

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.
- Legal counsel may not also serve as a director.

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.

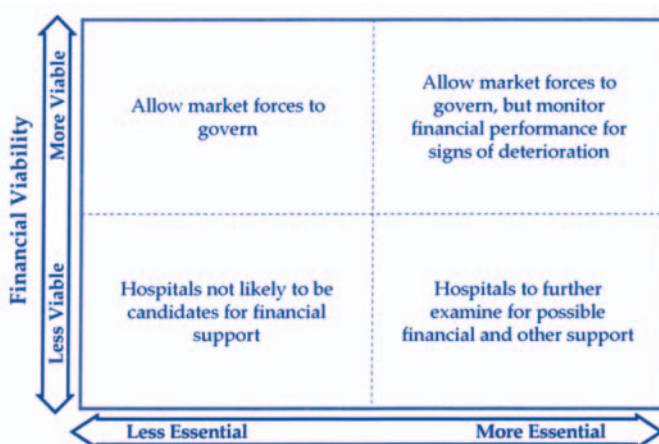
The Subcommittee's full report to the Commission is included in this report under Appendix 8.

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&resourcectype=1&disp_type=&author1=&fulltext=RHIO&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

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