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.