

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.

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.

¹⁵⁰<http://www.hospitalcompare.hhs.gov/Hospital/Search/SearchCriteria.asp?version=default&browser=Firefox%7C2%7CMacOSX&language=English&defaultstatus=0&pagelist=Home>

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) Mountainside 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.