Response to the Saint Michael's Medical Center Comments on the Greater Newark Healthcare Services Evaluation Report– 5/11/15

Following the release of the Greater Newark Healthcare Services Evaluation Report in early March 2015, Saint Michael's Medical Center issued a response to the report on April 6, 2015 and then issued a supplemental response on May 5, 2015. Both of these responses challenged the conclusions and recommendations outlined in the original report and the second response specifically challenged some of the analyses and analytical components of the report. In reviewing both responses from Saint Michael's Medical Center, it is clear that the authors of the responses have misinterpreted or misunderstood many aspects of the report and their challenges are without merit. This document provides a series of comments intended to correct the misinterpretations and clarify the misunderstandings contained in the Saint Michael's Medical Center responses to the Greater Newark Healthcare Services Evaluation Report.

April 6, 2015 Response to the Greater Newark Healthcare Services Evaluation Report

The April 6, 2015 response from Saint Michael's Medical Center, which was prepared by David A. Ettinger of the law firm of Honigman Miller Schwartz and Cohn LLP, cited three major objections to the Greater Newark Healthcare Services Evaluation Report:

1. The recommendations would "…result in the creation of an unregulated monopoly in inpatient hospital services in the Newark area."
2. The "…assumption in the Navigant report that the changes encouraged by the Affordable Care Act require such consolidation is completely without foundation."
3. The report "…tries to "pick winners and losers," rather than leaving that difficult task to the free market."

All three of these assertions are factually incorrect. First, the recommendations would **not** create a monopoly, as the residents of the Greater Newark area would continue to have access to the ten (10) hospitals (in addition to the hospitals in the Planning Area) located within a 15-mile radius of downtown Newark. And as the report clearly showed, many residents of the Greater Newark area are already traveling to facilities other than the five hospitals included in the report, as approximately 33% of the residents of the Planning Area defined in the study leave the Greater Newark area for their inpatient care. Secondly, the State of New Jersey currently has a well-defined regulatory system in place that includes Certificate of Need requirements, so the assertion that the recommendations would create an "unregulated monopoly" are clearly overstated and incorrect.

The second assertion is also incorrect. In fact, there is not a single reference to or citation of the Affordable Care Act in the entire report. So there is no "assumption" in the report related to consolidation. That said, it is important to note, as was done in the Strategic Context section of the report, that the healthcare industry is undergoing a profound transformation that has been decades in

the making. The long-term trends in the industry include an overall decline in hospital use and significant consolidation, as shown in the tables below, which document the changes in U.S. hospital supply, demand, and consolidation for the last thirty-five (35) years.

Inpatient Demand Metric	1980	2012	2013	% Change (80 v 13)
Admissions	36.1 M	34.4 M	33.6 M	(7%)
Admissions / 1000 Pop.	159.1	110.0	106.2	(33%)
ALOS	7.6	5.4	5.4	(29%)
ADC	747 k	507 k	500 k	(33%)

Source: Navigant analysis of AHA Guide and AHA Hospital Statistics, multiple years

Inpatient Supply Metric	1980	2012	2013	% Change (80 v 13)
Staffed Beds	988 k	801 k	796 k	(19%)
Staffed Beds / 1000 Pop.	4.3	2.6	2.5	(42%)
Community Hospitals	5,830	4,999	4,974	(15%)
Avg Age of Plant	7.0	10.1	10.2	46%

Source: Navigant analysis of AHA Guide and AHA Hospital Statistics, multiple years

Hospital System Metric	1990	2012	2013
Total Community Hospitals	5,384	4,999	4,974
Multihospital Systems	306	425	431
Hospitals in Systems	2,571	3,615	3,723
% of Hospitals in Systems	48%	72%	75%
Average System Size	8.4	8.5	8.6

Source: Navigant analysis of AHA Guide and AHA Hospital Statistics, multiple years

Nor does the report attempt to "pick winners and losers." The report merely documents what has happened in healthcare delivery in the Greater Newark area for the last several years and makes abundantly clear that in fact, the "market participants" (i.e., area residents) have made their choice and they have consistently selected to use facilities **other** than Saint Michael's Medical Center, as evidenced by the fact that SMMC's market share in the Planning Area is quite low and has declined steadily over the last three years from 10.6% in 2011 to 9.2% in 2013. Quite frankly, when 9 of every 10 residents in a region choose to use another facility for their healthcare, the market has clearly spoken and demonstrated its preference (or as the SMMC response puts it, picked "winners and losers"). Further evidence of the market's choice is reflected by the fact that SMMC does not provide more than 24% of the inpatient care in **any** of the zip codes in the Planning Area and its market share in many of the Planning Area zip codes is in single digits.

In their discussion of the "unregulated monopoly" the recommendations would supposedly create, the SMMC response misstates the market share figures of some of the key providers in the Greater Newark area. The SMMC response states "According to Navigant's own data, the combined share of Barnabas and University Hospital (even without St Barnabas Medical Center) is 77% of discharges." In fact, the data presented in the report shows that the five study hospitals **combined** (including SMMC and EOGH) have a 68% share in the Planning Area. The combined share of NBIMC and CMMC in the Planning Area is only 38%. If UH is added, this number becomes 52% - nowhere near the 77% claimed in the SMMC response.

The SMMC response claims the recommendations would result in a HHI index of 3700 in the "Newark area," although they do not define the specific geography of the "Newark area." In fact, if one were to assess the Northern New Jersey market as a whole and not just the 10-square miles of the Planning

Area, the HHI is less than 1500, which in the FTC's classification scheme is indicative of a market that is "unconcentrated." So the claims of monopoly are clearly incorrect and significantly overstated.

The SMMC response claims that the report "did not discuss the planned acquisition of Saint Michael's by Prime Healthcare…" The report in fact, **did** discuss the potential Prime acquisition and noted that, *"Based on our analysis of the Planning Area, it is unclear how the transfer of the assets of any of the study hospitals through a sale to another party would resolve the underlying overcapacity and unnecessary service duplication in the Planning Area. Rather, any such transaction would seem more likely to perpetuate the status quo than to facilitate the redeployment / transformation of resources to align capacity with need in the Planning Area. Transferring the assets of one or both of these hospitals would perpetuate—and probably intensify—the competition for the decreasing number of inpatients in the Planning Area. Nor would transferring the assets through a sale help address the current degree of fragmentation of the healthcare delivery system in the market. And a sale of one or both of the facilities would be unlikely to facilitate the organization of physicians. In effect, sale of one or both hospitals would appear to continue the status quo, which would not address the excess capacity and unnecessary duplication of services."*

SMMC's response quotes Prime's commitment to invest $25M in SMMC over 5 years. While this would clearly be helpful in addressing SMMC's capital needs, analysis of the SMMC facility by a team of facility planning experts identified an estimated $57M in capital spending needed to bring the SMMC facility up to adequate, modern standards. As a result, Prime's promised investment, while necessary, would not be sufficient.

Regarding comments that converting SMMC to an outpatient facility would make the hospital not viable from a financial perspective, it is important to note that the report's recommendations were designed to meet the current and future healthcare needs of area residents as opposed to trying to keep SMMC solvent in its current state. It should be noted that by almost any financial measure, SMMC is **not** on a sustainable financial path currently. It lost in excess of $50M from operations in 2012 and 2013 combined (**excluding** significant state subsidies) and has debt-to-capitalization ratios well in excess of industry and investment grade medians. It is has relatively little cash on hand, is losing money from operations, and has an unsupportable debt level in its current configuration.

The SMMC response talks at length about the projections of healthcare utilization and cites several academic studies and asserts the "projections are demonstrably inaccurate and incomplete." The SMMC response does not provide any data as to how or why the projections are inaccurate or incomplete and appears to fail to recognize the projections in the report were based on **actual** utilization trends that have occurred in the Greater Newark area. In fact, actual utilization of Planning Area resident (as measured by inpatient discharges) **declined** from 84,521 in 2011 to 76,762 in 2013, a decrease of more than 9%. The report cited a number of reasons for this decline and indicated that the expectation was that the factors behind this decline were likely to continue for the next several years, although the report did note that the rate of decline was moderated in the projections to provide for a more "optimistic" projection of future utilization.

In addition, the SMMC response asserts that the "report also fails to address, or even identify, the enormous subsidies that New Jersey tax payors are providing to University Hospital." Again, this is factually incorrect. The report does in fact identify and address the subsidy. With respect to subsidies, it should be noted that SMMC also benefits substantially from state subsidies-- the state's charity care subsidy represented 14% of SMMC's operating revenue ($26M on operating revenues of $192M), a higher percentage than any of the other hospitals in the study except UH.

May 5, 2015 Response to the Greater Newark Healthcare Services Evaluation Report

On May 5, 2015, Saint Michael's Medical Center issued a supplemental response to the Greater Newark Healthcare Services Evaluation Report. This supplemental response was prepared by David A. Ettinger of the law firm of Honigman Miller Schwartz and Cohn LLP and Dennis Pettigrew, CFO of Saint Michael's Medical Center. This supplemental response claims the "…projections are deeply flawed, and, in fact, are riddled with significant errors." **As was the case in the original response to the Greater Newark Healthcare Services Evaluation Report, these assertions are not factually correct and reflect significant misinterpretations and misunderstandings of the analyses presented in the report.** The supplemental response contends that none of the conclusions are supportable. In fact, the data clearly support **all** of the conclusions presented in the report.

The supplemental response states the report "…proposes shifts in patients between hospital facilities that are physically impossible given the available capacity at those facilities." This is clearly incorrect. Saint Michael's Medical Center had an average daily census in 2013 of approximately 116 patients and this total was comprised of 103 Med/Surg/Observation patients and 13 Behavioral Health patients. East Orange General had an average daily census of 110 in 2013, of which 22 were behavioral health patients. In total, therefore, the recommendation to transform SMMC and EOGH into ambulatory facilities would entail redistributing a maximum of 226 patients. And given the historical trends at SMMC and EOGH and in the market overall, the average daily census totals are likely to continue to decline in the future as they have over the last 15 years. Furthermore, given where the patients currently using SMMC and EOGH live, a number of these patients would find it more convenient to go to one of the other 10 hospitals within 15 miles of downtown Newark. As a result, the number of patients who would need to be re-accommodated would be substantially less than 226. Analysis of the SMMC and EOGH patient origin by zip code indicated that approximately 60% of them would likely receive their inpatient care at one of the other three study hospitals while the other 40% would find it more convenient to use another hospital outside of the Planning Area. This equates to a total of 136 current patients (which will likely be lower in the future as utilization continues to decline) who would need to be re-accommodated. As noted in the report, given this redistribution of inpatients, *"CMMC would need to add an additional 29 beds and NBIMC would require an additional 36 beds. Review of the facilities at CMMC and NBIMC showed that additional nursing unit rooms currently exist that could accommodate the additional inpatient volumes with minimal renovation expense. The resulting supply of available*

beds in this scenario (1,137) closely matches the bed need in the Planning Area (1,095)." Clearly, the potential shift of patients is **NOT** physically impossible.

The supplemental response claims that the report's "…projections are based on very significant errors." The supplemental response goes on to state that while the projections anticipate a decline in utilization, "…hospital length of stay has actually *increased* slightly in Newark in the previous three years." This comment clearly indicates the authors are misinformed about or do not understand the difference between utilization rates and length of stay. The supplemental response goes on to say that the report "provides no evidence or even a rationale to support (the belief that utilization rates will decline), and completely ignores the fact that Newark inpatient hospitalization rates are higher than New Jersey or national averages for a good reason. Newark has a poorer, sicker population, that needs more hospital care." In fact, the report **does** provide strong evidence and rationale for the anticipated decline in utilization and it **does** acknowledge the demographic factors prevalent in the Newark area. In terms of rationale for the anticipated utilization declines, the report notes that,

"These (utilization) declines are the result of a number of factors, including:

- *The lingering effects of the "Great Recession," which suppressed utilization of health services*
- *Growth in/shift of patients to observation status vs. being admitted as an inpatient*
- *Continued shift of volumes from inpatient to outpatient settings*
- *Growth in high deductible insurance plans, which is reducing utilization*
- *Shift to value-based/population health management and improvements in care management*

These trends are expected to continue to have a major impact on health services utilization for the foreseeable future both nationally and in the New Jersey market. Therefore, even though the inpatient use-rate in the Planning Area has declined significantly in the last few years, it is likely that the Planning Area will continue to see reduced inpatient utilization rates and inpatient volumes in the future, as the utilization rate in the Planning Area continues to be impacted by the changing dynamics of the healthcare industry."

This would clearly constitute strong rationale.

Furthermore, the report includes an **entire section** (Section 3) that profiles in detail the demographic composition of the Planning Area and includes extensive discussion about the area population trends, income levels, insurance coverage, and health status. So this assertion is also clearly factually incorrect.

It is important to reiterate the actual, historical fact that even given the demographic characteristics of the Newark area, the area has experienced a steady and dramatic decline in utilization dating back at least to 1999. As noted in the report, *"Trends in Planning Area healthcare utilization over time provide a context for understanding current market dynamics, as well as provide a basis for determining*

likely future utilization levels. Between 1999 and 2013, the Newark Union Metropolitan Statistical Area (a broader region than the Planning Area as described in Section 2) experienced a 30% reduction in staffed beds (from 8,298 to 5,783) and a 28% reduction in hospital average daily census (from 5,635 to 4,085), despite population growth of approximately 2%." Furthermore, as the report also notes, *"More recently, the number of inpatient hospital discharges of Planning Area residents declined substantially, dropping 9.2% between 2011 and 2013. Discharges at the five Planning Area hospitals declined at a faster rate than the overall market, declining 14% over the same time period. As a result of this faster than market decline in discharges, the combined market share of the study hospitals in the Planning Area declined from 71.2% in 2011 to 67.8% in 2013, a decline of 3.4 percentage points. This means that the five study hospitals are serving a smaller percentage of a shrinking market."* As a result, any contention in the supplemental response that utilization will increase in the Planning Area is flatly contradicted by the actual utilization figures of the last 15 years and most specifically the last three years.

Another contention in the supplemental response is that the report "…ignores the very real problem that does exist; the huge losses, and huge subsidies, for University Hospital." The report does **not** ignore UH's losses or its subsidies and in fact addresses them **directly** as shown in the following quote from the report: *"Of particular note is the fact that in 2013 the New Jersey Hospital Care Payment Assistance Program (New Jersey's charity care subsidy program) provided $177 Million (26% of the state total) to the five study hospitals. The majority of this subsidy was provided to University Hospital ($101 Million). Without this subsidy, the five hospitals combined for $209 Million in operating losses in 2013. It is also noteworthy that University Hospital's operating results are somewhat understated by the fact that the fringe benefits paid to its employees were absent from the operating expenses in its financial statements. This represents an additional $90 Million or more annually that has historically not been included in the presentation of UH's financials."* So the report did address this issue.

And as noted previously in this document, SMMC also benefits substantially from state subsidies-- the state's charity care subsidy represented 14% of SMMC's operating revenue ($26M on operating revenues of $192M), a higher percentage than any of the other hospitals in the study except UH.

Perhaps one of the more egregious misstatements made in the supplemental response relates to the actual occupancy at SMMC. The supplemental response states "Saint Michael's is operating at an average 80% of capacity, with a census of 117 and 147 staffed beds, in 2013." This again likely is attributable to the lack of understanding on the part of the authors of the supplemental response regarding the difference between staffed beds and available beds. As noted throughout the report, the bed counts used were **available** beds, not staffed beds. And in fact, the research team that conducted the analyses summarized in the report actually conducted a physical tour of the entire SMMC facility and met with and verified SMMC's actual available bed count with representatives from SMMC on September 17, 2014. The results of this inventory are shown in the chart below and clearly indicate that SMMC has an available bed capacity of 248 beds.

Level	Description	Beds

		Private	Semi	Total
3 Bldg A	Med/Surg	2	40	42
3 Main	Med/Surg	11	24	35
4 Bldg A	Med/Surg	2	40	42
6 Main	CCU	10	0	10
6 Main	MICU	8	0	8
6 Main	SICU	6	0	6
7 Bldg A	Med/Surg	2	40	42
8 Bldg A	Med/Surg	2	40	42
Subtotal	**Subtotal Acute**	**43**	**184**	**227**
8	Behavioral Health			21
	Total All			**248**
Note Behavioral Health includes 20 beds plus 1 seclusion.				

Source: SMMC

If, in fact, SMMC is only staffing 147 beds, then that is a clear admission on their part that they have more available beds than they need to meet patient demand. And it is also clear that the report did **not** use the wrong numbers. The report was consistent in its use of available beds. It would appear the authors of the supplemental response used the wrong numbers.

The supplemental response focuses on the contention that "…Clara Maass and NBIMC are at full capacity, and therefore are in no position to take additional patients." The supplemental response does acknowledge that University Hospital has additional capacity. When the actual utilization numbers for CMMC, NBIMC, and UH are examined, it is evident there is sufficient capacity to accommodate the portion of patients from SMMC and EOGH that would likely seek care at one of the Planning Area hospitals (rather than one of the other ten hospitals located within 15 miles of downtown Newark). The chart below shows the 2013 ADC, available bed capacity, beds needed at 83% occupancy, and capacity available to accommodate patients from SMMC and EOGH.

FACILITY	AVERAGE DAILY CENSUS	BEDS NEEDED (@ 83% OCCUPANCY)	AVAILABLE BEDS	AVAILABLE CAPACITY @ 83%

CMMC	230	277	317*	40
NBIMC	324	390	430	40
UH	245	295	360	65
TOTAL	**799**	**962**	**1107**	**145**

Recall from the discussion earlier in this document that of the total average daily census of 226 at SMMC and EOGH that approximately 135 patients would likely find it more convenient to seek care at one of the other three study hospitals. In light of that estimate, it is clear that the available capacity of 145 beds (at 83% occupancy) at CMMC, NBIMC, and UH would be sufficient to meet the current volume of patients that would need to be re-accommodated. Recognize also, that given recent and long-term trends in utilization, the future number of patients that would need to be re-accommodated is likely to be **less** than 135. So the contention that CMMC and NBIMC are at full capacity is clearly incorrect. Furthermore, it should be noted that there is no "rule" that prevents hospitals from running a higher occupancy rate than 80% or 83% and in fact, many often do. If the target occupancy were set at 85% rather than 83% in the analysis shown above (and 85% is **not** considered an extraordinarily high or unrealistic occupancy rate), the need for beds would drop to 940 and the available capacity would increase to 167 beds, more than enough to accommodate the patients who would need to be re-accommodated.

Another contention in the SMMC supplemental response is "There are no current inpatients at Saint Michael's or EOGH who would prefer to travel outside of Newark." This appears to be a very broad generalization and there are no data provided to support the contention that **none** of the current patients would prefer to travel outside of Newark.

The supplemental response also claims that SMMC would incur significant one-time closing costs. It is important to recall that the recommendations in the report call for the **transformation** of SMMC and **not** its closure. It is expected that SMMC would continue to operate as a vibrant ambulatory healthcare resource and would retain a substantial percentage of its employee base. The supplemental response provides no detailed information to support or substantiate SMMC's estimate of one-time "closing costs." And it bears noting that even if the one-time costs are in the range of the SMMC estimate, those one-time costs are dwarfed by the ongoing operating losses incurred by SMMC which were more than $50M in FY 2012 and FY 2013—**excluding** the state subsidies of more than $50M. The supplemental response also states that many of the fixed costs at SMMC "…are overhead and administrative costs that will apply as long as any part of the hospital will remain open." It is clearly disingenuous to assume that if SMMC transforms to an ambulatory facility that it would not be able to reduce **any** of its fixed costs. This inability to adjust its costs may, in fact, be a major contributor the hospital's unsustainable financial situation.

The SMMC supplemental response misinterprets the report's recommendations when it states that the report's recommendations don't follow from the analyses by recommending the closing of SMMC and EOGH over closing UH. In fact, the recommendations call for transforming SMMC and EOGH, not closing

them and a careful reading of the recommendations and the report show that the recommendations call for transforming SMMC and EOGH **and** NBIMC. Further, the financial projections show that this recommendation was the **ONLY** scenario that resulted in a positive operating margin on a combined basis for the five study hospitals. All of the other scenarios resulted in significant negative operating margins—although all of them were better than the suggestion contained in the SMMC responses of doing nothing.

It is evident in reviewing the SMMC responses to the Greater Newark Healthcare Services Evaluation Report that both the original and the supplemental response significantly misinterpreted information and misunderstood analyses. Both responses make dramatic but largely unsubstantiated accusations and claims, virtually none of which appear to be true or accurate. The Greater Newark Healthcare Services Evaluation Report was thoroughly researched and presented well-documented analyses and recommendations supported by actual, accurate data. The report outlines a series of recommendations that when implemented will align the healthcare resources in the Greater Newark area with the current and future needs of the area's residents in a more economical, efficient, and effective manner.