a hospital system which would provide greater financial stability, strategic planning skills or executive leadership. That relationship could take one of several forms, i.e., a cooperative contract, an affiliation or a change in ownership.
- DHSS will be invited to all Board of Trustees meetings and receive all appropriate materials during the agreed upon contract period.
- The hospital will be required to provide specific operational information at regular intervals based on the agreement.

• **Implementation/Monitoring**

The Department will monitor the hospital quarterly and as often as monthly in order to ensure compliance with the agreement and that the hospital is moving toward financial, operational and clinical targets.

- If the hospital does not meet specified quarterly targets, a corrective action plan would need to be prepared for DHSS review.

- Continuation of the subsidy is dependent on the hospital meeting specified targets.
- The subsidy will be subject to review based on the state's financial resources.

E. Additional Issues

During the course development of the quality/efficiency dashboard and the response to hospitals which request a subsidy, the Subcommittee made the following recommendations:

- Given the importance of and recent emphasis on quality indicators, the State may want to consider additional data collection in this area as part of a longer-term strategy. Those measures that warrant future consideration include: Institute of Healthcare

Improvement (IHI) safety measures; computerized physician order entry (CPOE), medical staff qualifications, such as board certification and/or eligibility, nurse staffing and agency nursing percentages.

- Ensuring quality and efficiency requires both market and financial viability to eventually fund an infrastructure-culture, people, tools, processes. Decisions on support must consider whether funds are available to create an infrastructure to support a quality performance operation.
- The Subcommittee agreed that information which the Department creates for the quality/efficiency dashboard should be available to the public.

Table 1:
Quality Measures

Indicators	Available for All Hospitals*	Source
Perfect Care Scores: AMI, pneumonia, CHF, SCIP	Yes	DHSS based on information collected for Hospital Performance Report
Nosocomial Infection Rates	Yes in 2009	DHSS will phase-in based on hospital reports
Hospital CAHPS	Yes in 2008	CMS
Mortality-Risk Adjusted for top 10 DRGs	Yes	DHSS based on APR-DRGs
AHRQ IQI Mortality: • Pneumonia • CHF • AMI • Stroke	Yes	DHSS calculates using AHRQ software and APR-DRGs
30 day Readmission Rates for top 10 DRGs	Yes	DHSS based on APR-DRGs
ALOS-Risk Adjusted for top 10 DRGs	Yes	DHSS based on APR-DRGs
Accreditation Status	Yes	Joint Commission

* Yes indicates that the measure may be calculated based on existing data.

Table 2:
Efficiency Measures

Indicators	Available for All Hospitals*	Source	Comments
FTE per adjusted occupied bed	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Non-labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Total expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Case mix adjusted ALOS	Yes	DHSS B-2 Forms and UB-92 data	Use APR-DRGs to calculate case mix index
Occupancy (maintained beds)	Yes	DHSS B-2 Forms	Licensed beds are fixed in short run but maintained beds can be adjusted.
Days in accounts receivable	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Average payment period	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Denial rate	No	Voluntary reporting from hospitals	Will not calculate statewide benchmark but will use as additional information to evaluate revenue cycle management

*Yes indicates that the measures may be calculated based on existing data.

Appendix 8.2A
Benchmarking for Efficiency and Quality
Subcommittee Membership

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Health Care Consultant
Commission Member

Robert Jacobs, MD, Co-Chair
Acting Chief Medical Officer
Jersey City Medical Center

Philip Bonaparte, MD
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Exec. Director of Practice Operations
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Senior Policy Analyst
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Peter Gross, MD
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David Knowlton
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NJ Health Care Quality Institute

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William Phillips
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Appendix 8.3: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 3: **Infrastructure of Healthcare Delivery**

Subcommittee Charge:

To explore the reasons for the lack of adequate information systems in health care, sketch the vision of a 21st century health-care information system, examine how much of that vision has been achieved by now in New Jersey or is actively being pursued, and finally offer recommendations to move New Jersey health care toward an information platform that adequately serves the state's people.

Overview

The Subcommittee was formed in May 2007 and was composed of 12 members which are listed below.

Membership

Uwe Reinhardt, Ph.D., Chairman

Subcommittee Co-Chair

Chairman, Commission on Rationalizing Health Care Resources

The James Madison Professor of Political Economy

The Woodrow Wilson School of Public & International Affairs, Princeton

University

Annette Catino, Subcommittee Co-Chair

President & Chief Executive Officer
QualCare, Inc.

Matthew D'Oria

Lead Staff to Subcommittee
DHSS Deputy Commissioner

Bruce Vladeck, Ph.D.

Member, Commission on Rationalizing Health Care Resources

Mark Barnard

Senior Vice President
of Information Technology
Horizon Blue Cross/Blue Shield of New Jersey

Sonia Delgado

Princeton Public Affairs Group, Inc.

Richard Goldstein, M.D.

President
NJ Council of Teaching Hospitals

Vincent Joseph

Senior Vice President
University Medical Center at Princeton

Michael Maron

President/Chief Executive Officer
Holy Name Hospital

Mitchell Rubin, M.D.

Neurology Consultants of BC

Kevin Slavin

President/Chief Executive Officer
East Orange General Hospital

Joseph Sullivan

Chief Information Officer
St. Barnabas Health Care System

An Information Infrastructure for New Jersey Health Care

It is fair to state that health care in New Jersey, in the United States and virtually everywhere in the world is rendered in a fog. People in that fog may be trying to do the best they believe can be done, but collectively they fall far short of the best that would be achievable with a lifting of that fog.

The fog in question is the lack of pertinent information that can, at once, guide decision making in health care and hold the participants in the health care sector accountable for their actions. It is also fair to state that, relative to other sectors in modern economies – e.g., the financial sector, the travel industry, and the retail industry, to mention but a few -- the health sector tends to be a unique underachiever in this regard. It devotes relatively fewer resources to information systems than do other industries and, for the resources it does deploy, achieves less. Much of the waste, fraud and abuse said to be part of modern health systems and considerable human suffering – in the midst of much succor and miraculous cures -- can be traced to this lack of an adequate information system.

The persistent fog surrounding the delivery of health care is particularly disturbing in the face of current attempts to convert what hitherto had been known as “patients” into “consumers” who are expected to shop around smartly for cost effective care under so-called *Consumer Directed Health Care*. Unless strident efforts are made at long last to lift that fog through more widespread application of modern information technology (IT) in health care, these “consumers” will resemble nothing so much as blindfolded shoppers thrust into department stores, there to shop smartly for wanted or needed items.

The IT subcommittee report explores the reasons for the lack of adequate information systems in health care, sketches the vision of a 21st century health-care information system, examines how much of that vision has been achieved by now in New Jersey or is actively being pursued, and finally offers some recommendation to move New Jersey health care toward an information platform that adequately serves the state’s people.

The Imperative of a Health System Information Infrastructure

At the core of an efficiently functioning health-care system is an information infrastructure that enables the various decision makers in health care — patients, physicians and nurses, the executives of health care facilities, insurance companies and government officials -- to make decisions that result in timely and cost-effective health care. Remarkably, relative to other sectors in the economy, the health sector has been uniquely lagging in its use of available IT. In exploring the reasons why this is so, it will be helpful to divide the sector into its supply side and its demand side.

The Supply Side: As a general rule, suppliers in any economic sector will actively seek the information that helps them achieve their own goals, but otherwise will shun the transparency that might expose them to the brunt of full-fledged competition on price and quality as well as public accountability for the use they make of resources.

That penchant is not evil. It is normal and perfectly human. Therefore, the supply side in health care cannot be expected to develop the information infrastructure required for cost-effective, high-quality health care unless it is mandated to do so by those who pay for health care. Here it must be noted that the users of health care (patients) and those who pay for health care (government and private insurers) so far have been remarkably tolerant of a high variance in both the cost and quality of the health care they procure, where “high variance” is technical jargon for the phenomenon that excellent and shoddy quality and wasteful as well as cost-effective health care are permitted to exist side by side within the same health-care system – e.g., that of a single state or even a single community. Instead, the payers have simply trusted the providers of health care to do the right thing.

The Demand Side: One can understand why patients, who usually are well-insured from the cost of health care, would not show much concern over the total cost of their care, as long as their out-of-pocket costs are tolerable. The patients’ manifest indifference toward variations in the quality in health care, however, is nothing short of remarkable. The only sensible

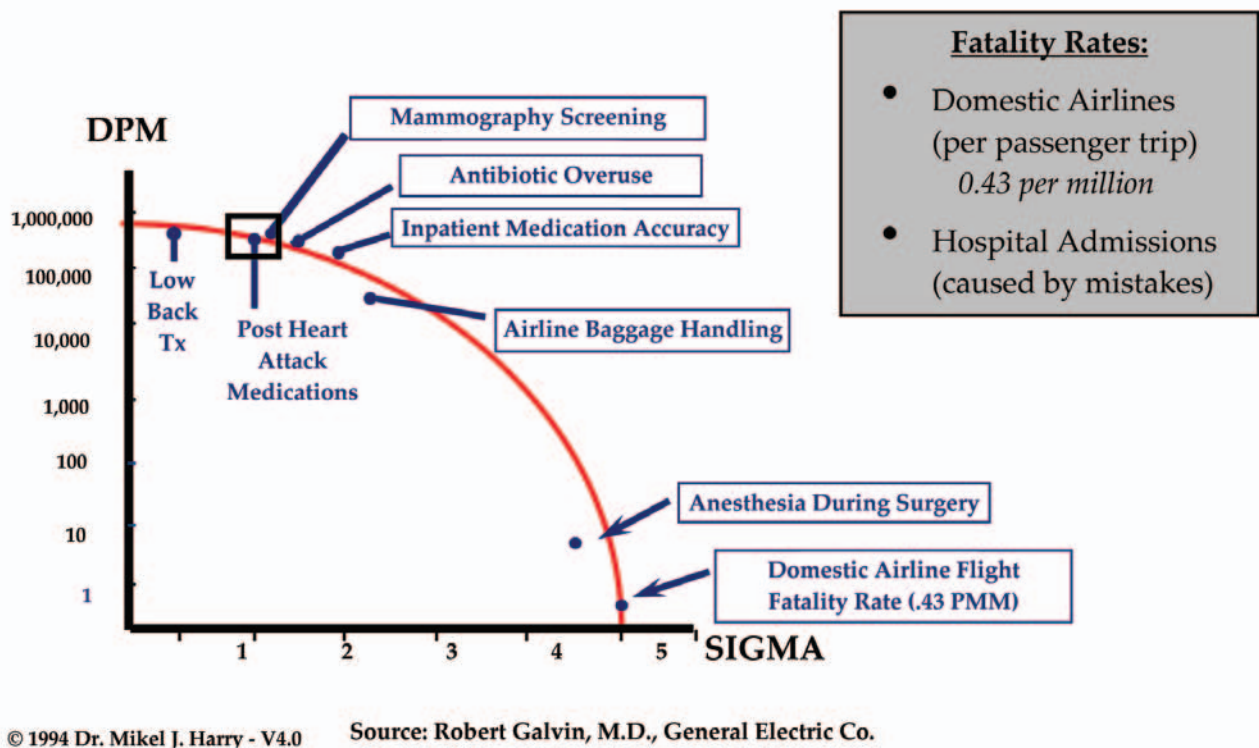
explanation is that so far patients have been kept ignorant of that variance, which has long been known to health policy analysts and at least some policy makers in the private and public sectors. Why both public and private insurers have been so passive on this score remains a mystery.

High Variance in the Quality and Cost of Health Care

In the mid-1990s, for example, benefit managers at the General Electric Co. popularized the six-sigma chart

shown below, indicating for a number of activities the number of defects per million opportunity for defect (DPMO), a metric used in six-sigma quality control. The chart indicated that more errors occurred in a number of medical treatments than in baggage handling by airlines, a notoriously error-prone activity. It is a quite stunning statement on the quality of U.S. health care, especially because Americans so often boast that theirs is “the best health system in the world.

Figure 1:
The Quality Imperative: The General Electric View



At the end of the decade, in 1999, the prestigious Institute of Medicine (IOM) of the National Academy of Sciences published its landmark study *To Err Is Human: Building a Safer Health System*, in which the Institute's panel of experts estimated that somewhere between 44,000 to 98,000 Americans died prematurely in hospitals as a result of avoidable medical errors, very frequently errors in the administration of drugs. Earlier in the decade, Lucien L. Leape, M.D. of Harvard University had likened these premature deaths due to medical errors in a seminal article published in the *Journal of the American Medical Association* as "the equivalent of three jumbo-jet crashes every 2 days."¹

The IOM's 1995 report was followed, in 2001, by the Institute's *Crossing the Quality Chasm: A New Health System for the 21st Century*. A passage in the Executive Summary is instructive for present purposes:

The health care system as currently structured does not, as a whole, make the best use of its resources. ... A highly fragmented delivery system *that largely lacks even rudimentary clinical information capabilities* results in poorly designed care processes characterized by unnecessary duplication of services and long waiting times and delays. And there is substantial evidence documenting overuse of many services – services for which the potential risk of harm outweighs the potential benefits. What is perhaps most disturbing is the absence of any real progress toward restructuring health care systems to

address both quality and cost concerns, *or toward applying information technology to improve administrative and clinical processes* (p. 3; Italics added).

Apparently, there has not been much progress since 2001 either. In a paper entitled "The End of the Beginning: Patient Safety Five Years After 'To Err is Human'," Robert Wachter observes that

Since 1999, there has been progress, but it has been insufficient. Stronger regulation has helped, as have some improvements in information technology and in workforce organizations and training. Error-reporting systems have had little impact, and scant progress has been made in improving accountability. Five years after the report's publication, we appear to be at "the end of the beginning."²

Shown on the next page are data on clinical outcomes from three standard procedures in tertiary centers, broken down into those declared by the Blue Cross Blue Shield Association to be Centers of Distinction and all other centers in the study. The data exhibit a remarkable variance in clinical outcomes, especially in the mortality rate associated with heart transplantation. These data raise two questions. First, what factors drive this high variance in clinical outcomes. Second, why do patients continue to be referred to centers with high mortality rates, and why do private insurers pay for procedures performed in such centers?

¹ Lucien L. Leape, "Errors in Medicine," *Journal of the American Medical Association*, 272(23) (December 21, 1994): 1851-58.

² Robert M. Wachter, "The End of the Beginning: Patient Safety Five Years after 'To Err is Human'," *Health Affairs Web Exclusive* (30 November, 2004): W4-534-45.

Table 1:
Blue Cross Blue Shield Outcomes Study for Tertiary Centers

	Blue Distinction Centers		All Other Centers	
	Mean	Maximum	Mean	Maximum
Short-term Major Complications from Bariatric Surgery	5%	8%	7%	37%
Heart Transplant Patient One-Year Mortality Rate	11%	30%	19%	57%
Inpatient Mortality (Heart Attack)	7%	15%	9%	40%

Source: Data provided by Nat Kongtahworn, Director, Network Strategies, Office of Clinical Affairs, Blue Cross Blue Shield Association.

Ignorance of these facts is likely to be the major explanation. While targeted studies can identify such variances, such data are not routinely collected, organized and publicized. Government's casual attitude towards these variances in mortality in the hospital sector stands in stark contrast to the stringent patient-safety standards government imposes on the pharmaceutical and medical device industries. Why should an avoidable, premature death in a hospital be taken more lightly than a death from a problematic prescription drug or medical device? The subcommittee makes note that New Jersey's various health report cards indicate significant and steady improvements in the quality of care at the State's hospitals. This evidence further confirms that the availability and transparency of health care data improves quality.

Finally, results from a recently published study in *The New England Journal of Medicine* suggest that, on average, children in the study received 46.5% of the indicated care³, a finding that parallels an earlier, similar study for adults published in the same journal.⁴

In sum, then, uneven quality of health care remains a significant feature of the American health care system, and New Jersey's health system, while improving, is not an exception to this finding. It would be puzzling indeed why patients accept this state of affairs with such equanimity – why they would opt to receive care at hospitals in which their chance of dying from low-quality care is higher than elsewhere -- were it not for the fact that patients have absolutely no idea that such quality differentials exist. Instead of transparency on so important a matter, patients have been lulled into complacency by the much-mouthed mantra that the American health system is the best in the world, a mantra actually contradicted by a growing body of evidence. As a recent cross-national study by the Commonwealth Fund concludes:

Despite having the most costly health system in the world, the United States consistently underperforms on most dimensions of performance, relative to other countries. This report—an update to two earlier editions—includes data from surveys of patients, as well as

³ Rita Mangione-Smith, M.D., M.P.H., Alison H. DeCristofaro, M.P.H., Claude M. Setodji, Ph.D., Joan Keeseey, B.A., David J. Klein, M.S., John L. Adams, Ph.D., Mark A. Schuster, M.D., Ph.D., and Elizabeth A. McGlynn, Ph.D., "The Quality of Ambulatory Care Delivered to Children in the United States," *The New England Journal of Medicine*, 272(15) (October 11, 2007): 1515-23.

⁴ Steven M. Asch, M.D., M.P.H., Eve A. Kerr, M.D., M.P.H., Joan Keeseey, B.A., John L. Adams, Ph.D., Claude M. Setodji, Ph.D., Shaista Malik, M.D., M.P.H., and Elizabeth A. McGlynn, Ph.D.,

information from primary care physicians about their medical practices and views of their countries' health systems. Compared with five other nations—Australia, Canada, Germany, New Zealand, the United Kingdom—the U.S. health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives. The U.S. is the only country in the study without universal health insurance coverage, partly accounting for its poor performance on access, equity, and health outcomes. The inclusion of physician survey data also shows the U.S. lagging in adoption of information technology and use of nurses to improve care coordination for the chronically ill.⁵

Information on the Cost of Hospital Care

In the context of health care the word “cost” has two meanings. It could mean the payment the patient’s insurer makes for a hospital service. A better term for it would be the “price” the insurer pays for the service. Or it could mean the cost the hospital (or doctor) incurs to deliver the treatment, that is, the cash providers pay for the inputs they use in the treatment of patients. Not much is known publicly about the payments hospitals receive from different payers for the same service. Almost nothing is known about the input costs different hospitals incur for different services or medical cases.

Payments to Hospitals: The price hospitals receive from insurers for a standard service varies significantly from private insurer to insurer, usually in inverse proportion to the insurer’s market power. That price is different again for Medicaid and different once again for Medicare. Finally, because they have virtually no market power vis a vis hospitals uninsured patients tend to be charged the highest prices, unless they are outright

charity cases. In the end, however, what low-income uninsured and non-charity patients actually pay hospitals tends to be just a fraction of the prices they were charged.

All of these varied prices for the same service have virtually no systematic relationship with the cost of providing these services, whatever they may be. Furthermore, with the exception of prices paid by Medicare and Medicaid, all prices paid hospitals from the various parties are kept a tightly guarded trade secret. Although, in principle, uninsured patients or those with high deductible health insurance ought to have information on the prices hospitals might charge them, as a rule there does not exist an information base to provide that information.

There is also a great variation in the volume of services for which New Jersey hospitals bill insurers for roughly similar patients. As Table 2 indicates, during the period 1999-2003, per Medicare beneficiary in the last two years of life, the number of hospital days, Medicare payments per day and Medicare payments for the entire two years varied by a factor of more than 3 across hospitals in New Jersey. The CMS Technical Quality Score appears to be completely unrelated to these resource costs.

Although the medical cases represented by these patients were not 100% identical, so that differences in patients might explain some of this variation, it is hard to believe that genuine differences in acuity could have accounted for such vast differences in health-care utilization. A more plausible explanation is that these differences reflect largely differences in the affiliated physicians’ preferred practice style. That style may be preferred for purely professional reasons, or for economic reasons, or both.

⁵ Karen Davis, Ph.D., Cathy Schoen, M.S., Stephen C. Schoenbaum, M.D., M.P.H., Michelle M. Doty, Ph.D., M.P.H., Alyssa L. Holmgren, M.P.A., Jennifer L. Kriss, and Katherine K. Shea, *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care* (May 16, 2007), available at www.cmwf.org.

Table 2:
Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries
(Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)

	Inpatient Reimbursements	Hospital Days	Reimbursements per Day	CMS Technical Quality Score
St. Michaels Medical Center	3.21	2.34	1.37	0.91
Kimball Medical Center	2.32	1.26	1.83	0.95
Raritan Bay medical Center	1.86	1.85	1.01	0.81
Christ Hospital	1.83	1.83	1	0.59
St. Mary's Hospital Hoboken	1.75	1.72	1.02	0.74
Beth Israel Hospital	1.58	1.86	0.85	0.83
Overlook Hospital	1.27	1.36	0.94	0.90
Medical Center at Princeton	1.17	1.26	0.93	0.94
Atlantic Medical Center	1.11	1.12	0.97	0.89

Source: Data supplied to the Commission by John H. Wennberg, M.D., Director of the Dartmouth Atlas Project, December 2006.

Unfortunately, under our system of physician-hospital affiliation, physicians have great leeway in this regard and can literally conscript the hospital's resources at will, and cause the hospital to bear costs, without being properly accountable to anyone for their use of society's health care resources or at personal risk for causing these expenses.

Technology exists that allows hospital executives to track every order entry by every affiliated physicians for every input used in the treatment of every hospital case. To be sure, the administrators of some hospitals may routinely assemble resource-use data by individual physician affiliated with the hospital, but such data are unlikely to provide adequate leverage in dealing with physicians on whose goodwill and referrals the hospital must rely for its revenue flow. After all, it is not usually the hospital patient but the referring physician who

effectively is the hospital's customer. The question the Governor and State legislators must explore whether than information should also be available to them to assess the efficiency with which a hospital is run before deciding whether or not a hospital warrants state subsidies of any sort.

The Input-Cost of Hospital Services: The hospital industry regularly laments that Medicare and Medicaid pay hospitals less than 100% of the full cost of treating Medicare and Medicaid patients in hospitals. It is a plausible argument, but it leaves open the question whether the 'costs' to which the payers' payment rates are compared are invariably justified. To say that Medicaid pays only about 70% of a hospitals cost be misleading if the hospital's cost are 120% of a reasonable benchmark of what efficiently produced health care in hospitals should cost.

Here, too, New Jersey lacks a sophisticated information system that can routinely inform government on how a particular hospital's cost compares to reasonable benchmark costs.

The Potential Role of State Government in Health Information Systems

The troublesome circumstances described in the preceding subsections lead to the question what role State government has in financing and constructing an information infrastructure designed to drive the entire health system – patients, insurers and providers alike -- towards higher levels of performance. Alternatively put, the question is whether Americans can rely on the private sector to develop that infrastructure, given that sector's undistinguished history in this regard.

So far, neither the federal nor the state governments have done much to force greater transparency on the activities of the providers of health care whose revenues depend heavily on government financing. Only in the past few years have governments begun to address this important task seriously. Although private employers and their agents (private health insurers) equally had every opportunity in the past several decades to hold the providers of health care more rigorously accountable for the cost and quality of the services paid for by private insurers, and to provide the insured public with greater transparency on the cost and quality of health care delivered by health care providers, for the most part they, too, have failed to do so and are only now making timid steps in that direction.

If the state's government wishes to drive the state's health system more rapidly towards high performance, in terms of both cost and quality, government probably will have to intervene rather heavily to guide the invisible and timid hand of the private market place. To illustrate, a good faith cooperative effort is currently under way by Horizon Blue Cross Blue Shield of New Jersey and the New Jersey Hospital Association to develop a so-called regional health information organization (RHIO) that would facilitate the sharing of clinical information on patients across providers. Participation in any such effort, however, would be voluntary and thereby makes it difficult to develop a business model for the system from the individual hospital's perspective.

A strong business case for such an infrastructure could be provided if government mandated participation in the RHIO which, in turn, probably would require sustained financial support of the venture by government. That support could easily be defended on economic grounds, as a RHIO has a strong dimension of a public good. Economists make the case that, left to its own devices, the private sector will always under-supply public goods, unless their production is subsidized explicitly by government.

A Full-Fledged 21st Century Health Information System

A full-fledged, state-of-the art health-care information system already being developed in several parts of this country and, sometimes even more rapidly, in other nations would serve the following distinct objectives.

1. It would allow physicians and other providers of care throughout the state carefully authorized access to each patient's complete medical record.
2. It would endow patients with a personal electronic health record that would help them better to manage their health and their use of health care.
3. It would offer the providers of health care and those who pay for it (mainly third-party payers) adequate information to facilitate the business transactions surrounding health care more smoothly and more cost-effectively than is now the case.
4. It would routinely provide data required especially by government (which pays for close to 50% of all health care in the U.S.) and communities to hold the providers of health care accountable for their use of real health care resources in the treatment of patients.
5. In particular, it would yield the data to hold physicians routinely accountable for their use of their own and their affiliated hospital's real resources in the treatment of patients. Thus one could explore, for example, the huge variations in resource-use exhibited in Table 2 above and hold the individual physicians driving these variances formally accountable for them.

Different Records in a Health Information System

It would not make sense to develop one giant electronic record that could serve all of these diverse objectives at once. Instead, there should be a common master file –

sometimes called the “spine” – that would contain data used in raw form or transformed by several or all of a set of electronic records customized and enriched with yet other data to serve the narrower objectives listed above. These various electronic records may be described as follows.

Electronic Health Record (EHR): An electronic record is any combination of text, graphics, data, audio, pictorial, or other information representation in digital form that is created, modified, maintained, archived, retrieved, or distributed by a computer system. An EHR is a larger concept in that the electronic information is more than the clinical information; it includes demographic information and sometimes payment codes, such as IDC and CPT codes. The electronic information may be shared within a larger organization or with a second outside health care entity and follows federally recognized standards such as HL7 and X12. EHR can and should be certified by the CCHIT. The master “spine” might consist of such EHRs.

Electronic Medical Record (EMR): The purpose of the EMR is designed to be an electronic interface among clinicians. It would allow any physician authorized to do so by the patient or the patient’s guardian to access that patient’s full medical record, or authorized parts of it, which would include a medical history, the patient’s current drug regimen, all tests previously done and observations recorded by other physicians. The EMR would be kept in the clinical language understood by clinicians. This objective could be accomplished either by a smart card carried by the patient or by what is known as the VISA system, that is, a card carried by patients that permits authorized access to a central storage location for the patient’s file. The EMR would meet the first of the objectives listed above.

Personal Electronic Health Record (PEHR): The second objective listed above is met in various locations around the world by a PEHR, which is a multipurpose record written in language lay people can understand and allowing patients to see their most recent test results, graphical or tabular histories of test scores for particular metrics (e.g., blood pressure), their current and past prescription-drug regimen and so on. There would be electronic links from test results to explanations of these results and further links to the relevant literature,

perhaps ordered by level of difficulty. Patients would also find on this record relevant treatment options for particular medical conditions, and guidance for proper health maintenance, including nutrition. Ideally, such a file should also provide links to reliable information on sundry dimensions of the quality of care rendered by individual providers of health care and, to the extent that it is relevant to patients, information on their share of the cost for procuring health care from particular providers of care. Finally, patients could make appointments with physicians via this record, or communicate directly with individual physicians.

All of these desiderata may appear as too much of a load for a PEHR to carry. The fact is, however, that such records are already in use here and abroad and are spreading rapidly. Here it must be noted that the establishment and maintenance of a PEHR requires a sponsor who both finances and manages it. One alternative is to lodge that responsibility with third-party payers, who could recover their costs through premiums or user fees levied on the insured. Another alternative would be to lodge that responsibility with the patient’s “medical home,” that is, the patient’s primary-care physician, who would be explicitly paid for that service by third-party payers (or strictly by government). The model of the “medical home,” now still mainly a concept on the drawing board, has captured the imagination of health policy makers around the world.

One could imagine entrepreneurial companies to establish medical homes, replete with sizeable computer systems and staff to support it, should physicians in their medical practices shun this task. These entrepreneurial companies could contract with both private and public insurance systems.

The other objectives listed above would similarly be met by customized electronic records all of which, however, would share a common, standard nomenclature, to permit easy transmission and comparability of the data. History suggests that the development and adoption of such a nomenclature would require the guiding hand of government, along with at least some public financing.

Of particular note here would be a data system tailored to meet the fifth objective listed above, namely, a system capable of tracking the hospital resource use of

individual, affiliated physicians by medical case and by input, to facilitate holding physicians accountable for the health-care costs they authorize over their signature.

The Financing of a Health Information System

As noted in passing earlier, a state's or nation's health information system has dimensions of a public good. In economic analysis a public good is one whose consumption or use by one person does not detract from any other person's use of that good. A second, less important dimension of a pure public good is that it is non-excludable, which means that everyone can enjoy its use.⁶

The information produced by scientific research is a pure public good – e.g., Einstein's famous equation $E = MC^2$ or the Pythagorean theorem – is a pure public good, as is the security provided by national defense and homeland security. Clearly, a common database, once it is established, has this feature. Economic theory shows that such goods would be underproduced by the private sector unless their production were collectively financed, typically by mandatory levies such as taxes.

Even goods that appear basically private consumption goods exhibit so-called “positive ties” that represent public-good dimensions. Telephone networks, for example, are such goods, because the value of a privately owned telephone increases with the number of other privately owned phones to which each telephone connects. When one person buys a telephone, all other telephone owners benefit. Economic theory suggests that the production or purchase of such goods should receive public subsidies as well if society wishes them to be produced in sufficient quantity.

The upshot of these reflections is that, because of its connectedness across the health system, a healthcare information infrastructure has dimensions of a public good and thus ought to be supported with public subsidies. The development and maintenance of the system's common data base (its “spine”) in particular should be heavily government funded, even if the actual development and maintenance is delegated to a private entity.

Furthermore, as already noted as well, to reap the full benefit of a health information infrastructure, participation in it by individual providers of health care should be mandatory.

Progress to Date in New Jersey

Legislation has been proposed that would create a central repository under the authority of the Department of Banking and Insurance. Under the proposal the initial source data for populating the repository would be the electronic claims data processed and maintained by health insurers, including the NJ Medicaid program.

In addition to that information, the proposed repository could also be populated with health data maintained by state agencies, including the following:

- NJ Hospital Discharges (UB-92)
- Cardiac Utilization
- Quality Reporting
- Patient Safety Reporting
- Cancer Registry
- Childhood Immunization Health Registries
- Medicaid/NJ FamilyCare Claims
- Annual Hospital Cost Reports
- Annual Hospital Financial Statements
- Unaudited Quarterly Financial and Utilization Reports

As referenced earlier, the New Jersey Hospital Association and New Jersey Blue Cross/Blue Shield formed the EMR/EHR taskforce to develop Regional Health Information Organizations (RHIO) around the state. Data collected through these organizations could also be used to populate the repository.

Recommendations

New Jersey should develop a clearinghouse/repository for electronic health data that can be accessed by all interested parties.

In essence it is envisioned that the clearinghouse would function as a spine from which users would be able to extract and utilize data to suit their particular needs. While it is anticipated the development of such a system will take several years and occur in incremental steps, there are basic guiding principles that must be followed.

⁶ Sometimes an intrinsically public good is artificially made excludable through law – e.g., by patent protection.

1. Public/Private Partnership – the sensitivity of the data mandates that security is paramount. Therefore the oversight and control must ultimately reside with government but the operation and output should include and reflect private sector concerns.
2. Standardization – As with any system the consistency of the terminology is critical.
3. Transparency – the systems basic functionality and data elements must be available at little to no cost and be understood by the general public.
4. Routine Outcome/Health Status Reporting – there should be regular periodic publications that summarize and report key utilization and health indicators.
5. Information already available in payer data warehouses must be used to begin populating the database with historical information that already exists.
6. Hospitals and individual practitioners must have an easy-to-use, one stop repository that can be accessed securely over the internet without forcing the adoption of another unique hardware/software configuration.
7. Laboratories, imaging and radiological facilities should file test results, reports and digitized images with the EHR Custodian for use by providers.
8. Pharmacy Benefit Managers should be required to supply filed prescription information with the EHR Custodian. Steps should be taken to remind consumers to follow recommended medication usage especially in chronic disease management.
9. Durable Medical Equipment Providers and other health care support providers should file reports with the EHR Custodian.

Conclusion

Transparency is a critical step toward improving the performance and accountability of the health care system to “lift the fog” that is currently hindering progress toward high quality, cost-effective care. An information infrastructure is necessary to address the unjustified variances in clinical practice across the state and the nation as a whole. Government must play an important role in the creation of a 21st Century health information system. The characteristics of such a system resemble that of a public good, which firmly calls for a government role – the absence of such a role will lead to chronic underinvestment in this important area and a failure to maximize value from the health care system.



Appendix 8.4: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 4: **Reimbursement and Payment**

Subcommittee Charge

The Reimbursement and Payment Subcommittee of the New Jersey Commission on Rationalizing Health Care Resources will undertake a review of the following issues and report back to the full Commission in the fall of 2007. Among the issues the Subcommittee will review are:

1. The long term viability and adequacy of the Charity Care payment system
2. The adequacy of the current Medicaid payment rates, to both general acute care hospitals and to physicians including recommendations for potential changes. The Work Group will address the recommendation of the NJHA proposal for the establishment of a Medicaid Commission to review the performance of the Medicaid Managed Care companies operating in New Jersey and overall payment rates for Medicaid Services.
3. Review with the Department of Banking and Insurance current policy regarding Medical Loss Ratio's of private health insurers in New Jersey and other issues related to the adequacy of private insurer payment rates to general acute care hospitals.
4. Assess and quantify the loss of Medicare outlier payments to the State of New Jersey in light of recent Medicare changes.
5. Identify the potential impact to New Jersey hospitals of proposed Medicare changes to GME and DSH payments.
6. Propose a plan of work for a robust forecast of likely impacts of payment changes over the next several years to the financial state of hospitals in New Jersey.
7. As appropriate the Work Group will solicit the views from a wide range of stake holders on the items listed in 1 – 6 above.

Subcommittee Membership

See Appendix 8.4A for a list of the subcommittee members

Overview of Subcommittee Process

The Subcommittee met three times during the summer of 2007. In addition to the meetings, members were provided with materials related to issues listed in the subcommittee's charge. These included data on state payments to hospitals (subsidies and Medicaid reimbursement) and white papers on some of the issues (NJHA paper on freestanding ambulatory surgery centers and RWJ Hospital paper on NJ Subsidy Programs).

The meetings generally involved a review of materials provided by subcommittee members, then discussion of the various issues included in the subcommittee's charge. Although the subcommittee looked at all issues listed in the charge, members felt that some were beyond either the subcommittee's or the commission's ability to make a difference (e.g. Medicare reimbursement issues). Because the subcommittee did not want to get ahead of DOBI's planned initiatives to improve transparency in the payment claims process, it did not develop any recommendations on this issue. Limits on time and resources also led the committee to focus on three primary topics – how hospital closures can make existing reimbursement “go farther,” leveling the playing field with respect to freestanding ambulatory surgery centers, and more effective distribution of state subsidies.

Key Findings

Distribution of charity care subsidies

The subcommittee was persuaded that there are many flaws in the current methodology for distributing charity care subsidies. Based in part on a white paper prepared by John Gantner, CFO at the Robert Wood Johnson University Hospital the subcommittee found that:

- 1) by not taking into account efficiency, some subsidies are rewarding inefficient hospitals;
- 2) by not taking account profitability, some subsidies are going to hospitals that do not need them to be financially viable;
- 3) lags in data collection and hold harmless provisions prevent the subsidies from truly following the patients;
- 4) the documentation requirements encourage hospitals to spend money on documenting charity care rather than pursue collection procedures;
- 5) hospitals often have to use a portion of their subsidies to pay for physician services for charity care patients; and
- 6) the delivery of charity care is totally unmanaged.

As a result, there appears to be little correlation between the distribution of the charity care subsidies and county wide poverty rates.

The subcommittee believes that part of the problem is that the state has never really settled on whether the subsidies are support to institutions that serve a particular population or an insurance plan for individuals meeting a certain eligibility tests. On the one hand, there are the documentation requirements and the specific calculations to determine the number of charity care patients seen by each hospital that make it look like an insurance program. On the other hand, the legislative earmarks and hold harmless provisions make it look like an institutional support plan.

The subcommittee recognizes that no supplemental funding is available at this time to expand the various state subsidies. Therefore, the subcommittee discussed two alternative approaches to distributing charity care subsidies.

1. Refine the existing methodology to factor in efficiency and/or profitability.

The Benchmarks Subcommittee has identified a number of efficiency criteria, including measures such as cost per adjusted admission, full-time equivalent staff per adjusted admission, case mix adjusted average length of stay, and days in accounts receivable (a complete list is included in Appendix 8.4B). Charity care subsidies could be adjusted based on an evaluation of hospitals using these or other efficiency measures.

Similarly, the subsidies could be limited to hospitals below certain profitability levels. Calculation of profitability should exclude subsidies because some hospitals with positive operating and/or profit margins would be losing money without the subsidy dollars. The limits could be based on absolute cutoffs or graduated reductions. For example, one approach would be to say that any hospital with an operating margin above x % would be ineligible for a subsidy; an alternative would be to reduce the subsidy for each dollar the hospital was above that target.

Separately or together, these refinements would funnel the subsidies to an arguably more deserving set of hospitals. However, it would still leave issues related to time lags and documentation.

2. Incorporate charity care and other subsidy funding into the Medicaid rates

This proposal is based on the belief that there is a high correlation between a hospital's Medicaid and charity care patient loads. In other words, the subsidy dollars would go to the hospitals provided the bulk of charity care. Such an approach would also eliminate the need to spend millions documenting charity care and the problems associated with data lags.

This proposal carries with it several implications. First, it is in part driven by the notion that current Medicaid rates are low. Second, there would be a shift in the administration of the charity care funding from the Department of Health and Senior Services to Medicaid,

within the Department of Human Services. Third, since some Medicaid managed care rates are linked to Medicaid fee-for-service rates, the State would have to adjust payments to the managed care companies. Fourth, putting the entire amount of the charity care subsidies into Medicaid rates would cause the State to exceed the Medicaid upper payment limit. This problem could be addressed by distributing the subsidies based on the distribution of Medicaid reimbursement (fee for service and managed care) without actually folding the subsidies into the Medicaid rates.

Freestanding ambulatory surgery centers

Subcommittee members found two significant problems created by freestanding ambulatory surgery centers (ASCs). While most of the discussion in this area was in the context of ASCs, subcommittee members noted that many of the same issues applied to other types of freestanding outpatient facilities as well.

First, the ASCs are not legally obligated to take Medicaid and charity care patients while hospitals are bound by law to accept such patients. For the hospitals, the ASCs represent an economic threat to their financial viability by taking some of the most profitable patients out of the hospitals.

Payers benefit from the lower unit cost at freestanding centers, which makes the ASCs the providers of choice for some plans. However, they also recognize that in rate negotiations, the hospitals attempt to recover the lost reimbursement that results from this adverse selection.

The subcommittee discussed requiring that ASCs serve all payer classes but doubts that such a proposal is workable. Another approach is to deny licenses to new ASCs unless they are partnered with a hospital. Many doubted that this was possible and noted that if only applied to new facilities, it could only have a limited affect at best.

There was more consensus within the subcommittee on the need to level the playing field with regard to regulations and data reporting. Currently, ASCs are not

subject to certificate of need requirements, facilities with a single operating room are not licensed by the Department of Health and Senior Services, and reportable events for ASCs are not consistent with reporting requirements for hospitals. The state has little data beyond the number of freestanding facilities; other information on volumes, revenues, and quality is not routinely reported.

If the Commission accepts the need for more consistency, the steps to cure the situation are complex and will require either new regulation and/or additional legislative authority. The subcommittee was in agreement that all operating rooms should be regulated for quality and data reporting regardless of the setting or the number at a particular location. The subcommittee also agreed that, as has been the case in New York State (which recently passed a law imposing new oversight authority for operating rooms in physicians' offices), that it is most likely merely a matter of time before a significant medical error would occur in an office-based operating room. Therefore, reportable events should be same, regardless of the setting. Finally, the subcommittee (with the Medical Society of New Jersey dissenting) recommended that the licensure exception for facilities and offices with a single operating room should be removed.

Incentives to encourage hospital closings

The subcommittee has strongly articulated the view that the "hospital system" would be financially stronger if a subset of hospitals closed. The argument is essentially that the reimbursement that follows the patients to the remaining hospitals will exceed the marginal costs of treating those patients, resulting in improved operating margins for the remaining hospitals. An ancillary benefit of such closures could be improved quality as well, given that the closed hospital was struggling financially and may not have had sufficient volume to ensure high quality of care.

The state could create a pool of funds to pay some or all of the costs of closing, which could include the outstanding debts, covering losses during a wind down period, and costs to transition the facility to other uses.

The pool need not be funded solely with State monies. Surviving hospitals in the region might be required to contribute to the fund since they would be expected to see a financial boost from the closure of a competitor. Using a simplified model in which the costs of closing were assumed to be net liabilities plus 6 months of operating losses at a rate of 15%, the cost of closing eight hospitals currently in severe financial distress was about \$150 million. On the other hand, the model suggests that closing those eight hospitals would generate an additional \$160 million in operating gains for surviving hospitals in the first year after closure.

A core issue here is pacing: Should the State avoid market intervention and allow hospitals to wither away at their own pace or should the process be expedited, through intervention, in an effort to restructure the market in favor of essential hospitals? Subcommittee members suggested that a slow process could create quality of care concerns and increase the costs of the eventual workout.

Appendix 8.4A

Reimbursement and Payments Subcommittee Members

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Appendix 8.4B
Efficiency Measures
 prepared by the Benchmarking for Efficiency and Quality Subcommittee

Indicators	Available for All Hospitals*	Source	Comments
FTE per adjusted occupied bed	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Non-labor expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Total expense per adjusted admission	Yes	DHSS Cost Reports and UB-92 data	Adjust volume for outpatient activity (using gross revenue), case mix/severity (using APR-DRGs)
Case mix adjusted ALOS	Yes	DHSS B-2 Forms and UB-92 data	Use APR-DRGs to calculate case mix index
Occupancy (maintained beds)	Yes	DHSS B-2 Forms	Licensed beds are fixed in short run but maintained beds can be adjusted.
Days in accounts receivable	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Average payment period	Yes	DHSS/NJHCFFA Financial data base	Measures efficiency of revenue cycle management.
Denial rate	No	Voluntary reporting from hospitals	Will not calculate statewide benchmark but will use as additional information to evaluate revenue cycle management

* Yes indicates that the measure may be calculated based on existing data.

Appendix 8.5: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 5: **Regulatory and Legal Reform**

Introduction

The New Jersey Commission on Rationalizing Health Care Resources was established to advise the Governor on issues related to maintaining a system of high-quality, affordable, and accessible health care. The Commission in particular was charged with examining the New Jersey acute care hospital system. The evolution of health care in the United States and in New Jersey has presented challenges to New Jersey's hospitals. Hospitals are faced with severe fiscal strains, the people of New Jersey are faced with reductions in the availability of care, and the State is presented with the challenge of whether, and in what manner, to intervene to serve the public good.

The Commission acknowledged in its June 29, 2007 Interim Report the fiscal pressures faced by hospitals, and made some preliminary recommendations regarding funding. It noted, however, that other factors must be considered in fulfilling its charge. The Commission charged the Regulatory and Legal Reform Subcommittee with those issues concerning the regulatory structure within which hospitals operate. The Subcommittee met six times. It was chaired by Commission Member Joel Cantor, and included Commission Members Debra DiLorenzo and Steven Goldman, and twenty experts on New Jersey health care law and regulation.¹

A primary recommendation of this Subcommittee is that the systematic under-funding of acute care hospitals in this State must be addressed. While other recommendations can and should be made, it is the belief of this Subcommittee that until the underpayment issues are addressed, the acute care hospital industry in New Jersey will continue to struggle. This is evidenced by the 17 closures in the past decade and five bankruptcies in the past 18 months.

I. Subcommittee Charge

The Commission charged six Subcommittees to address particular issues to advance the overall project of the Commission. The Commission charged the Regulatory and Legal Reform Subcommittee as follows:

To gather and review background information about current statutory and regulatory requirements governing health care facilities specifically in regards to licensing, certificate of need, and oversight through reporting of administrative, financial, and quality data; identify and review issues pertaining to the Certificate of Need Program including impact of trends in health care delivery, issues related to the implementation of the Certificate of Need Program, and recommendations; identify and review issues related to licensure and health care delivery; recommend revisions in statutes, administrative rules and programs; and serve as liaison to Commission subcommittees to assess necessity for legislative reforms.

II. Overview of Subcommittee Process

The Subcommittee met six times from August to December 2007. Rutgers' Center for State Health Policy in New Brunswick generously hosted the meetings. Before the meetings, staff circulated material describing New Jersey's statutory and regulatory structure, particularly as it pertains to Certificate of Need ("CON") and licensure. Staff also circulated materials on other states' regulatory structures, and materials produced from non-governmental sources such as the American Health Lawyers Association and the Joint Commission. The Subcommittee requested and received copies of reports of two Commission subcommittees: Benchmarking for Efficiency & Quality and Reimbursements/Payers.

¹ See Appendix 8.5A for full roster of Subcommittee members.

The deliberations focused on CON matters associated with the closure of hospitals and alternatives to the existing statutory process for closure, including, but not limited to, the development of an early warning system for distressed hospitals. Additionally, deliberations focused on licensure matters, particularly those concerning the interrelationship of hospitals and ambulatory care facilities and those concerning the governance structure of hospitals. The deliberations were informed by the proceedings of other committees and the Commission activities generally. There was robust discussion, sometimes disagreement, but ultimately the consensus of the subcommittee reached a number of recommendations.

III. General Approach to the Issues

Deliberations focused on several clusters of issues, to which the members returned regularly. These cross-cutting concerns arose in discussion of CON structure, licensure, and other statutory and regulatory issues:

- Adequacy of hospital reimbursement. Members recognized that other Subcommittees were primarily responsible for this issue, but asserted forcefully that the under-funding of acute care hospitals in this State must be addressed. It is the belief of this subcommittee that until the underpayment issues are addressed, the acute care hospital industry in New Jersey will continue to struggle
- Planning. Members recommended several steps to improve the function of health planning.
 - The State of New Jersey, through both the Department of Health and Senior Services (the Department) and the Health Care Facilities Financing Authority (the HCFFA), has data that can be used to create an “early warning system.”
 - CON regulations should be reviewed regularly to assure that they are consistent with industry and regulatory practice.
 - Prospective health planning should be employed to rationalize health care (particularly hospital) delivery when market forces drive the closure of hospitals. In particular, local and market area health planning was advocated as a means to avoid problems that arise when market forces, rather than prospective planning, are allowed to drive the closure of hospitals.
- The CON process should be comprehensively reviewed to respond to the unacceptable consequences of market forces, which limit access to essential health care services.
- In particular, the CON process for hospital closure should be modified to recognize the realities of the process of the winding down of a failing hospital.
- “Leveling the playing field.” The mixture of regulation and markets in New Jersey leads to some discontinuities disadvantageous to hospitals. Areas of focus included,
 - The imbalance between the regulatory burden on hospitals and ambulatory care facilities, particularly in terms of hours of operation and obligations to accept all patients.
 - The imbalance in the regulatory attention paid to hospitals and ambulatory care facilities, particularly in terms of monitoring quality and reporting of utilization, quality measures, and payer data.
- Governance. Although much of the distress suffered by New Jersey hospitals has resulted from outside forces, members considered possible changes in the regulation of hospital boards. Discussion focused on two issues:
 - Best practices, including some drawn from the application of Sarbanes-Oxley to non-profit boards, should be included in licensure regulations.
 - The Department of Health and Senior Services role should be to improve the ability of governing bodies to respond to changing market conditions. In particular,
 - Board members should receive appropriate training, which is already mandated for new board members by the Hospital Trustee Education law, P.L.2007, c 74 . The Department is in the process of promulgating regulations to implement this new law.
 - The Department should provide “early warning” information to boards to allow them to make informed decisions well in advance of times of distress.
- Other legal/regulatory issues. Two additional concerns were the subject of substantial discussion:
 - New Jersey’s physician self-referral law (the “Codey law”) has been interpreted by the Board

of Medical Examiners to permit physicians to operate ambulatory care facilities in a manner that creates challenges to hospitals.

A Superior Court decision (*Garcia v. Health Net*) recently adopted an interpretation of the Codey law that appears to be substantially narrower than that articulated by the Board of Medical Examiners. Some members of the Subcommittee advocated a narrower interpretation of the Codey Law to reduce this competitive pressure.

- The competitive relationship between physicians and hospitals raises concerns, some of which are addressed by other Subcommittees. Two in particular were raised:
 - Hospitals and physicians experience conflicting incentives with respect to the intensity of services provided inpatients; some realignment is called for.
 - The fiscal pressures experienced by physicians, combined with the sometimes competitive nature of the relationship between hospitals and physicians, have resulted in hospitals experiencing difficulty in providing physician coverage for essential services.

IV. Findings and Recommendations

A. Reimbursement shortfalls drive many of the problems in New Jersey's hospital industry.

A major factor that must be taken into consideration in examining the distress experienced by New Jersey's hospitals is the level of reimbursement paid by governmental payers. In particular, Medicaid and Charity Care reimburse most hospitals for most procedures at a level below hospitals' costs, and below the level of Medicare and private payers. Hospitals can no longer cost-shift to make up the difference.

Recommendation:

Governmental payers' practices must be reviewed to ensure that adequate reimbursement is provided to hospitals and healthcare providers who provide services to beneficiaries of public programs and to the underinsured and uninsured.

B. New Jersey's health planning process at times does not match with the evolving needs of the health care delivery system.

New Jersey's health care system is subject to both market pressure and State regulation. Market conditions can change more quickly than regulatory systems. Health planning regulations should be reexamined to make sure that they perform their intended functions in this mixed economy.

B.1. Planning regulations sometimes fall out of date, and are eclipsed by practice.

Recommendation:

The Department should review its CON regulations and update those that are no longer reflective of practice, and discard those that are no longer used by the Department.

B.2. CON regulation of hospital and other health care services clashes at times with the market-driven pressures to which health care providers are also subjected, but proper CON regulation may help to rationalize New Jersey's health care services.

The Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., established the CON process to ensure "that hospital and health care services of the highest quality, of demonstrated need, efficiently provided, and properly utilized at a reasonable cost are of vital concern to the public health." The original purpose of the Act was to encourage highly centralized regional planning. See N.J.S.A. 26:2H-6.1. This process has largely been supplanted by a regulatory process that maintains the structure of planning while becoming largely reactive to market forces rather than prospectively identifying need. Reestablishment of comprehensive State health planning could be problematic because the speed of market changes tends to render regulations quickly obsolete. In addition, the resources that would be needed to maintain a comprehensive planning process are not likely to be readily available to the Department. The Subcommittee agreed, however, that continued State health planning in some form – some argued in a very robust form – is necessary to maintain rationality in the health care delivery market.

The time constraints on the Subcommittee process prevented the full review of this issue that is warranted. The Department should convene a workgroup to review New Jersey's CON process.

B.3. In some areas of the State, some reconfiguration of hospitals will take place, through market forces or otherwise. The State currently approaches these problems on a hospital-by-hospital basis, and tends to intervene only when a hospital has failed. This process is unnecessarily disruptive to the communities served in these areas.

Recommendation:

The State health planning process should undertake a review of a troubled hospital's market area to permit a more rational hospital closure and realignment process than results from market forces and the bankruptcy process.

In addition, the Subcommittee strongly recommends that the State of New Jersey create an "Early Warning System" under which representatives of the State, including the Commissioner of Health and Senior Services, a Deputy Commissioner of Health and Senior Services, and the Executive Director of HCFFA (or a senior member of HCFFA), would meet with any hospital CEO and Board of a hospital whose financial indicators moving in the wrong direction early in the process when the hospital might still be able to turn things around. While the Subcommittee did not definitively agree upon the financial indicators to be utilized and instead deferred this to the appropriate Commission subcommittee, we discussed indicators such as "days cash-on-hand, total margin of facility, occupancy, and period of time in which bills are paid. The concept of the Early Warning System is that the State has much data that it receives that shows early signs of hospital distress. Since some members of the Subcommittee expressed concern that hospital boards are not always kept apprised of such distress, this Early Warning System would be utilized to alert the CEO and the Executive Committee of the Board (who can then alert the full board) that the State sees signs of trouble, and give the facility time enough to work on a turn around plan. The feeling of the

Subcommittee is that State officials are often involved in a situation of financial distress when it is too late in the process, and since they end up spending enormous amounts of time with distressed facilities prior to closing, this would be time well spent by all involved.

B.4. The current closure process is unwieldy and too narrowly focused on the hospital itself. If a hospital must be closed, the process should be well coordinated to minimize adverse effects on available health care services within the community, and facilitate the continuation of services in the most effective settings possible.

CON applications for closure authorization usually come when closure is a foregone conclusion. The applications, then, become applications for assistance in maintenance of continued operation of surviving services and in ensuring access to other facilities' resources until shutdown. Problems with cash shortages, labor shifts, and loss of control over the availability of community services can be exacerbated if a bankruptcy court is involved. On the positive side, the CON closure process allows for public involvement and input and often highlights issues related to disposition of employee benefits and essential health care services needs. In limited circumstances, the CON closure process allows the Commissioner to establish conditions for services to continue in a new setting to maintain community access.

The Subcommittee discussed the possibility of shortening the length of time it takes to allow a financially troubled hospital to close, including shortening the completeness review to a specific number of days from application filing. The subcommittee also discussed the coordination of hearing processes required by the State Health Planning Board (SHPB) and the Office of the Attorney General, in order to avoid duplication while protecting the community's interests.

The Subcommittee advocates a revision in the CON statute to emphasize the need, during the closure process, for maintaining and coordinating the continuation of needed services as a facility is closed. The statutory process should focus on the need for the hospital and the Department to plan for a closure, with the goal of facilitating community

notification and input, and supporting the creation of alternative health care services and provision of essential resources, rather than the simple unwinding of the failed hospital business.

Recommendation:

There should be a specific deadline for the Department completeness review of hospital closure applications, along with the Commissioner of Health and Senior Service's final determination. The Department's completeness review should not exceed 60 days, which will allow time for the Department's initial review, submission of questions to the hospital if the additional information is needed and consideration of the hospital's response. Final approval by the Commissioner should occur within 30 days of receiving recommendations from the SHPB.

The public hearing held by the Office of Attorney General pursuant to the Community Health Assets Protection Act and the public hearing held by the SHPB for a CN Closure should be coordinated to occur on one hearing date.

C. Ambulatory care facilities have expanded in New Jersey, as elsewhere. In many cases, for example, ambulatory surgery centers, the facilities compete directly with hospitals. The competitive playing field, however, is not level, as hospitals retain obligations that have not been imposed on ambulatory care facilities.

New Jersey has partially deregulated health care facilities in recent years. Following this deregulation, ambulatory care facilities have increased throughout the State. See Appendices 8.5B and 8.5C. This deregulation, in addition to being partial, is also uneven in its application. For example, ambulatory care facilities, unlike hospitals, are no longer subject to CON requirements, although they are subject to licensing regulations. See P.L. 1998, c. 43. For example, hospitals are required by law to provide "charity care" access for all medically necessary treatments, although the State's reimbursement for those services is in many cases far short of the hospital's cost of providing those treatments. In contrast, ambulatory care facilities have no such obligation, even in those circumstances, such as outpatient surgery, where the hospitals and ambulatory facilities are in direct competition.

Hospitals face hurdles not faced by the ambulatory care facilities in addition to the incompletely reimbursed costs of charity care. For example, most hospital facilities must be available 24/7 in order to serve the needs of emergency departments. In addition, hospitals assert that the ambulatory care facilities with which they are in competition "cherry pick" the less intense cases as well as the insured cases, leaving the more complex and under-insured or uninsured (and therefore more expensive) cases for the hospitals. Finally, hospitals assert that the entrepreneurial nature of modern practice reduces the availability of physician coverage for hospitals, including hospital emergency departments – in part because the charity care system does not pay physicians for their services.

Some of these tensions are the inevitable result of shift in medical practice, as more and more services may appropriately and conveniently be provided in ambulatory settings away from the hospital. The Subcommittee determined, however, that the uneven application of regulations to the two settings exacerbates the effect of this shift, harming hospitals and creating windfalls for ambulatory care providers. The Subcommittee considered two types of regulations in this context: those that mandate the provision of services, and those by which the State engages in oversight, data collection, and quality control.

As to the former, the solutions are somewhat uncertain. The burden of providing charity care, focused as it is solely on hospitals, might be extended to some categories of ambulatory care facilities. For example, New Jersey recently enacted a law that requires outpatient renal dialysis facilities to provide a limited amount of free care. See P.L. 2007, c. 79. In addition, many ambulatory care facilities are required to pay assessments in lieu of providing free care.² The funds derived from this assessment during the 2005 – 2007 period is significant, but many of the Subcommittee believed it was not adequate to fairly offset the cost of charity care provided by hospitals during that time. Some members suggested that a careful study is

² NJSA 26:2H-18.57 establishes the ambulatory care facility assessment. It requires facilities with gross receipts of at least \$300,000 and licensed to provide one or more of the following services to pay a gross receipts assessment: ambulatory surgery, computerized axial tomography, comprehensive outpatient rehabilitation, extracorporeal shock wave lithotripsy, magnetic resonance imaging, megavoltage radiation oncology, positron emission tomography, orthotripsy, and sleep disorder.

Number of Facilities	State Fiscal Year	Total fees collected
287	2005	\$24,100,628
288	2006	\$23,426,868
307	2007	\$26,554,395

necessary to assess the burdens of providing charity care and the impact on hospitals and ambulatory care facilities to determine an equitable and appropriate assessment.

With respect to data collection and quality assurance, the Subcommittee was able to reach concrete recommendations. The Subcommittee determined that the licensure regulations for ambulatory care facilities should be amended to require forms of data reporting and quality control at a level similar to those applied to hospitals, while taking into account the differences between the forms of operation.

C.1. The current structure of health delivery results in direct competition between hospitals and ambulatory care facilities for many services, but the regulatory burden on hospitals to operate emergency departments and to provide care to all regardless of ability to pay or source of payment imposes an imbalance that should be addressed.

Recommendation:

The State should remedy the competitive imbalance between hospitals and ambulatory care facilities to the extent the imbalance is exacerbated by State regulation. If charity care continues to be required to be provided by hospitals across all hospital settings (emergency room, inpatient care, surgery, outpatient care, etc.), the State must take steps to assure that the burden of charity care does not unfairly disadvantage hospitals in their competition with ambulatory care facilities. Similarly, the

requirement that hospitals, but not ambulatory care facilities, accept Medicaid and other public forms of insurance suggests that the State should act so as to avoid this requirement from creating unfair competitive imbalance.

C.2. The migration of increasingly complex services to ambulatory care facilities has not been matched by proportionate regulatory oversight of these facilities. As a result, the State may not adequately monitor the service quality, payer mix, and administrative structure of these facilities.

Recommendation:

The Department of Health and Senior Services should review the reporting requirements of ambulatory care facilities to ensure that it receives appropriate information to permit it to monitor the quality of the care provided, and to ensure it receives appropriate data on utilization, payer sources, cost reporting, and the identity and number of practitioners participating in care. The gathering of these data could be provided through the use of uniform bills and other reporting mechanisms now employed to gather information from hospitals.

The Department should examine whether it can adopt the standards employed by such organizations as the Accreditation Association for Ambulatory Health Care (AAAHC) or the American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) for these purposes. Adopting approval by these oversight entities as “deemed

status” for at least some purposes could streamline the regulatory process for both the Department and the facilities.

C.3. The Department should develop reporting mechanisms and implement reporting requirements for ambulatory care facilities to provide complete data regarding utilization, patient visits by payment source, number of visits, number of practitioners, cost reporting and quality measures. In addition freestanding ambulatory care centers must issue a uniform bill (UB04) for all patients so volumes and referrals may be tracked. Ambulatory care centers should have to comply with all aspects of the Patient Safety Act, and be subject to the same reporting and quality requirements as hospitals. Physician specific data should be unbundled so that physician referral patterns may be tracked and evaluated.

D. The governance of non-profit hospitals in New Jersey is accomplished through the leadership and/or contributions of volunteer directors and trustees. The structure of this governance and the regulation of non-profit boards have changed little during the decades in which the operation of hospitals has grown increasingly complex. The regulation of these boards and the recommendation of best practices to their members should be reviewed and brought up to date.

Non-profit hospitals rely on their boards to oversee the hospital’s management, and to ensure that the hospital operates in a way that is consistent with the needs of the community. Those boards are populated by volunteers, often people from the community with little experience in the oversight of entities operating on the scale of modern hospitals, and frequently with little familiarity with hospital operations. This community source and orientation of board members has remained unchanged as hospitals have become more complex.

Several national organizations have examined the role, structure and regulation of non-profit boards, including the boards of non-profit hospitals in recent years. The Joint Commission, the American Law Institute, and the

American Health Lawyers Association are all engaged in such reviews.

D.1. Board members need appropriate education on their obligations, their hospital’s mission, and the operations of non-profit hospitals. Orientation of new members is particularly important.

Recommendation:

The law requiring new hospital board members to attend orientation sessions should be implemented to maximize new members’ ability to engage in appropriate oversight. N.J.S.A. 26:2H-12.34.

D.2. New Jersey law vests with the Attorney General the responsibility of overseeing the conduct of the boards of not for profit corporations. This oversight is particularly important as not for profit corporations, unlike for-profit corporations do not have shareholders with an interest and the ability to monitor the corporation’s conduct. The Attorney General is charged by law with filling this void by exercising appropriate oversight of board conduct.

Recommendation:

The New Jersey Attorney General should respond appropriately to information, from whatever source, tending to show that the board of a non-profit hospital is derelict in its obligations to carefully oversee the management of the hospital. It should investigate promptly to determine if board misconduct or inattentiveness imperils the hospital. The Department, as the regulatory agency most intimately familiar with hospital operations, should in appropriate cases make referrals to the Attorney General for such purposes. The Attorney General should intrude into board affairs only when necessary to preserve the hospital’s community mission.

D.3. The Subcommittee recognizes concerns that board members are sometimes unaware of a hospital’s financial difficulties until too late, and that they are sometimes not provided by

hospital management with adequate information to respond to financial crises.

Recommendation:

Hospital management should be encouraged to share appropriate financial information with board members on a timely basis. The Department should work with hospital management, boards, and the HCFFA to ensure that boards are aware of financial crises as well as the options available to salvage the hospital's resources and health care mission, on a timely basis. Sale and closure should not occur in circumstances of extreme crisis, and should be initiated well before significant dissipation of assets and allow conversion of resources to sustainable uses that are mission-consistent.

D.4. Information regarding the makeup of hospital boards, even including the names of the people who serve as directors or trustees, is often not available to the people of the community. Hospitals are important community assets, and the governance of boards should be approached with an eye toward transparency.

Recommendation:

Information regarding the governance of hospitals should be available to the people of the community. While dated, much of the information is available on the Internet for those who know where to find it at locations such as www.guidestar.com.] Some Subcommittee members believed Hospital Boards should place information on the hospital's website, including their Form 990, an information return that most secular exempt organizations with incomes above \$25,000 are required to file annually with the IRS, to permit easy access for the public.

D.5. Board governance in the for-profit sector has been rocked by repeated scandals in recent years, as board members and management have intentionally flouted their responsibilities to their shareholders and the public. One result was the passage of the American Competitiveness and Corporate Accountability Act of 2002 (the "Sarbanes-

Oxley Act"), which mandated certain corrective steps in corporate governance. Many of the steps mandated for commercial firms have been recommended for adoption by non-profit firms.

Recommendation:

The Department should mandate the adoption of suitable portions of the Sarbanes-Oxley requirements by non-profit healthcare facilities. It should be noted that time constraints prevented the subcommittee from identifying which provisions of Sarbanes-Oxley should be extended to non-profit providers in New Jersey.

E. The relationship between hospitals and their physicians is sometimes not harmonious, and instead creates competitive tensions. As is described above, ambulatory care facilities are in direct competition with hospitals for some services, and those facilities are often operated by the hospital's own physicians. In addition, hospitals and physicians can experience conflict on the management of patients within the hospital, and can disagree on the obligations of physicians to cover needed patient care services within the hospital.

Several developments in health finance have combined to complicate the relationship between hospitals and physicians. As is noted above, hospitals have contended increasingly with competition from ambulatory care facilities. Those facilities are typically owned by physicians. The physician-owners perform procedures in these ambulatory care facilities that they had previously performed in the hospitals with which they now compete.

New Jersey and federal law limit the ability of physicians to refer patients to facilities in which they have an ownership interest. See 42 U.S.C. 1395NN (the "Stark Act") and N.J.S.A. 45:9-22.4 *et seq.* (the "Codey law"). There is currently conflicting authority on the proper interpretation of the Codey law. The Board of Medical Examiners has described an interpretation of the Codey law that permits physicians to refer to ambulatory care facilities in which they have

an ownership interest, while a recent Superior Court decision has articulated a narrower interpretation. Several members of the Subcommittee urged that the law is most properly interpreted narrowly to restrict many of the forms of ownership and referral currently permitted under decisions of the New Jersey Board of Medical Examiners.

In addition, the Subcommittee considered the tensions that distort hospital finances when payers – particularly but not exclusively Medicare – create incentives for hospitals to economize on patient care and simultaneously for physicians to practice expansively within the hospital. As it is physicians and not hospitals that control admission, management, and discharge of patients, this conflict is difficult for hospitals to manage. This issue, as the Subcommittee was informed, is within the charge of another Subcommittee.

Finally, the changing economic pressures and incentives experienced by physicians interfere with a cooperative relationship by which hospitals have historically staffed necessary services such as emergency departments. Physicians are under increased pressure to stay in their offices, seeing patients, rather than taking call at hospitals. In addition, some of the call services are in direct conflict with the activities of some of these physicians within their outside ambulatory care facilities.

E.1. Hospitals, physicians, and proprietors of ambulatory care facilities disagree on the proper scope of self-referral laws, particularly the Codey law. It is in New Jersey's interest to have this conflict resolved quickly.

Recommendation:

The Department, in conjunction with the Office of the Attorney General, Division of Consumer Affairs and the Board of Medical Examiners, should take measures to ensure that the self-referral provisions of federal and state law are properly enforced.

E.2. Hospitals and physicians are subject to conflicting pressures with respect to the management of hospital patients. This conflict distorts the management of hospitals, and limits the ability of hospitals to manage patient care consistently and appropriately.

Recommendation:

The Department should examine methods to align the incentives of hospitals and physicians in the management of patients, consistent with appropriate patient protection standards.

E.3. Changes in physician practice has eroded the ability of hospitals to rely on voluntary staffing by physicians of necessary hospital services.

Recommendation:

The Department should undertake a comprehensive review of this problem in conjunction with hospitals and physicians. To the extent it can be addressed cooperatively by accommodating the needs of all parties, such cooperative solutions should be favored.

Appendix 8.5A
Regulatory and Legal Reform Subcommittee Members

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Charles Wowkanech

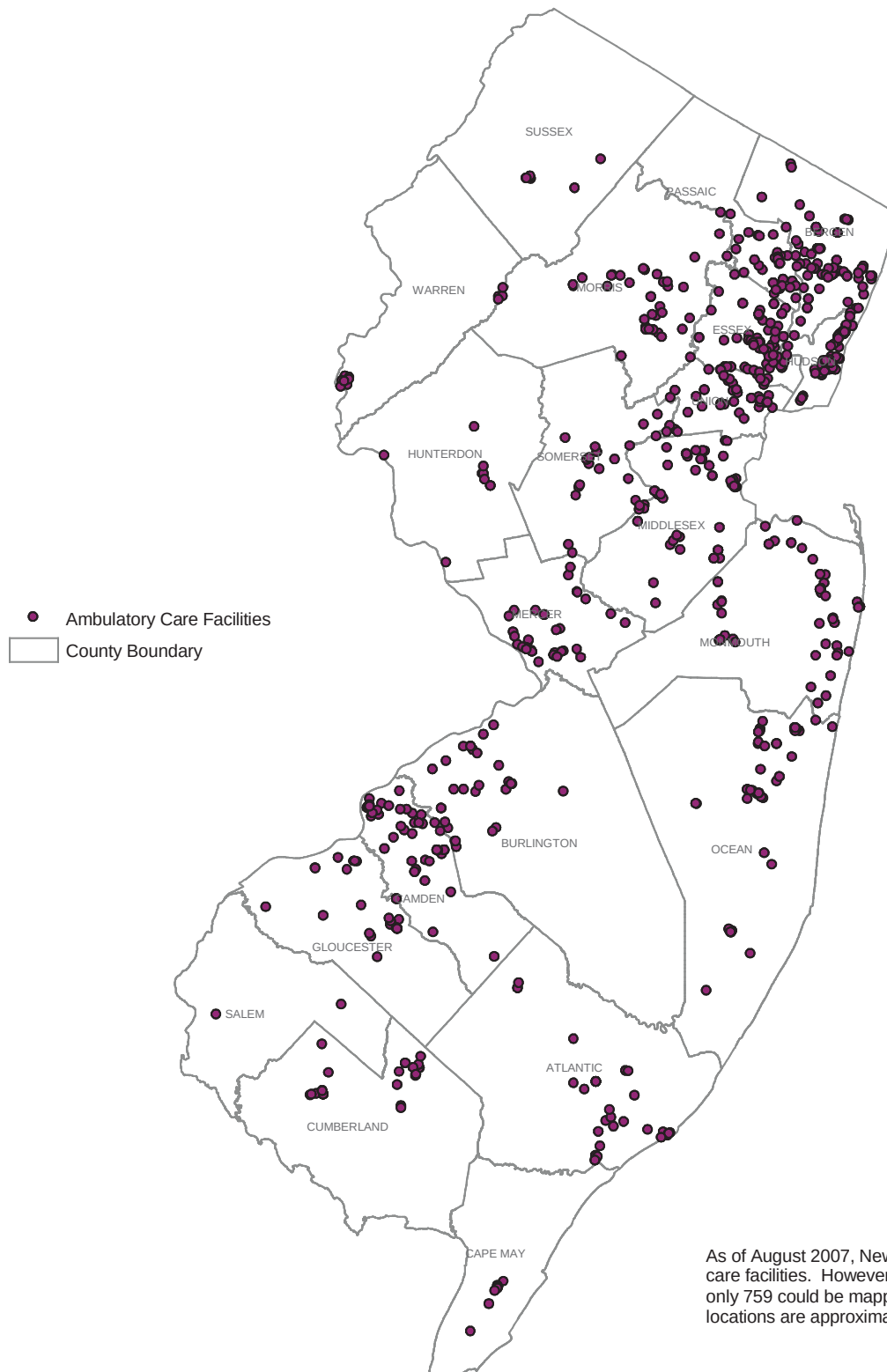
President
New Jersey State AFL-CIO

Barbara Wright, Ph.D., R.N., FAAN

Policy Advisor

Appendix 8.5B

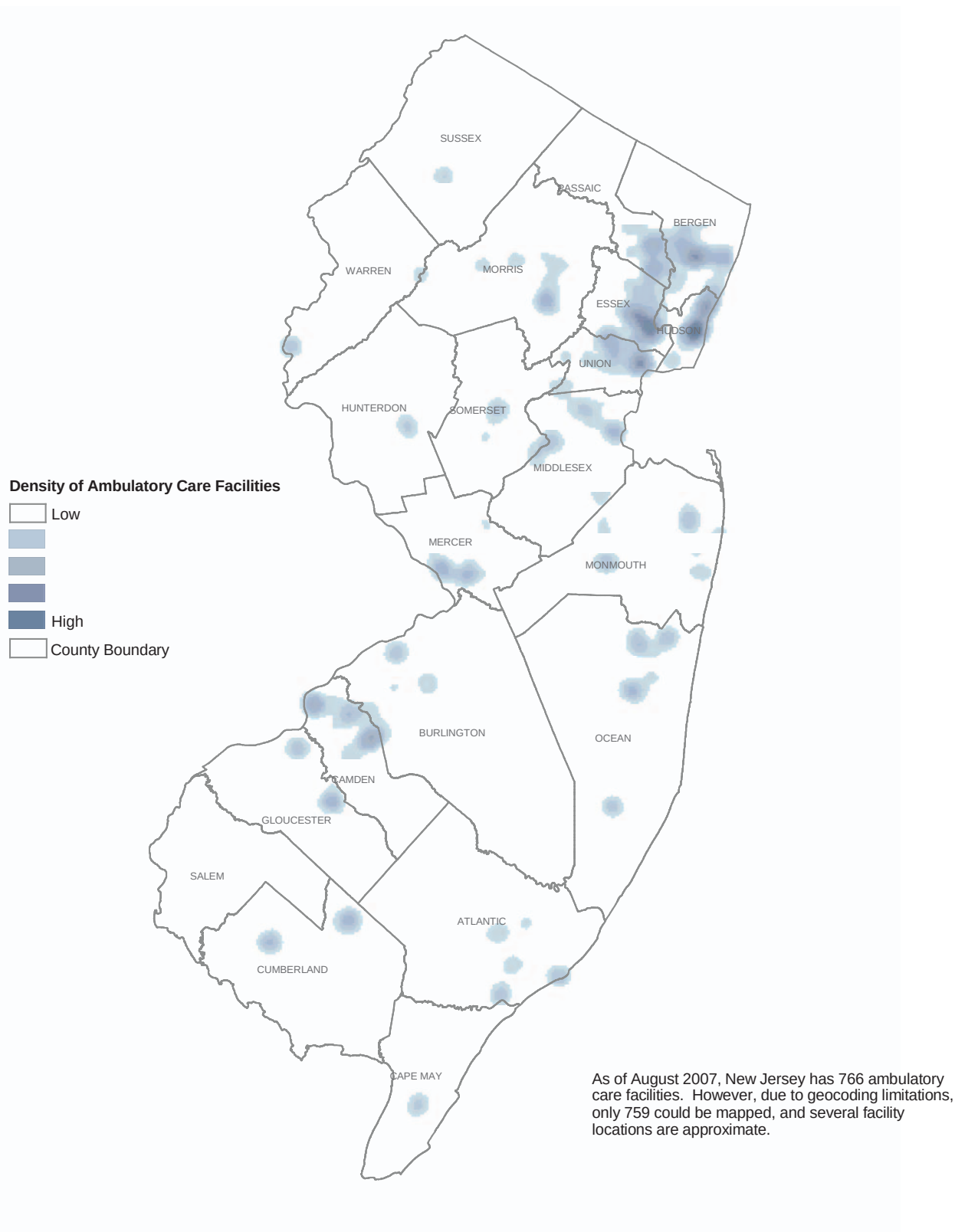
Ambulatory Care Facilities, New Jersey



As of August 2007, New Jersey has 766 ambulatory care facilities. However, due to geocoding limitations, only 759 could be mapped, and several facility locations are approximate.

Appendix 8.5C

Ambulatory Care Facilities, New Jersey



Appendix 8.6: FINAL SUBCOMMITTEE REPORTS

Subcommittee Report 6: **Hospital/Physician Relations and Practice Efficiency**

Executive Summary

- The present report represents the work of the Subcommittee on Hospital/Physician Relations & Practice Efficiency, one of six empanelled to advise the Commission on Rationalizing Health Care Resources in New Jersey Commission established under Executive Order 39, promulgated by Governor Jon S. Corzine on October 19, 2006.
- The Subcommittee on Hospital/Physician Relations and Practice Efficiency was charged to:
 - Identify and characterize the most significant factors and aspects of the relationship among New Jersey's acute care hospitals and physicians.
 - Focus on high-cost high reward aspects of physician practices and performance.
 - Evaluate the importance and application of available standards and metrics.
 - Report findings and recommendations to the full Commission.
- The Subcommittee met in plenary session four times with additional workgroup meetings, considered expert opinion and information, raised issues and discussed possible initiatives and action in the following four areas:
 - Payment System
 - Institutional infrastructure
 - Metrics and Reporting
 - Regional Coordination
- The Subcommittee's attention was drawn to several areas that bear critically on hospital and physician relationships but which are too broad to fit within its charge. Reform and change in these areas is vital to the long-term improvement of New Jersey's health care system.
 - Regionalization of health care resource allocation and utilizations.
 - Tort reform.
 - Medical Malpractice insurance reform and relief.
 - Alternative concepts for delivery of acute care services.
- The Subcommittee proposes ten recommendations specifically addressed to improving hospital and physician relations and improving practice efficiency.
 - These recommendations are especially relevant and essential for financially stressed institutions.
 - These ideas also have general applicability to and offer value to all acute care institutions.
 - These recommendations are summarized below for ready reference and discussed in detail in the body of this final report.

Summary Recommendations

- 1. Encourage alignment-oriented payment systems** or models for acute hospital care that financially impact, engage and involve physicians.

Structural non-alignment of financial incentives invites abuse and rewards medically irrational and counter-productive decisions.
- 2. Promote physician accountability** through a physician report card of evidence-based acute care performance and outcomes measures.

Evidence-based medicine standards are under-utilized and un-enforced in the acute care setting.
- 3. Coordinate care** from admission through post-discharge with standards and incentives based on quantitative metrics and results.

Coordinated patient care from admission through in-patient treatment to discharge and follow-up treatment and services is not the standard of care in New Jersey.

- 4. Increase institutional transparency for acute care costs,** utilization and care alternatives to enable cost and treatment-effective decisions.

Imperfect knowledge of acute care costs and resources inhibits informed, rational choices, decreases trust and confidence and disables accountability.

- 5. Establish 365 day standards of operation** for an expanded range of services that optimize acute care resources utilization.

Service and coverage reductions on weekends and off-hours inhibit best practices and cost-effective resource utilization.

- 6. Set standard and parameters for physician on-call obligations** for emergency department service regionally and state-wide.

Hospitals cannot impose ED service call obligations on physicians, and often pay significant fees to secure essential coverage.

- 7. Make “intensivist model” the standard of ICU care** and a priority for all hospitals, especially financially distressed institutions.

Intensive Care Units provide patients with life-sustaining medical and nursing care on a 24-hr. basis but are not typically staffed with optimally trained personnel.

- 8. Leverage scarce physician services** through the expanded use of practice-extenders and other means to increase effective access and availability.

Scarcity of key medical specialties can create service bottlenecks and inefficiencies.

- 9. Exploit existing IT systems** and technology to enhance physicians-hospital interaction, improve access to in-patient data, and take greater advantage of information resources.

Hospitals do not to take advantage of IT to increase interaction with physicians.

- 10. Create an acute care data warehouse,** hospital network, and uniform data standards and formats.

Comparative hospital performance metrics, data compatibility and exchange capabilities are lacking in New Jersey.

Subcommittee Membership

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Vice President for Medical Affairs & Chief Quality Officer, Christ Hospital

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President and CEO, Robert Wood Johnson Foundation
Member, Commission on Rationalizing Health Care Resources

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President, New Jersey Chapter, American College of Physicians

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Introduction

On October 19, 2006, Governor Jon S. Corzine promulgated Executive Order #39, identifying the need to examine the availability and delivery of health care services in New Jersey, and develop recommendations toward the creation of a state wide health plan. The Commission on Rationalizing Health Care Resources in New Jersey, chaired by Dr. Uwe E. Reinhardt, Professor of Economics and Public Affairs, Woodrow Wilson School, Princeton University was established to implement the Order.

The work of the Commission was assigned to six subcommittees, each addressing a particular topic relevant to the overall mission. The present report represents the efforts of the Subcommittee on Hospital/Physician Relations & Practice Efficiency, co-chaired by Risa Lavizzo-Mourey, MD, Co-Chair, President and CEO, Robert Wood Johnson Foundation, and Anthony C. Antonacci, MD, SM, FACS, Co-Chair, Vice President for Medical Affairs & Chief Quality Officer, Christ Hospital. Fred M. Jacobs, M.D., J.D., Commissioner, Department of Health & Senior Services, also served on this subcommittee.

Charge

The Subcommittee on Hospital/Physician Relations and Practice Efficiency will:

- Identify and characterize the most significant factors and aspects of the relationship between New Jersey's acute care hospitals and physicians affecting institutional viability and financial integrity, cost-effective use of resources, physician relations and practice efficiency, and the delivery of quality health care.
- Focus on high cost-high reward aspects of physician practices and performance. Examine key criteria, including: length of stay, prescription drug charges, procedure charges, consults, etc.
- Evaluate the importance and application of available standards and metrics, e.g., best practices, Leapfrog, "report cards", etc., paying special attention to the impact and importance of these issues to the situation of New Jersey's most financially stressed acute care hospitals.
- Report findings and conclusions to the full Commission and recommend institutional, legislative and policy initiatives that will positively

impact the financial and care crisis affecting New Jersey's acute care institutions.

Membership

The Subcommittee on Hospital Physician Relations and Practice Efficiency consisted of 23 individuals who freely contributed their time and energy to achieving its goals. Candidates were identified and selected through a painstaking process undertaken by the Commission, its Executive Director and the Governor's Office of Appointments. The membership of the subcommittee now represents a wide range of interests, backgrounds and perspectives relevant to many of the shared concerns and issue affecting hospitals and physicians. A list of members and administrative personnel appears immediately before the introduction to this report.

Meeting Schedule:

The Subcommittee held four meetings in the course of its operations. The initial meeting was held at the Department of Health and Senior Services, the Robert Wood Johnson Foundation provide meeting space, conference facilities and amenities for the second and third meetings, and the final meeting was hosted by the Medical Society of New Jersey. The Subcommittee gratefully acknowledges the organizations and their staff for making the required arrangements. The schedule of meetings held appears below:

- July 5, 2007
- July 24, 2007
- August 21, 2007
- September 10, 2007

Methodology

The Subcommittee convened its initial meeting under the co-chairship of Drs. Risa Lavizzo-Mourey and Anthony C. Antonacci on July 5, 2007. Fifteen members attended in person and 7 by conference call. The meeting proceeded in open discussion resulting in a decision to develop and circulate a conceptual framework that would guide the work to be done.

A second meeting was held on July 24, 2007 with 20 members present and one call-in. The conceptual framework was reviewed and a decision made to divide the work of the Subcommittee among four areas of strategic focus:

- **Payment System** – addressing issues of discontinuities and disparities among payors, individual providers and institutions, in compensation, reimbursement and their relationship to abuse and medically irrational and counter-productive decisions.
- **Institutional Infrastructure and Support Systems** – addressing the unmet needs of acute care institutions for systems and procedures that incorporate best practices and make optimum use of available resources to minimize excess costs, delays and waste.
- **Institutional Reporting and Metrics** – addressing the potential for improving adverse event and outcome reporting and quality metrics throughout New Jersey's acute care facilities.
- **Regional Coordination of In-Patient and Out-Patient Care** – addressing deficiencies in pre-admission and post-discharge care and follow-up to minimize admissions, maximize clinical progress, and reduce readmission rates.

Each member picked an area of interest and contributed in subsequent work sessions.

Workgroup assignments were as follows:

WG1 - PAYMENT SYSTEM

Gregory J. Rokosz, D.O., J.D.
William A. Rough, MD
William B. Felegi, D.O.
Robert Spierer, MD
Ira P. Monka, DO
Richard G. Popiel, MD, MBA
Michael J. Kalison, Esq.

WG2 – INFRASTRUCTURE

Carolyn E. Bekes, MD
Linda Gural, R.N.
Benjamin Weinstein, MD, PhD
Virginia Treacy
Sara Wallach, MD

WG3 - REGIONAL COODINATION

Anthony C. Antonacci, MD, Co-Chair
Henry Amoroso
Ann Twomey
Joseph W. Kukura, Rev.
Michael Shebabb, CPA
Gary S. Horan

WG4 - METRICS AND REPORTING

Risa Lavizzo-Mourey, MD, Co-Chair
Darlene Cox
Charles M. Moss, M.D.

These work groups each produced a brief report and recommendations which provided the basis for further discussion and comment and formed the foundation of this report.

On August 21, 2007, the Subcommittee held its third meeting. Sixteen members attended, with three call-ins and 4 members unavailable. The work groups shared their discussions, findings and recommendations with the entire subcommittee. Comments and suggestions were noted. Core recommendations were prepared and circulated prefatory to submission of a draft report to the membership for review and revision.

All input was collected and incorporated in a draft report sent to the membership in advance of the final meeting of the Subcommittee held on Monday, September 10, 2007 at the Medical Society of New Jersey. Twenty-one members attended with three call-ins and one member unavailable. Comments, changes and editorial suggestion were made and a final report sent by email for approval. The present final report represents the end-product of that process.

General Observations and Comments

The New Jersey Commission on Rationalizing Healthcare Resources is focused on the situation faced by New Jersey's most financially distressed hospitals and the critical factors contributing to their distress. The tasks of its subcommittees are aimed at identifying problems and issues and developing recommendations that will aid institutions in crisis regain a sounder financial footing, improve management and efficiency, enhance the delivery of quality health care, and maintain essential services in light of current and future health care needs.

The Subcommittee on Hospital Physician Relations and Practice Efficiency has made a number of specific recommendations which it believes may together or separately contribute to improving elements of the relationship among New Jersey's acute care hospitals and their physicians. While many of these recommendations will require the agreement and collaboration of different stakeholders and may take considerable time and energy to implement, the governors, trustees and senior management of each acute care institution bear direct and ultimate responsibility for the fortunes of facilities under their collective direction and control.

Management, oversight and direction of the State's acute care institutions must start from within, be driven from the highest levels of executive authority, and carry the weight of organizational commitment. Each individual holding a senior position of responsibility must understand his or her role as an active and engaged participant in the life of the hospital, and understand that role as one for which they can and will be held accountable.

The Subcommittee is also aware that its recommendations cannot be considered apart from larger issues affecting health care in New Jersey. Issues such as the state's fiscal crises, medical insurance and tort reform, economic and life-style pressures on physicians, the needs of New Jersey's highly diverse population, and the growing number of under- or non-insured persons all contribute to and complicate the present crisis.

Acute care facilities in New Jersey share a responsibility to deliver a comprehensive range of care to all persons,

regardless of their ability to pay. Notwithstanding, it is impossible and irrational, medically, economically and otherwise to maintain identical capabilities at all acute care institutions. Some form of regional coordination is essential to rationalize the utilization of scarce resources and provide essential services to all populations in the state. Regionalization of scarce health care services must play a key role in rationalizing health care in New Jersey.

Medical malpractice insurance costs and the threat of costly, even devastating litigation is a powerful disincentive to systemic reform, practice improvement, and innovation. It dissuades physicians from practicing in this state and contributes to shortages in key specialties. Tort reform is a politically charged, legislatively challenging but essential component of a long term solution to New Jersey's health care crisis.

Declining revenues are as much a cause of the financial distress experienced by many of New Jersey's Hospitals as rising expenses. In a long-term trend, both private and public payors have reduced payments and reimbursements for medical services, consumables and resources, and have adopted more restrictive authorization standards. The financial squeeze is exacerbated by the growing impact of non-paying users – the uninsured or under-insured.

It is beyond the scope of this report to examine or comment on the implications, justifications and rationale for the present state of affairs – it may be enough to observe that even as the base of adequately insured, paying patients weakens, the weight of uninsured care grows unabated. This is a questionable recipe for a sustainable system of care.

Physician-owned for-profit ambulatory care centers have made significant inroads into the traditional profit base of many acute care institutions. It is increasingly difficult for traditional acute care institutions to derive sufficient income from insured patients and high-value procedures to offset the costs of uninsured charity care. State charity care payments defray only a portion of those costs. While ambulatory care centers undoubtedly meet a growing market demand and often offer a cost- and quality effective alternative to acute care institutions, there are pragmatic as well as ethically grounded reasons that argue these centers should share some of the charity care burden.

In some localities, the state is now virtually supporting certain acute care institutions. Close scrutiny and oversight of performance and management are required in circumstances where significant public funds are being spent. The imposition of these controls, however, is creating something very like virtual public hospitals. This unintended consequence begs the question of whether, assuming the prospects of these institutions is unlikely to change, instituting some more formal and explicit system of public health care ought, in some cases, be examined as an alternative.

Regardless of which recommendations may be selected for further study, the Subcommittee strongly urges that all “stakeholders” be involved from the earliest planning stages through implementation and ongoing management and oversight of initiatives. Only if all parties affected understand the crisis, are assured their interests are represented and viewpoints considered, and have confidence that needed changes and compromises further the common good and not a private or partisan agenda will there be reasonable prospects for success. Private, not-for-profit and public entities can play a vital role in the necessary process of public education, discourse and debate.

Much use of the term “stakeholders” is made in this report and elsewhere in discussing the healthcare system. In the interests of clarity the Subcommittee offers its own, non-exclusive list of “essential” stakeholders and potential participants:

New Jersey’s acute care hospitals and health care systems
 Medical Society of New Jersey (MSNJ)
 The New Jersey Association of Osteopathic Physicians and Surgeons (NJOAPS)
 New Jersey Hospitals Association (NJHA)
 Catholic Health Partnership of New Jersey
 New Jersey Council of Teaching Hospitals (NJCTH)
 State Board of Medical Examiners
 New Jersey State Nurses Association
 Physicians’ professional associations
 Private medical insurers and payors
 Health care worker’s unions and associations
 Public Sector payors (Medicaid, Medicare)
 New Jersey Department of Health and Senior Services (NJDHSS)
 New Jersey Department of Banking and Insurance (NJDOBI)

Issues, Findings and Recommendations

The Subcommittee has selected what, in its view, are the most critical issues for New Jersey’s acute care hospitals and physicians. While many of the recommendations made in this report can be expected to make a significant impact on financially distressed institutions, they also have broad relevance for the relationships among New Jersey’s acute care hospitals, physicians and payors, as well as the communities they serve.

The relationship among New Jersey’s acute care hospitals and the physicians who provide essential care is complex, and no one factor or solution can be identified as either the cause or cure for all problems and risks. Some of the more salient aspects of the situation are mentioned below:

- Hospitals and physicians do not operate on a common or compatible set of practice-oriented and financial concerns with respect to the medical management of patients and the provision of in-patient services.
- Hospitals have not provided financial details and transparency on the cost of services or care. It is not surprising that physicians have little appreciation of the cost implications of their care and treatment decisions on hospitals.
- Physicians face little accountability for consumption of hospital resources, consults, length of stay, etc. Over-utilization of medical resources and “defensive medicine” is common practice at many institutions.
- There are no accepted standards of measurement for hospitals and physicians and consequently no means to compare or evaluate performance, quality, effectiveness and efficiency.
- New Jersey physicians have not, in many instances, been quick to adopt even the most widely recognized and accepted evidence-based protocols, guidelines, and best practices.
- There are no financial incentives to coordinate care or assure patients have access to continued care once they leave the hospital.
- Economics of small practice groups which characterize the New Jersey market makes broad-based innovation and change more difficult than in markets characterized by larger specialty group and multi-specialty group practices

The Subcommittee on Hospital Physician Relations and Practice Efficiency believes its findings and recommendations provide insight and guidance for the better management of acute care facilities in general and especially those facing financial challenges.

Payment System

Closer alignment of hospital and physician financial incentives for hospital care almost certainly holds significant potential for improving cost efficiency and rationality of health care resource utilization. There are several strategies that may be employed to help achieve such a goal including goal-based incentives, reimbursement systems for physicians based on severity-adjusted Diagnosis-Related Groups (DRGs) or Relative Value Units (RVUs), or other means of sharing gains in productivity and cost-savings. Detailed study and evaluation of plans and strategies for improving alignment of payors¹, hospital and physician financial incentives is a key recommendation.

Certain physician practices and behaviors can have a significant impact on the effectiveness (quality) and the efficiency (resource consumption) of outpatient and inpatient care resulting in waste, inefficiency, delay and unfunded inpatient care. For example, a commercial payor may deny or downgrade a hospital stay as medically unjustified, but nonetheless reimburse the physician responsible for the decision. Medicare payors pay hospitals a fixed rate, but hospitals remain at risk if a physician is an inefficient user of hospital resources. Presently, hospitals have no effective means available to correct, discipline, or exclude outliers and even outright abusers.

On the other hand, New Jersey physicians receive some of the lowest reimbursement rates in the nation for treating Medicaid patients, while hospitals are paid at considerably higher rates. Such a misalignment of incentives is regarded as a key reason for lack of physician availability in hospitals serving a large proportion of Medicaid patients.

Better alignment of financial and practice incentives among hospital systems, physicians and payors will help

close service gaps, reduce counter-productive attitudes, and encourage more cost-effective practices. Any such initiative must take measures to avoid the risk that, as physicians and hospitals payments are more closely aligned, patients' interests may be unduly constrained. For example, patients who, for medical reasons, should receive extended or more intensive care may be faced with increased or more complex barriers. Safeguards including procedural checks, rights to second opinions, and a swift and straightforward route of review and appeal are essential to assure fairness and protection of patient rights as the economic interests of physicians, hospitals and payors are brought into alignment.

Institutional Infrastructure and Support Systems

Hospital infrastructures and support systems are in many cases ill-adapted to present institutional needs, financial realities and physician practices. Attempts by physicians and hospital staffs to compensate for these deficiencies can result in practices and behaviors that can weaken the institution and diminish the quality of care.

Unlike some hospital resources, sickness, disease and trauma do not diminish on weekends and holidays. Service and coverage reductions on weekends and off-hours impact more than patient care and convenience. They can result in needlessly extending hospital stays, may place patients at greater risk for hospital related complications, and cause waste and delay. New Jersey's acute care institutions should consider the economic feasibility of providing a more comprehensive range of services every day of the week to ensure timely and effective care, optimize resource utilization, and control costs.

Physician availability, particularly among certain specialties and especially in the ED, is a major limiting factor in improving the overall performance of ED services and optimizing the use of physical and human resources on a daily basis. There is a growing disinclination among some physicians to accept traditional on-call obligations, an increasing trend toward limiting care for charity cases to the initial ED encounter, little apparent interest in innovations such as the increased use of practice extenders, or receptivity to improvements in practice and practice models.

¹ "Payors" as used here refers to public and private third party payers, and excludes self-insured individuals or co-payees.

Reductions in public and private physician reimbursements, increasing concerns over medical liability, life-style issues, and increasing numbers of under- or uninsured individuals all play some role in creating and perpetuating this situation. Physicians must become active partners and be convinced of the value to themselves and their patients of making practice changes and working with their institutional partners to achieve desired changes.

Metrics and Reporting

Establishment of standards and measures of quality, outcomes and efficiency for physicians and hospitals is a key to strengthening the acute care system. It is well established that measurement improves performance among hospital staff, physicians, and institutions in general. Tracking resource utilization, length-of-stay, end-of-life issues, and performance on key clinical indicators associated with the most frequently used DRGs, among other metrics, is a key to raising quality, efficiency and performance.

Lack of confidence in and acceptance of performance criteria, collection methods, data analysis and reporting have been major hurdles to agreement on the meaning and interpretation of results, their relevance and validity, identifying problems, and deciding on action steps and solutions. The logistics, IT resources, expertise and costs involved in developing establishing and maintaining state-wide metrics and reporting are significant. No one institution can or should bear this cost. The source of funds to defray expenses and provide the necessary resources requires serious and careful consideration. Unless these issues can be resolved, they will mean defeat for any effort to establish quantitative standards.

The implementation of professionally endorsed, evidence based, and unbiased institutional and physician metrics and reporting would be a major step forward in realizing the benefits of evidence-based medicine on a broad scale in New Jersey. Active engagement of all key stakeholders in the endeavor is essential.

Regional Coordination of Health Care

Regionalization can be an important strategy in achieving a more rational and sustainable health care system. Coordination of care on a regional basis involves redefining acute care “market areas” within a broadened conceptual framework. Such a framework must take into consideration a range of economic and demographic factors and an evaluation of the “essentiality” of both institutions and key services modules.

Regionalization is one way hospitals may achieve the goal of providing a comprehensive range of services on an everyday basis. It is very likely some institutions will find it impossible to provide all such services in the face of shortages of key specialists, or simply because it is economically unfeasible to do so. In such cases, providing certain services on a regional basis may be the best workable solution.

The concept of Centers of Excellence is not new in the health care field but is one that can be readily adapted to provide enhanced service and quality, sounder financial management, and improved utilization and efficiency on a regional basis. New Jersey has already made a significant move in this direction with the establishment of its Level 1 Trauma Centers. Conditions of a non-emergent nature could be candidates for similar programs.

The subcommittee is aware this topic is receiving in-depth consideration by other subcommittees advising the Commission and is confident their recommendations will be in accord with its own concerns.

Critical Areas for Structural Reform

Regionalization of health care resources, tort reform, restructuring medical malpractice insurance within New Jersey and consideration of alternatives to traditional concepts and patterns for delivering acute care will have profound and far-reaching impact in and outside the health care system. While specific recommendations for change and reform in these areas are outside the charge and scope of this Subcommittee, these issues are regarded as so crucial to the long-term resolution of New Jersey’s health care crisis they demands mention

here, even in summary manner. The Subcommittee is confident these subjects are being thoroughly studied by other subcommittees advising the Commission and that well-considered recommendations will be forthcoming.

Regional Coordination of Health Care

Regionalization of scarce health care services offers some of the most challenging and potentially rewarding opportunities to rationalize New Jersey's acute care system. There is a wide disparity across the state in the scope, quality and availability of acute care services. Acute care facilities in New Jersey vary considerably in their economic resources, physician and staff availability, scope of physical plant and in-house capabilities and services.

Many institutions are essential to their service areas but cannot, for financial or other reasons, provide all needed services on a sustainable basis. Conversely, there are other institutions with ample physical plant and medical resources which would benefit from increased utilization. Nevertheless, they all have an equal responsibility to deliver a comprehensive spectrum of care to all persons, regardless of ability to pay.

Regional coordination will require either regulatory or legislative action and in any case will not be immediately attainable. An effective plan of regionalization must take into account a thorough assessment of community needs on a local and regional basis. Such a plan may need to encompass adding or expanding essential services where gaps are identified, as well as combining capabilities and eliminating or reducing clinical redundancies. Support will be required to assist institutions transitioning operations from non-essential to essential services, and relocating under-utilized resources and capabilities to more robust institutions. Above all, hospitals (and other key stakeholders, such as unions) must be persuaded such far-reaching structural changes are in their best long-term institutional and financial interest.

The following points represent some of key issues and concerns that will arise in considering how regionalization can be realized:

- What is the structure envisaged? Vertical (acute, rehab, LTC, etc.)? Horizontal (new shared service entities)? Hybrid?

- Community needs must be balanced against institutional viability and rationality at every point in the process of regionalization.
- Are physical, intellectual and human resources being rationalized, re-used, recycled, retooled and restructured wherever possible?
- Is there a net positive impact on quality care, access and cost? How does this break down by patients, physicians, communities, payors, and caregivers?
- How well are logistics, transportation, and community needs addressed?
- Does the regionalization plan serve a broad range of patient needs efficiently and effectively?

Regionalization should be initiated on a demonstration or pilot basis, with the involvement and oversight of the Commissioner, Department of Health and Senior Services. Such an initiative should engage and involve all key stakeholders, including community groups, payors, physicians, institutional staff and management and focus on meeting service gaps in critical specialties and redirecting utilization of scarce resources. Hudson County may be especially well-suited for such a demonstration project.

Reformation of Tort Liability Law

There is now a serious lack of key specialties in New Jersey (e.g. obstetrics, neurosurgery, mammography services) driven in part by the reputation of New Jersey's courts as "plaintiff-friendly" and the steep rise in medical liability insurance rates. Action by the legislature will undoubtedly be needed if meaningful tort reform is to become a reality in New Jersey. Comprehensive tort reform represents a formidable political and legal challenge but remains one of the key objectives for improving the long-term viability and vitality of New Jersey's health care system.

A crucial objective is ensuring the continued availability of essential on-call specialties and reducing the disparity in tort liability between acute care institutions and physicians providing ED services. This could be accomplished by raising the tort standard from simple negligence to gross negligence/willful misconduct for all care rendered for such services by on-call physicians.

Medical Malpractice Insurance Relief

Increases in medical liability premiums in New Jersey have contributed to a crisis in both the availability and affordability of mandatory medical liability insurance. Moreover, recent court decisions suggest a continuing judicial bias in favor of plaintiffs, notwithstanding contractual and other legal barriers. A key long-term objective should be to ameliorate the burden of medical liability insurance first on specialists in high risk practice areas to ensure New Jersey residents continued access and availability to these vital services, and then more generally to physicians in all lines of practice.

The state should explore affordable, alternative means of obtaining insurance at appropriate levels, while maintaining the right of injured individuals to recompense for damages. It may also be feasible to condition such preferred liability coverage to approved programs that incorporate compliance with well-validated and widely recognized, evidence-based standards of care and treatment.

Comprehensive medical malpractice insurance and tort liability reform must be part of long-term plans to rationalize health care resource utilization in New Jersey. Targeted tort reforms aimed at retaining key acute care specialties and services must at a minimum receive serious consideration.

- On-call/ER physician services
- Obstetrics
- Neurosurgery
- Critical care and trauma physicians
- Oral/maxillofacial specialists
- Primary Care

Alternative Concepts for Delivery of Acute Care Services

For-profit ambulatory care centers are a growing presence on the health care landscape. Many physicians have significant financial interests in these centers and often refer their patients to them in preference to hospitals providing the same services. Procedures done at these centers are typically high value, and even if not

“cherry-picked,” divert an important revenue stream away from acute care hospitals. If New Jersey is to have a unified system of care, these centers should be required to shoulder some portion of the burden of charity and uncompensated care which now falls entirely on the hospitals and the physicians providing that care.

In other markets, the payer mix, demographics, access, and population density may be insufficient to sustain the necessary level of care and services, even with the best management, processes and oversight available. Some hospitals in these areas seem chronically resistant to change, have persistent issues of fiscal crisis and mismanagement, and suffer from consistently sub-standard quality and patterns of misuse and abuse.

Regionalization, service initiatives, programs and mandates may not be enough to address the problems these hospitals face. While these same institutions are often vital and “essential” to the communities they serve, they may only continue to operate with massive long-term financial support from the state.

The necessity for oversight and accountability for public funds is creating in some of the most severely stressed institutions something approaching a de facto public hospital status. In view of this, it may be prudent to consider a broader range of options, including but not limited to the creation of a formal public hospital designation or perhaps a state-funded public hospitals corporation with the mandated requirements of performance, transparency and accountability. Obviously, such a step is not to be undertaken lightly, but it should be borne in mind that such systems can work and in fact have long records of meeting vital public health needs.

Recommendations

1. Alignment of Hospital and Physician Financial Incentives

Issue

Structural misalignment among payors, individual providers and institutions, and inadequate reimbursement invites abuse and rewards medically irrational and counter-productive decisions. Inefficient patterns of practice, misuse of scarce resources, denials or delays in coverage or payment, unduly burdensome pre-certification processes, and panels with too few participants may serve short-term financial interests, but have lasting adverse effects on physicians' willingness to provide care, institutional strength and patient health and well-being.

Acute care institutions are often caught between conflicting demands for service by physicians and coverage decisions by payors. The absence of a coherent framework of incentives for providing and compensating cost-effective medicine and care is at the root of the problem.

Discussion

Admissions and discharges are typically driven by physician decisions. However, where such decisions do not meet reimbursement criteria for medical necessity or level of services, it is irrational and inimical to institutional financial health for payors to deny reimbursement to the hospital while continuing to compensate for physician services.

There are also instances where a payor may cover an ED visit, but deny payment for physician services. For example, it is common for a payor to require referral to an "in-network" provider for a patient stabilized in the ED service. But if a patient cannot locate such a specialist promptly, and requires subsequent follow-up in the ED, coverage may well be denied for the treating physician's services.

Misuse and overuse of consultants is a significant problem in many institutions. Presently, hospitals have little or no control over this aspect of physician practice which can lead to sharply increased expenses without an improvement in patient care. Beyond instances of

outright abuse, there is a large opportunity to improve practice and reduce costs by eliminating unnecessary and extended consults.

Examples of irrational decisions and counter-productive results could be multiplied, but the lesson to be drawn is the same. Payment and coverage decision-making is deeply and often critically disconnected from care-giving and medical decision-making, often to the detriment of patients and providers. While payor decisions are clearly a major factor, it is a dangerous oversimplification to place the blame entirely on insurers, or for that matter, any other single player or stakeholder group. New paradigms of care, payment, accountability, and patient involvement and responsibility are clearly needed.

If a medical or treatment decision, admission, continued stay or discharge is not medically necessary, both the institution and physician should bear similar financial and legal consequences. Both the physician and the hospital should be at risk for non-payment if a medically inappropriate decision (i.e. one not supported by an agreed treatment algorithm) is made, and conversely be equally exposed to (or protected from) litigation for the consequences. Institutions, physicians and patients alike should have ready access to review and revision if such any decision results, or is likely to result, in patient harm. This would stimulate better working relations among physicians, the hospital, physician advisors and case managers to improve overall efficiency in operations and rational utilization of resources, while assured patients rights are maintained, protected and defended.

However, not every medical decision translates readily into increased or decreased costs or impacts length of stay, nor can desired change in all cases be achieved by placing pressure on the primary care physician. For example, if a treatment or test is postponed because a service is closed or a specialist unavailable, it is both unfair and ineffective to penalize the primary care physician for the delay. Thus, an across-the-board system of rewards and correction cannot be applied to all physician decisions that may result in additional in-patient days.

One solution to avoidable delays and extensions of stays may lie in achieving seven-day per week operations as

discussed elsewhere. Another approach may involve innovative ideas regarding compensation of physicians for in-patient care that increase alignment of financial incentive among physicians, hospitals and payors.

Alignment-oriented payment schemes that provide physicians appropriate incentives for cost-efficient case management through case-rates or severity-adjusted payments but that do not unduly impose penalties for unavoidable or unintended consequences should be thoroughly examined. This is an area requiring careful study of alternatives and demonstration projects before widespread implementation can confidently be recommended.

Physician education is a key to rationalizing proper use of consultants. The process should begin in medical schools and continue through training programs and CME. Demonstrating that cost-effective medicine has a positive financial impact and that over-utilization neither improves outcomes nor reduces lawsuits is an available strategy that may reduce the use of non-essential consults.

Public payors and private insurers must adopt uniform standards of review and consequences so physicians and hospitals can make consistent and rational decisions without regard to the source of payment.

Benefits and Risks:

- Educate and incent physicians to practice cost-effective medicine, reward physicians based on system cost savings, and eliminate or reduce incentives to over-utilize resources and continue defensive medicine tactics.
- Rationalize the appropriate use of consultants and consulting practices through physician and medical student education.
- Align financial interests and liability exposure for hospitals and physicians to improve physician accountability for appropriate use of hospital resources.
- Establish uniform hospital and physician payment criteria for all payors (public and private sector.)
- Alignment-oriented payment systems must not actually or apparently improperly incentivize hospitals, physicians or payors to withhold, curtail, or deny medically necessary care.

Recommendation

- Establish, enable or support the implementation of alignment-oriented payment models or systems for acute hospital care that financially impact, engage and involve physicians.
 - Funding for the incentives required to implement such a system must come from savings generated within the present scope of payments and reimbursements.
 - Payor fees schedules should be completely and publicly disclosed.
 - Safeguards must be built-in to protect patient rights to all medically necessary care and provide percentage-based payment for out of network services.
 - A carefully designed, geographically limited and closely monitored pilot or demonstration project would be a prudent first step.

2. Physician Accountability and Evidence-Based Practice in Acute Care Institutions.

Issue

The value of evidence-based medicine standards is well-recognized for producing improved case management, better patient outcomes and cost-efficiencies in the acute care setting. This is especially true for some of the most common and costly diagnoses where such standards have been extensively researched and promulgated.

Even where such standards are widely recognized, however, New Jersey hospitals and physicians have made little progress in agreeing how to implement them, measure results, or how to reward, induce or coerce compliance. This has made it nearly impossible to assess the level of practice, identify leaders and outliers and implement any system of evidence-based rewards and corrective action within a given institution.

Discussion

Though hospitals have a vital interest in physicians practicing the most cost-effective medicine, their ability to induce such behaviors is limited. Collection and dissemination of information on physician performance, whether available to the public at large or a more limited

peer group can promote physician accountability and adherence to evidence based practice guidelines.

Many physicians regard such measures with suspicion as unwarranted intrusions into their professional prerogatives. Some find the mere suggestion of standards and the threat of publicity offensive, if not threatening, and move business to less aggressively managed hospitals. Unless the effort is based regionally or state-wide, attempts to use metrics and peer-pressure will put all but the strongest institutions at increased competitive disadvantage and potential financial risk.

Physician report cards can work only if they are designed so that the information is valued and used by the physicians themselves. Standards of measurement must be widely accepted and validated if ratings and rankings have the desired effect of motivating and modulating behavior in positive directions. Implementation of such tools demands a cooperative and collaborative effort, as well as agreement on shared goals and outcomes.

Many insurers have access to demographic and clinical data that can be used to produce performance metrics at the physician and patient level. New Jersey insurers should be strongly urged to cooperate in developing standardized quality performance reports for New Jersey similar to those developed in New York (MetroPlus) and Minnesota (HealthPartners). Such reports could represent an important component of an acute care report card initiative.

Benefits and Risks

- Broad participation in standards development encourages buy-in and reduces bias concerns.
- Regional implementation of physician report cards levels the playing field for weak and strong institutions and encourages best practices, especially in key specialties.
- Implementation may disadvantage institutions dependent on marginal providers and possibly divert business elsewhere.

Recommendation

- A properly validated, well-accepted, independently complied, and publicly available physician report card system that measures performance and

outcomes on critical, evidence-based standards of acute care practice should be developed and implemented on a regional or state-wide basis.

- Priority and focus should be first placed on key specialties and high-cost, high-risk conditions and diagnoses.
- Insurers, MSNJ, NJHA and other state-wide organizations should participate in the study, research and validation required for this effort.

3. Coordinating the Continuum of Care

Issue

New Jersey's health care system does not adequately ensure the management of a patient from admission through in-patient treatment to discharge and follow-up treatment and services. Lack of organizational structures and financial incentives for such a continuum of care adversely affects medical outcomes and increases the total cost of medical care. Discontinued care or lack of follow-up can result in a readmission which might have been avoided by a more timely intervention.

The problem is made worse by the practice of some physicians who restrict their engagement with charity care patients to a single ED encounter, limit the range of services they are willing to perform, or fail to manage the clinical condition to conclusion. Reimbursement and liability concerns are likely drivers, but fall short of excuses, for such behaviors, which in extreme cases can amount to the virtual "abandonment" of the patient. This increases clinical costs, creates liability exposure, may place patients at increased risk and degrades health care quality.

Discussion

There are at least three key components to establishing a continuum of care that are within the existing capabilities of New Jersey's acute care facilities. Hospitals can establish guidelines to assure patients are admitted to the most medically appropriate service, insist ED physicians manage patients to an appropriate point of transfer, and ensure discharge procedures provide for appropriate follow-up, after-care, or outpatient services.

Hospitals traditionally do not question admission to a primary care provider's service or make an independent

determination whether another service or specialist care would be more appropriate and efficient. However, procedures that ensure patients are admitted to the appropriate service will increase their likelihood of receiving well-managed treatment from the onset of care through discharge or transfer. Consultation and/or recruitment of other providers should be coordinated by the appropriate admitting physician. In situations where hospitals lack needed specialty resources, regional relationships could fill the gap.

Hospital policies must clarify the scope of physician responsibility for all ED cases, and articulate unambiguous professional, ethical and legal standards to ensure patients receiving treatment in the ED service are managed through to clinical resolution and appropriately stabilized, discharged or transferred. Stronger inducements, including legislative mandates may be necessary if such encouragements prove insufficient.

Utilization of appropriate post-discharge care can mean better outcomes, more compassionate care, and greater cost-efficiency. This may include local or regional access to long term ventilation units, vent/dialysis units, long-term acute care facilities (aka LTACs), nursing homes, and hospice care. Discharge procedures should encourage such choices and efforts should be made to reduce or eliminate any financial barriers that may inhibit considering such alternatives.

Managing the continuum of care for the highest cost diagnoses (DRGs) may offer the best opportunity for realizing a measurable benefit from a coordinated approach. CHF (congestive heart failure) is a good example, representing one of the most common and costliest DRGs. Coordination of in-patient care and outpatient support through specialists, anticoagulation and/or CHF clinics is likely to prove a readily available, cost-effective strategy.

In all cases, incentives or other forms of encouragement are needed to achieve better management of patients throughout the continuum of care.

Benefits and Risks

- Ensure optimal management of all patients from admission to post-discharge treatment to conserves the benefit of treatment, reduce readmission rates, and forestall clinical deterioration.

- Ensure involvement of the appropriate specialist from admission through discharge or transfer.
- Restructuring significant aspects of the physician-patient relationship and ED practice patterns will require engagement and commitment by senior management and institutional governance.

Recommendation:

- Encourage coordinated care through a system of appropriate incentives and standards for achieving measurable results, that will at a minimum:
 - Assure patients are admitted to the most medically appropriate service
 - Require ED physicians to manage patients to an appropriate point of transfer, and
 - Establish discharge procedures that provide for appropriate follow-up after-care or outpatient services.
- Study and development of specific guidelines for implementing coordinated care on an individual institutional basis is a likely necessity and strongly urged.

4. Transparency & Accountability for Acute Care Resource Utilization Costs

Issue

Imperfect or non-existent knowledge of the cost of care and resources inhibits physicians and consumers from making informed, rational choices, decreases trust and confidence and disables accountability for decisions.

Discussion

The cost of hospitalization and associated resource utilization is not widely appreciated by treating physicians, much less by the public at large. Without such information, physicians and patients may make unwarranted or inappropriate demands for non-essential services, over-use or misuse hospital resources, and fail to appreciate justified denials or consider alternatives to such services. These factors tend to raise the overall level of dissatisfaction in and distrust of many aspects of the health care system.

Greater financial transparency would increase comprehension of the financial impact of treatment

decisions and make creation and adoption of quality and cost performance expectations for physicians rational and equitable.

Benefits and Risks

- Financial transparency engages physicians in resource utilization decisions
- Removes elements of uncertainty contributing to suspicion and distrust
- Empowers consumer-directed health care choices.
- May threaten marginal institutions dependent on higher cost services to offset uncompensated care.

Recommendation

- Increase institutional transparency for acute care costs, utilization and care alternatives to enable cost and treatment-effective decisions.
 - Hospitals should explore ways of publishing and communicating accurate, relevant and timely information on the cost of care, resource utilization and alternatives to inform and help guide physician decision toward the most cost and treatment-effective choices.

5. 365 day Optimization of Hospital Resources

Issue

Hospitals maintain emergency department and other essential services at all hours of the day or night, providing vital and life-saving resources to their communities. However, hospital staffs and ancillary in-patient services are reduced or limited on weekends and off-hours which, while saving money, can mean important diagnostic tests or treatments must be delayed, sometimes for days.

Consequences of this may include medically unnecessary stays, patient inconvenience and exposure to infection risk, and associated waste, delay and cost. While some service capabilities should undoubtedly be provided on a 365-day basis, it is unclear whether and to what extent non-essential services would be cost-justified if available on a similar basis.

Discussion

Optimizing hospital resource utilization throughout the year is not formulaic and will require study, tailored recommendations and well-managed implementation for each institution's unique situation. The importance and role of institutional governance in such an endeavor cannot be too strongly emphasized.

While it may not be possible for a hospital to provide every service at all hours throughout the day, there are identifiable aspects of effective coverage that all hospitals can and should maintain every day throughout the year. These include the implementation of specially trained coverage for ICU units, physician extenders and actions to address any deficits in on-call coverage.

Benefits and Risks

- Enhanced patient care, improved outcomes.
- Incremental implementation can start with highest cost units.
- Spread work load to normally less productive hours.
- Reduce unjustified (and unreimbursed) LOS

Recommendation

- Hospitals management should be encouraged to define and adopt standards of operation for an expanded range of services that optimize utilization of physical plant and human resources on a 365 day basis.
 - Where essential in-house resources or specialized services are unavailable or not cost-justified, management should seek to form and/or participate in regional networks to address the identified deficiencies.
 - Hospitals should invest in and incent programs such as Intensivist and physician extender programs that are proven to have a measurable impact on cost-savings, resource optimization, efficiency and effective patient care.
- Funding of such programs must be internally cost-justified. The State should provide assistance in developing economic and business modeling for financially distressed hospitals.

6. Standardization of Emergency Department Service Call Requirements

Issue

New Jersey is one of the few states in the Union that has foregone creation of public hospitals in favor of a state-mandated requirement that all acute care hospitals provide medical care to all persons regardless of ability to pay – the so-called “Charity Care” system. As a practical matter, this often means the Emergency Department must provide an extensive range of comprehensive care and services.

In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA), also known as the patient anti-dumping law, encompasses emergency care in the ED (including on-call specialists as required), OB care for women in labor, and psychiatric emergencies. The law provides for an appropriate medical screening examination for any person requesting examination or treatment for a medical condition at an emergency department. It is the hospital’s obligation to determine if there is an emergency medical condition and if so, to stabilize the patient or arrange transfer him to another appropriate facility.

Many hospitals can no longer enforce Emergency Department (ED) service call obligations on physicians, and in a growing trend, must pay significant fees to physicians in order to secure urgently needed and essential coverage. While this may not be a burden to some institutions, it is undoubtedly problematic for others.

In some cases, the lack of ED on-call physicians means patients have limited access to needed medical care and lack of appropriate follow-up or continuity. Change is needed to ensure all acute care institutions have the access to critical specialty physicians needed to fulfill their obligations.

Discussion

Physicians (specialty physicians in particular) are increasingly disinclined to accept on-call obligations, resulting in strains on access and availability of key medical services to the particularly vulnerable populations for whom the ED may represent the only means of access to the health care system. “On-call”

physicians are (unlike hospitals and their employees) fully exposed to tort liability and risk not being compensated for treating the uninsured (unless, as is increasingly the case, the hospital has contracted them to do so.)

Historically, ED service obligations were more or less expected from physicians in consideration of attending privileges. A return to the former “soft” system of obligation is not anticipated. One option is a mandatory on-call requirement for all physicians. However, making on-call service “mandatory” for all physicians via regulation, legislation or hospital policy raises difficult questions of equity, bargaining power, legality and enforcement.

Fines and licensure actions seem too extreme, while suspension or curtailment of privileges is not a realistic option for many institutions. Moreover, the institutional landscape is not uniform. Requiring obligatory on-call service would be far less burdensome on physicians in suburban hospitals due to the relatively small number of charity care and Medicaid cases. Urban hospitals, in contrast, would face difficulty recruiting and retaining physicians who could expect to shoulder a substantial burden of uncompensated care. (There is also a widespread but largely anecdotal perception that charity care patients pose a higher medical liability risk than other patients.)

Paying for on-call services is a poor but in some cases necessary strategy, inasmuch as hospitals are mandated to provide certain services under EMTALA. Where such arrangements provide for flat fees only and do not pay for each episode of care, there is a built-in bias toward under-delivery and over-payment. Moreover, flat fees are paid independent of any reimbursement or other compensation a physician might receive. A better system might tie payments to services actually rendered on some equitable pre-determined basis.

Initiatives considered elsewhere in this report and perhaps by other subcommittees may provide a partial solution. Establishment of and participation in a comprehensive system of regionalized care or Centers of Excellence and expedited transfers may provide a medically responsible and financially sustainable means meeting public expectations of the ED service, as well as the legal demands of Charity Care and EMTALA

mandates. The widespread use of such centers has the potential to change the current paradigm of ED care and alter the traditional pattern of reliance on on-call services.

The crisis in on-call service is exacerbated by the problems and risks, real or perceived, of providing care in the ED setting. The issues of compensation and liability for providing such services need to be addressed to ensure adequate and consistent on-call coverage and continuity of care.

Benefits and Risks

- Increasing on-call service will reduce service bottlenecks and disparities in care for under-served populations.
- Increasing the trend toward payment for “on-call” status is a poor solution that places additional strain on institutional finances.
- Mandating on-call obligations is a controversial and potentially divisive concept that poses major obstacle to implementation, may adversely impact care, and perhaps reduce availability and access.
- Compensation for on-call services is a better approach in principle but presents unresolved issues of funding.
- Regionalization could reduce the need for each institution to have access a wide range of on-call specialties.

Recommendations:

- Physician obligations and expectations with respect to ED service should be standardized (or at least rationalized) regionally or even state-wide to ensure adequate medical coverage and fulfillment of statutory mandates. However, there is lack of consensus on the means to accomplish this end. Several ideas have been proposed:
 - [Mandatory \(via statute or regulation\) call and continuity of care obligations for all physicians at all facilities.](#)
 - [Increased incentives for Medicaid and uninsured cases, compensation for taking call in urban areas, and perhaps malpractice premium relief.](#)
 - [Compensation for EMTALA-related services on an episode-of-care basis rather on a flat fee basis.](#)

- [Regional Coordination and Centers of Excellence should be examined in light of their impact on demand for on-call services.](#)
- [Lifetime or age cap for on-call service hours.](#)

7. Intensivist Model for ICUS

Issue

Intensive Care Units provide patients with life-sustaining medical and nursing care on a 24 hour basis but are not typically staffed with specially trained personnel. Typically, ICU patients are among the sickest, highest risk and most expensive cases in the hospital.

Discussion

Quality of care and cost-effective treatment in the ICU setting are maximized when they are provided by trained staff whose only responsibility is the care of patients in the unit. Such “Intensivist” programs, when properly executed are recognized as cost-savings measures that also improves the quality of patient care.

A minimum requirement for such a program would provide service on a 365 day basis for at least eight hours per day, preferably during hours of greatest risk and/or limited coverage. In some institutions, telemedicine and remote centers can be a highly effective and cost-efficient means to implement intensivist capabilities in whole or in part. An “Intensivist Model” of ICU care and case management provides multiple benefits.

Benefits and Risks

- Better utilization of resources and ICU beds, organizational throughput and lower LOS,
- Better adherence to practice guidelines and best practices and coordination of care in complex cases
- Better patient outcomes, lower mortality rates, potentially higher patient and family satisfaction, more effective treatment of end-of-life issues, improved organ donation efforts.

Recommendation:

- Adoption or implementation of an Intensivist Model of ICU Care should be a priority for acute care hospitals statewide and especially financially distressed institutions.

- Hospitals should be encouraged, rewarded and/or recognized for implementing intensivist programs and capabilities.
- The State or other organizations should enable and assist program development wherever possible.

8. Leverage Professional Resources

Issue

Physician availability is a critical factor that impacts a hospital's ability to respond effectively to patient need and efficiently utilize its resources. Reduced services, staffs and coverage on week-end and holidays, declines in on-call physician availability and shortages of key medical specialties can limit access and availability.

Even where physicians are available to provide inpatient coverage, the pressure to maximize the use of their professional hours is often extreme, reducing the amount of time available to each case and each situation demanding their attention. These factors contribute to service bottlenecks and inefficiencies, and may result in added costs and increased risk.

Discussion

While there is no short-term means for increasing the supply of specialty physicians in under-served localities in New Jersey, there are other strategies for leveraging scarce physician resources in the acute care setting that potentially offer economic and quality improvements.

In many situations, "practice extenders", such as Intensivists, case managers, hospitalists, physician assistants and advance practice nurses have the potential to provide cost-effective means of achieving quality and efficiency goals in appropriate circumstances. Advanced practice nurses, for example have independent practitioner (IP) status which enables them to be independently compensated. Recognition of and compensation for the services of other practice extenders, such as Physicians' Assistants ("PAs"), would expand their use, helping to realize more effective and cost-efficient resource utilization.

According a class of practice extenders such as Physicians' Assistants IP status might facilitate this, and could allow greater flexibility in matters such as getting

orders co-signed within narrow time constraints. On the other hand, this may raise new issues of practice autonomy, training and expertise, and liability. It is also not clear whether and under what circumstances Physicians' Assistants themselves might desire or accept independent status. Any such change will require further study and should not distract attention from the need to expand their utilization through recognition of and compensation for the value added.

Other capabilities such as telemedicine services could, if appropriately compensated, help multiply the effective reach of vital physician services. Financial incentives or support from the state or other organizations may be required to overcome cost barriers to acquiring the IT infrastructure needed for telemedicine and remote monitoring.

Extensive implementation of leveraging strategies will impact and alter the practice model of individual physicians in important and perhaps radical ways. Institutional priorities must reflect and embody the commitment of the governing board and senior management to the needed change and establish clear goals. Practice leaders, staff and employee representatives must be brought into and "buy into" the process.

Benefits and Risks

- Reimbursement for the services practice extenders more generally would expand their use and enable more cost-effective leverage of scarce physician resources.
- Patients will receive a net increase in care, hospitals will gain greater coverage at reduced cost, and physicians can make better and more profitable use of billable time.
- Various combinations and patterns of practice extenders, intensivists, case managers, hospitalists, advance practice nurses, remote and telemedicine capabilities can be combined to augment the delivery of care and expand physicians' availability.
- Solutions can and should be tailored to meet the needs and capabilities of each individual particular institution and health care system.
- Initiatives in this area must be undertaken and endorsed at the highest levels of hospital governance in cooperation with payors, physicians

and representatives of the various groups of practice extenders to succeed.

- Hospitals (and especially financially stressed institutions) may need guidance to make cost-effective selections among the wide range of available options.

Recommendation

- Hospital management should explore and expand the use of practice extenders and other options for leveraging, extending and augmenting the professional presence and expertise of physicians.
 - Provide enhanced compensation for the use of selected practice extenders, such as Physician Assistants, even if not separately compensated as “Independent Practitioners”.
 - Hospitals should work closely and cooperatively with its physicians and regional hospitals to optimize the benefit of such efforts for patients, doctors and the institution itself.
 - The State should assist financially-distressed institutions in identifying qualified consultants and solution providers who can help define and implement such initiatives.

9. Exploit Existing Electronic Capabilities and IT

Issue

Electronic data, communication and information technologies continue to evolve and proliferate through the economy and society, but so far these tools are underutilized by the healthcare system. There are significant efforts already underway, notably NJHA’s efforts to enable a Regional Health Information Organization (RHIO) in New Jersey which promise to dramatically improve connectivity and communication among physician, hospital facilities and staff. These efforts require long-term commitment, substantial investment, support and encouragement. Nonetheless, it may be possible to realize more modest gains sooner, and with much less effort and cost.

Discussion

There are many ways to make use of advances in information technology that are far less complicated and more readily attainable than the widespread implementation of electronic medical records or the creation of broad-based health information complexes.

The web is an existing resource that could dramatically enhance the relationship and communication between physicians and hospital staff without major reengineering or capital investment. Existing hospital IT systems could be used to provide physicians’ offices with the ability to remotely monitor hospital patients to achieve more timely, quality- and cost-effective decision on interventions, treatment, discharge or other dispositions.

On-line information, consultation and reference resources for physicians and hospital staff are within reach of existing technology and could be implemented at comparatively low cost. Electronic sharing of information, case histories, and best practices could be a cost effective means of education and promoting better medical and cost-efficient management. Intranet messaging may prove a useful and readily accessible means of communication as it has in other contexts.

The discharge and transfer process could be better handled through electronic means and as discussed elsewhere, may help ensure continuity of care. Electronic means could be used to obtain real or near-time information on discharge and intermediate care options, hospice, palliative care, rehab, LTC, etc., to shorten discharge time. The state might be able to offer assistance in locating consultants and solution providers.

Finally, institutions, payors and other stakeholders, perhaps pharmaceutical firms or insurers might find it in their interest to support aspects of the effort to improve connectivity and communication among target groups of practitioners and selected institutions, even on a limited basis.

Benefits

- Improve physician-hospital communications to increase efficiency and productivity.
- Near or real-time remote access to patient records can improve accuracy and timeliness of clinical decisions.
- Distance learning technologies can enhance access to reference resources, learning and enable information exchange.
- Private sector support and/or funding are worth exploring.

- Legal and regulatory issues (HIPAA, Stark, IRS, etc.) must be considered and addressed.

Recommendations:

- Utilize existing hospital IT systems and standard web access to provide physicians remote, real-time access to clinical monitoring and/or data.
 - Institutional and text messaging, physician home page, etc could be an integral part of such a system
- Establish on-line practice resources and institutional physician information
 - Medical references, research, journals and other library services
 - Institutional and/or healthcare system-specific information on resources, treatment protocols, best practices and other informational bulletins and updates.
 - State IT and library resources may be available to help pool resources and reduce subscription costs.
- Explore feasibility of using on-line discharge information systems or providers to shorten discharge wait times and improve patient placement.

10. New Jersey Health Care Data Warehouse

Issue

Quantitative comparative measures of hospital performance do not exist in New Jersey. Disagreement over whom and what to measure delays or prevents needed action, and can have but one outcome for a failing institution. Beyond agreement on the tools and criteria, there must be confidence in the impartiality and objectivity of the process.

Discussion

A vital task of the Commission is to help determine the viability of hospitals that are currently operating “marginally,” and recommend incentives for improvement. The availability of reference standards and measures of performance would inform and benefit all acute care institutions, but is an absolute necessity for the effective management of hospitals in crisis.

The mechanics of such a system – the data collection instruments and evaluation algorithms and criteria - can be developed on a regional or state-wide basis, drawing from good practices, experience and evidence-based guidelines and use quality assurance experts, trained statisticians and data base development experts as needed. Data on patient outcomes and institutional performance would be submitted by New Jersey’s acute care hospitals to a central data repository or warehouse.

It is essential that all stakeholders be involved in the process of developing metrics and the methodology of collection, collation and dissemination of the information. The end product should be a comprehensive hospital patient health care and outcomes data set, collectively designed and independently maintained, to serve as a publicly available reference standard.

Such a system may well be implemented as a spin-off of the RHIO initiative mentioned above. However, as the data warehouse concept could be implemented at an earlier date and with less expense. It might also be utilized as a precursor to the more ambitious data collection aims of the RHIO project.

Benefits and Risks

- Increase transparency and metrics for New Jersey’s acute care hospitals and health care system
- Wide availability to all payors, healthcare plans, institutions and physicians will encourage broadly accepted metrics and performance standards.
- Serve as the mandatory standard of reference for all institutions requesting or requiring extraordinary (beyond currently authorized Charity Care) state financial assistance for their operations.
- May impose extra costs on institutions, compete with or made superfluous by other public or private efforts.

Related initiatives that may further such a project:

New Jersey Hospital Management Data Network

New Jersey acute care hospitals do not presently have the means for real-time exchange of non-proprietary, non-confidential data. Like many

institutions in the state, hospitals tend to be local and relatively isolated, with limited interaction with peer institutions.

- A hospital management data network, created by the hospital associations and member institutions, could provide managers of acute care institutions non-confidential information to better assess their performance and progress compared with their peers.

Uniform Data Standards and Formats

Uniform data standards and formats would enable much improved oversight, data and best-practices sharing, as well as transparency, measurement and accountability among New Jersey's acute care institutions.

- Standard for forms and data capture and entry should be created and promulgated implemented by all hospitals. Immediate candidates for standardization include a uniform clinical data reporting sheet and a new, customized New Jersey UB Type 04 medical claim form.

Recommendations

- Consideration should be given to establishing a New Jersey Health Care Data Warehouse containing outcomes and performance data from a wide spectrum of participating acute care institutions.
 - New Jersey should assist all acute care institutions in identifying consultants and solution providers to develop the required IT and MIS resources.
 - Standardization (or at a minimum, agreed ways of normalizing) of admission, charting, treatment and discharge procedures should be developed to allow comparative assessments of performance.
 - Contributors must include the Medical Society of New Jersey, the hospital associations, health care insurers, public payors, appropriate professional societies and the final product must bear their unanimous endorsement.

- The state should explore options to host, support and maintain the database, to assure compliance with HIPAA and other applicable laws and regulations, and provide neutrality.
- Funding options should be explored, including grants, user fees, subscriptions or subsidies for financially distressed institutions.

Conclusion

The crisis in acute care facing many communities and institutions in New Jersey is profoundly affected by the relationship between the hospitals that provide access to services and the physicians who provide the care. While these stakeholders share many interests and goals in delivering effective and high quality medical care, in too many instances financial pressures, structural inefficiencies, imperfect information and irrational patterns of traditional practice, resource allocation and use defeat or deflect the achievement of these ends.

The recommendations provided in this report if implemented in whole or in part, can be part of the answer to rescuing New Jersey's most at-risk institutions, bringing quality care to underserved communities, and raising the level of health care available to all persons seeking it within the state.

