New Jersey Commission on Rationalizing Health Care Resources

Interim Report

June 29, 2007

THE GREAT SEAL OF THE STATE OF NEW JERSEY

Jon S. Corzine
Governor

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Executive Summary

New Jersey's hospitals form an essential base for the State's health care delivery system, and serve as economic anchors for their communities. They are embedded in a dynamic health-care delivery system that finds itself buffeted by numerous forces largely or wholly outside of their control, including:

- the emergence of costly new health technology, growing labor shortages, especially of nurses and other highly skilled health workers;

- a shift of ever more of the delivery of care from the inpatient to ambulatory facilities, with many of the latter owned and operated by teams of independent entrepreneurs and physicians;

- a gradual but inexorable erosion of the employment-based health insurance system, especially among low-wage workers, without a replacement system in sight;

- the associated growing number of low-income residents without health insurance and ability to pay for costly care, whom hospitals must serve nevertheless; and

- fiscal pressures from the federal and state governments seeking to control their budgets in part by reimbursing hospitals at fees far below the cost of caring for publicly insured patients.

Hospitals are pressed to respond to these changes in a competitive health-care delivery marketplace that often pits hospital against hospital and that frequently leaves hospitals serving financially stressed segments of the population at a competitive disadvantage. Nationally, these forces subject many hospitals to fiscal strains. In New Jersey, these strains add up to an outright fiscal crisis for too many hospitals.

In recent years, a number of fiscally pressed New Jersey hospitals have turned to the State for emergency financing to stave off collapse. Requests for such financial assistance frequently arise at moments of crisis, forcing the State to react quickly, without the opportunity to reflect on the larger picture of New Jersey's needs for health care services.

In October 2006, Governor Jon S. Corzine created the *Commission on Rationalizing Health Care Resources* ("the Commission") to obtain expert advice on the means by which the State can regulate and support New Jersey's health care delivery system thoughtfully and prospectively, avoiding regulation by crisis management. Executive Order 39 charged the Commission to advise the Governor on means to support a system of high-quality, affordable, cost-effective and accessible care. In an era in which the State not only licenses hospitals, but in which the State's taxpayers also provide approximately one-quarter of all hospital revenue as a purchaser of services for Medicaid, Family Care, State and local employees and retirees, and through Charity Care and other grants, the Governor established the Commission to "ensure that

taxpayer dollars are spent wisely, to help meet New Jersey's healthcare needs in a sustainable way, and to enhance oversight and accountability."

The Governor appointed as Commission Chairman, Princeton University Professor Uwe E. Reinhardt. The Governor appointed eight additional voting members, and as non-voting members, three members of his Cabinet. A full listing of the Commission's membership is attached as Appendix 1. The Commission's charge included ten tasks:

- Assess and benchmark the financial and operating condition of New Jersey's general acute care hospitals, and assess the effectiveness of the programs and services offered by hospitals in the context of the services needed in their regions;

- Analyze the characteristics of New Jersey's most financially distressed hospitals to identify common factors contributing to their distress including the availability of alternative sources of care such as federally qualified health centers and other ambulatory care providers;

- Determine appropriate geographical regions for the assessment of the provision of care by hospitals and other health care providers including care for those who are low-income and medically underserved, and assess the current and projected future demand for services against existing capacity;

- Develop criteria for the identification of essential general acute care hospitals in New Jersey and use the criteria developed to determine whether a financially distressed hospital at risk of closing is essential to maintaining access to health care for the residents of New Jersey;

- Recommend the development of State policy to support essential general acute care hospitals that are financially distressed, including the development of performance and operational benchmarks for such hospitals;

- Assess and recommend improvements in current State policy concerning assistance to financially distressed hospitals that are non-essential and that seek to close but require debt relief or other assistance to enable them to do so;

- Evaluate appropriate alternative uses to which such facilities might be put, including but not limited to, their potential redeployment as federally qualified health centers, other ambulatory care providers, physician offices and treatment facilities;

- Recommend means for reviewing and approving the development and/or redeployment of health care assets and services around the State;

- Review existing Certificate of Need statutes and regulations to ensure consistency with State health care needs, and recommend amendments and/or revisions to achieve that objective if necessary; and

- Issue a written report of its findings and recommendations no later than June 1, 2007, to the Governor, the Senate President, the Senate Minority Leader, the Assembly Speaker, and the Assembly Minority Leader.

Although Executive Order 39 originally called for a final report by June 1, 2007, the Governor subsequently extended the time for the Commission to file its final report to December 1, 2007, requesting, however, that the Commission produce an interim report.

The Commission received a broad mandate in Executive Order 39. The Commission will address each of the ten tasks in its final report to the Governor and legislative leaders. The charge of the Commission is not to create a centralized, prescriptive plan for the provision of health care in New Jersey. That project is beyond the Governor's charge, and would fit uncomfortably in today's context of governmental and market influences on health care delivery. Instead, the Commission will provide advice on the means by which New Jersey might take steps as a purchaser, grantor, and regulator to improve the health of New Jersey's hospitals for the benefit of the people of New Jersey.

In this Interim Report, the Commission focuses on two aspects of the Governor's charge: the assessment of the financial and operating condition of New Jersey's hospitals, and the development of criteria for assessing whether and to what extent financially distressed hospitals seeking State assistance are essential in their current configurations for maintaining appropriate access to health care services for the people of New Jersey. The Commission is still in the midst of its process, and the conclusions contained in this report are therefore subject to revision. The Commission believes, however, that it is able to provide substantial information in response to the Governor's request.

A. THE FINANCIAL CONDITION OF NEW JERSEY HOSPITALS

Developments in health care delivery during the past two decades have forced changes on hospitals nationwide. Much care has moved from inpatient to outpatient settings and, for most inpatient episodes, lengths of stays have fallen. In response to these nationwide trends, some hospitals have reduced bed capacity and services, or closed altogether. Approximately seven percent of the nation's hospitals have closed since 1995. New Jersey has experienced an even greater number of closures: seventeen percent of our hospitals have closed in the same period.

Changes in health care finance have followed from changes in health care delivery. These financial shifts are central to an assessment of New Jersey's hospital system.

On all major financial indicators, New Jersey hospitals score, on average, below national benchmarks. Although some New Jersey hospitals are financially quite sound, many struggle to break even in their core hospital operations and in their overall activities. They have very little cash on hand to meet their financial obligations on a day-to-day basis, and they are chronically financially insecure. Many New Jersey hospitals have much more debt compared to their capital assets than do their national counterparts, further hampering their ability to meet current obligations to plan for future needs of their communities. Some New Jersey hospitals are faced with the need to improve aging buildings and invest in new technologies without financial reserves or access to credit to support the necessary investments.

The impact of all of these factors on the financial condition of New Jersey hospitals has been exacerbated by the economics of American hospitals in general – features not found anywhere else in the world and, indeed, so antithetical to sound health-sector management that no other country in the world would dream of copying them. These features are: (1) the endless attempts among payers for hospital care to shift financial responsibility for covering a hospital's cost among themselves through price discrimination; (2) the control American physicians have over resource allocation by and in hospitals, without commensurate accountability and responsibility for the costs hospitals incur as a result; and (3) the large number of uninsured and underinsured patients whom hospitals are mandated to serve without commensurate compensation. Chapter 2 will explore these peculiar features at greater length. Here it merely is noted that many, if not all, of the fiscal problems faced by New Jersey hospitals are rooted in these features of American health care.

The Commission's complete analysis and suggested long-term responses to these conditions will be provided in its final report. For purposes of this Interim Report, the Commission focused on the likelihood that the most strained of New Jersey hospitals will seek State aid to help them cope with their financial difficulties. That eventuality mandates some assessment of the role New Jersey hospitals play in health care delivery in their regions.

B. IDENTIFYING HOSPITALS WARRANTING STATE ASSISTANCE

In the context of New Jersey hospitals' troubled financial situation, the Commission is charged with assessing the extent to which financially troubled hospitals serve an essential role in their region. The aim is to develop for New Jersey government an evidence-based platform on which to base decisions on allocating the government's scarce fiscal resources to New Jersey's hospital system, rather than letting such decisions become the product of competition among political forces. An assessment of hospitals in terms of their financial viability and their essentiality is necessarily comparative.

Any approach to rationing scarce government resources to competing ends inevitably will not meet all needs, which means that any objective, evidence-based approach to the problem is likely to invite criticism. The same, however, is true of all systems of resource allocation – whether evidence-based or not. It is true even of rationing by competitive markets on the basis of price and ability to pay.

The question to be addressed by the Commission, then, is whether and to what extent a troubled hospital is in need of additional State financing, providing needed services would not adequately be provided by other available sources of care, should the hospital in question cease to operate. In its work, the Commission canvassed prior relevant research, notably:

- the *Final Report* of the New York State Commission on Health Care Facilities in the 21st Century (the "Berger" Commission), which concluded its work in December 2006;

- the highly respected work on hospital market areas and hospital activity of the Dartmouth Atlas Project by researchers at Dartmouth University; and

sundry other documents, newspaper articles and commentaries that bear on the task before the Commission.

Criteria for "Essentiality"

Inspired in part by the criteria of *essentiality* used in the above cited New York State report, and after much analysis and discussion supported by research performed for the Commission by Navigant Consulting, the Commission proposes the following factors as criteria for essentiality:

- **The intensity of the hospital's use compared to others in its service area**
    - Percent of emergency department visits in the service area
    - Inpatient occupancy – what percentage of staffed beds are used, compared with other hospitals in the service area
    - Total patient days and emergency department visits
- **The provision of high-level emergency care**
    - Trauma center designation
- **Provision of care for financially vulnerable populations likely to have few other sources of care**
    - Medicaid and uninsured patient discharges
    - Medicaid and uninsured patient emergency department visits
    - Ratio of dual eligible (Medicare/Medicaid) patient days to total Medicare patient days

Criteria for "Financial Viability"

The Commission settled on three major metrics to represent the financial condition of a hospital:

- ***Criterion: Profitability***
    - ***Metric: Operating Margin:*** Profitability here, in the context of non-for-profit hospitals, refers to the difference between operating revenues and operating expenses. Operating revenues consist mostly of payments received from third-party payers for services rendered to patients in the hospital. Operating expenses include salaries and benefits, supply and pharmacy costs, and capital expenses (depreciation and interest). Some positive margin is important even at not-for-profit hospitals to provide a cushion for inevitable swings in revenue, to undertake necessary improvements in their facilities and services, and to innovate in the delivery of services.

- ***Criterion: Liquidity***

    - ***Metric: Days Cash on Hand:*** Liquidity refers to a hospital's ability to pay for goods and services ordered and delivered. A lack of liquidity impairs a hospital's ability to do business and harms its ability to borrow. "Days cash on hand" is a useful measure that asks, "If income stopped today, how long could we continue to pay our expenses with current cash?" Businesses, including hospitals, use this measure to assess whether they are in a position to make reasonable short-term plans for continuing operations.

- ***Criterion: Capital Structure:***

    - ***Metric: Long-term Debt to Capitalization:*** Hospitals need access to funding to replace aging facilities and to make major improvements. This criterion measures the extent to which the value of a hospital's assets (and therefore its attractiveness to lenders for improvement projects) is offset by the long-term debt it has already taken on. Just as a house cannot be mortgaged for more than its value, so too a hospital faces limits on how much it can borrow against its existing assets to finance improvements.

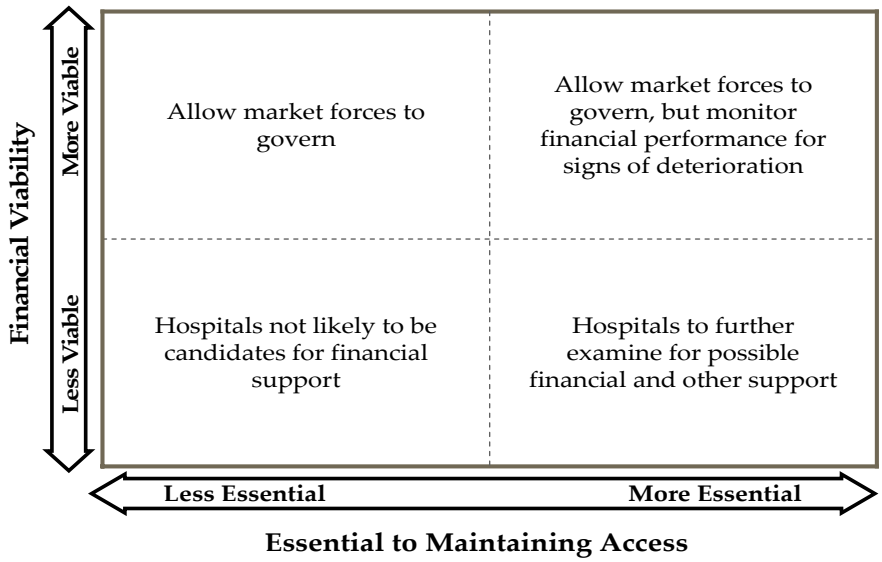
The Commission recommends using these criteria for the "essentiality" and "financial viability" of hospitals as a good starting point in assessing the relative urgency and advisability of providing additional state funding to distressed hospitals. It recognizes that in each particular case, the metrics should be reassessed to determine whether changes of circumstances change the analysis.

In addition to these purely quantitative metrics, there are important qualitative variables, not easily quantified, that the State will wish to consider in each case. These additional factors include but are not limited to:

- whether all services are accessible elsewhere in the region;
- travel time to other locations of service;
- whether a hospital is part of a system which has financial responsibility for it;
- public transportation alterations or other transportation modifications that may be necessary to maintain access;
- quality of care issues;
- impact of systems alterations on particular population groups; and
- impact on employment in the region.

To use the selected criteria underlying the two dimensions "essentiality" and "financial viability" in a comparative analysis of New Jersey hospitals, the Commission agreed on the following analytic framework for assessing the relative merits of individual hospitals for state support.

COMPARATIVE FRAMEWORK FOR EVALUATING HOSPITALS



Each hospital can be represented as one point in this grid, and the location of the hospital in the grid provides a first pass at evaluating a hospital's request for State aid. As noted earlier, however, a second pass will consist of taking into account the sundry qualitative factors listed above, and possibly still others.

Public Comment on the Proposed Criteria

The Commission posted this analytic framework on its website, www.nj.gov/health/rhc, for comment. In response, the following organizations submitted comments:

- Catholic HealthCare Partnership of New Jersey
- Health Professionals and Allied Employees (HPAE), AFT, AFL-CIO
- Hospital Alliance of New Jersey
- Meridian Health
- New Jersey Hospital Association
- Solaris Health System
- Somerset Medical Center
- Valley Health System

The Commission is grateful to these organizations for submitting their insightful remarks, which the Commission addresses with initial responses in Appendix 9. Some of the comments already have been incorporated into this Interim Report; others may be reflected in the Commission's subsequent work and final report.

Several overarching themes emerge from the comments:

- Hospitals need more financial resources. They receive inadequate reimbursement for Medicaid and charity care services. In addition, notwithstanding "prompt pay" laws, HMOs and insurance companies often do not pay adequate rates and sometimes deny and delay payment for services.

- State support should be tied to performance indicators that include quality and efficiency measures (e.g. governance, CEO turnover, length of stay, physician utilization, payer mix, investments in technology and capital programs, etc.).

- What constitutes "comprehensive services?" Hospitals have a whole host of key services (e.g., dialysis, cardiac surgery, obstetrics, and unique services offered by hospitals in each region like elective angioplasty) that should be weighted in the Commission's framework.

- Issues around essentiality, both the term and the criteria for measurement. In particular, mention was made of GME and allied health, geographic accessibility, economic impact to the community, and care provided to undocumented immigrants.

- Issues around measuring a hospital's financial viability and the metrics used to determine that.

- The framework needs to be grounded in comprehensive statewide health planning and not be limited to acute care hospitals.

Future Work of the Commission

Beyond the work reported in this Interim Report, the Commission plans to explore many other facets of New Jersey's hospital and general health-care system. To that end, it is in the process of creating a number of subcommittees that are to be composed of Commission members and experts drawn from the broader New Jersey community.

Furthermore, the Commission also looks forward to its public hearings, which will give it an opportunity to hear from a wide range of people who work in health care, and, more significantly, who rely on New Jersey's health care facilities for their families' well-being.

The Commission thanks Navigant Consulting for its technical assistance in its work so far, and thanks staff from the New Jersey Departments of Health and Senior Services and Human Services, the New Jersey Health Care Facilities Financing Authority, and the Office of the Governor for their hard work. In particular, the Commission thanks its Executive Director, Michele Guhl, and her assistant, Cynthia McGettigan, for their leadership and guidance.

Structure of Interim Report

As already noted, in this Interim Report, the Commission presents its preliminary findings focused on the financial condition of New Jersey hospitals and on developing criteria for assessing a hospital's "financial viability" and "essentiality."

In Chapter 1, the report will provide an outline of the Commission's tasks and its *modus operandi*. It then provides, in Chapter 2, a brief overview of the current state of New Jersey's hospitals. Next, in Chapter 3, the report addresses the financial condition of these hospitals in more detail. Finally, in Chapter 4, the report provides background and a justification for employing the criteria described above for assessing the comparative financial condition and the essentiality of New Jersey's hospitals.

Chapter 1

The Commission's Tasks

A. ESTABLISHMENT OF THE COMMISSION

Governor Jon S. Corzine created The Commission on Rationalizing Health Care Resources by executive order on October 12, 2006. Executive Order 39 set out ten tasks, which can be summarized as follows:

- Assess and benchmark the financial and operating condition of New Jersey's general acute care hospitals, and assess the effectiveness of the programs and services offered by hospitals in the context of the services needed in their regions;

- Analyze the characteristics of New Jersey's most financially distressed hospitals to identify common factors contributing to their distress including the availability of alternative sources of care such as federally qualified health centers and other ambulatory care providers;

- Determine appropriate geographical regions for the assessment of the provision of care by hospitals and other health care providers including care for those who are low-income and medically underserved, and assess the current and projected future demand for services against existing capacity;

- Develop criteria for the identification of essential general acute care hospitals in New Jersey and use the criteria developed to determine whether a financially distressed hospital at risk of closing is essential to maintaining access to health care for the residents of New Jersey;

- Recommend the development of State policy to support essential general acute care hospitals that are financially distressed, including the development of performance and operational benchmarks for such hospitals;

- Assess and recommend improvements in current State policy concerning assistance to financially distressed hospitals that are non-essential and that seek to close but require debt relief or other assistance to enable them to do so;

- Evaluate appropriate alternative uses to which such facilities might be put, including but not limited to, their potential redeployment as federally qualified health centers, other ambulatory care providers, physician offices and treatment facilities;

- Recommend means for reviewing and approving the development and/or redeployment of health care assets and services around the State;

- Review existing Certificate of Need statutes and regulations to ensure consistency with State health care needs, and recommend amendments and/or revisions to achieve that objective if necessary;

- Issue a written report of its findings and recommendations no later than June 1, 2007, to the Governor, the Senate President, the Senate Minority Leader, the Assembly Speaker, and the Assembly Minority Leader.

Here it should be emphasized that Executive Order 39 does not envisage the New Jersey Commission to be a hospital-closing commission, as was New York State's recently completed *Commission on Health Care Facilities in the 21st Century (the "Berger" Commission).* Unlike New Jersey's Commission, established by the Governor's executive order, New York's commission had been established by statute of the legislature and was tasked with identifying hospital candidates for closure, for conversion into other health-care facilities or for consolidation into other hospitals. The New York Commission's recommendations were to be approved or rejected by the legislature in an up-or-down vote, just like an army base closing commission. By contrast, the New Jersey Commission is an advisory body established to make recommendations on the allocation of scarce state assistance funds to hospitals on an objective, evidence-based platform that can help the State's government allocate these funds more rationally.

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

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

B. THE COMMISSION'S *MODUS OPERANDI*

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

Although the Commission was initially charged with producing a final report by June 1, 2007, the Governor, instead, has asked that the final report be provided by December 1, 2007, and that the Commission provide an interim report, to which request this Interim Report is responsive.

The Commission received a broad mandate in Executive Order 39. The Commission will address each of the ten tasks in its final report to the Governor and legislative leaders. The charge of the Commission is not to create a centralized, prescriptive plan for the provision of health care in New Jersey. That project is beyond the Governor's charge and would fit uncomfortably in today's context of governmental and market influences on health care delivery. Instead, the Commission will provide advice on the means by which New Jersey might take steps as a purchaser, grantor, and regulator to improve the health of New Jersey's hospitals for the benefit of the people of New Jersey.

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

done over many years by the Dartmouth Atlas Project at Dartmouth Medical School. The Dartmouth Atlas Project has produced extensive data on health care utilization trends and, in particular, on geographic differences in health care utilization.

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

- the *2006 New Jersey Health Care Almanac* (October 2006) by the Washington, D.C. based consulting firm Avalere Health LLC, supported by research grants from the Robert Wood Johnson Foundation and Horizon Blue Cross Blue Shield of New Jersey;

- *New Jersey Acute Care Hospitals Financial Status* (2006), a report commissioned by the New Jersey Hospital Association;

- New Jersey Department of Health and Senior Services, *New Jersey 2006 Hospital Performance Report*;

- Hospital Alliance of New Jersey, *Examining the State of Our Health Care System: The Unique Challenges Facing Urban Hospitals and their Importance in our State* (October, 2006); and

sundry other documents, newspaper articles and commentaries that bear on the task before the Commission.

The entire Commission has met in person on six occasions, and has conducted numerous telephone conferences. Working with its technical consultant and State staff, the Commission has begun to work through the Executive Order's charge. Included in its six meetings was a meeting specially devoted to hearing from the four hospital associations in the State: the New Jersey Hospital Association, the New Jersey Council of Teaching Hospitals, the Hospital Alliance of New Jersey, and the Catholic Health Care Partnership of New Jersey. It also received information on hospital-physician interactions from a New Jersey-based consulting firm.

C. THE WORK OF SUBCOMMITTEES

The Commission has created subcommittees in the following areas:

- Access & Equity for Medically Underserved

- Benchmarking for Efficiency & Quality

- Infrastructure of Health Care Delivery (with emphasis on IT)

- Reimbursement/Payers

- Regulatory & Legal Reform

- Hospital/Physician Relations and Practice Efficiency

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

The Commission will also conduct three public hearings during the summer months. These hearings will be in the Northern, Central, and Southern parts of New Jersey. The hearings will give the public an opportunity to provide additional information to the Commission, and will permit the Commission the opportunity to hear the concerns of the people of New Jersey well in advance of its preparation of its final report. The public is also invited to submit comments on the Commission's website, www.nj.gov/health/rhc.

The Commission will gather information from these various sources in the fall, and will deliberate and draft its final report by December 1, 2007.

D. MAJOR THEMES EMERGING FROM THE PROCESS

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

The Commission has been developing information basic to its overall charge, and has been focused on the materials necessary for the completion of this Interim Report. Any conclusions provided at this time are, of course, tentative, as there will be many opportunities for the Commission to gain additional information and to deliberate on the complex issues before it. The information received to this point, however, permit the discussion of several emerging, if tentative, themes:

1. Testimony provided by hospitals and their organizations have reiterated the point that they are in dire financial condition. The hospitals report strained payment streams, rising costs, aging facilities, and projections for more of the same.

2. The hospitals' prescription has been for increased funding. The Commission acknowledges the seriousness of the hospitals' financial condition. In determining the proper public policy response, however, the Commission is considering a number of other factors. For example, information provided by the Dartmouth Atlas Project and others suggests wide variations in practice patterns without apparent medical justification. These data suggest that a public policy response might include measures to ensure that care is of appropriate quality and efficiently provided.

3. Addressing the relationship between hospitals and physicians is central to the task of addressing the financial condition of hospitals. As has long been recognized, the means by which hospitals and physicians are paid creates tensions between physicians and hospitals. Hospitals are often paid by the case, receiving a set sum for a course of treatment largely independent of the intensity of services provided to a particular patient. The hospital, however, does not manage the care provided. Rather, it is the physician

who manages that care. The physician, unlike the hospital, is often paid more when a patient receives more intense services, although it generally is the hospital, and not the physician, that absorbs the cost of increased intensity of care. There are several emerging models for aligning the incentives and interests of hospitals and physicians in this regard. The Commission will examine those models as it considers means to rationalize health care in New Jersey.

4. Additional funding for hospitals, particularly essential hospitals in very weak financial condition, may be necessary. However, the State of New Jersey, as both a regulator and as the provider of approximately one-fourth of the revenues of New Jersey hospitals, has a responsibility to provide hospital funding prudently. The Commission will consider the extent to which extraordinary assistance should be provided only when a hospital agrees, where appropriate, to specific steps assuring responsible governance, high quality care, and efficient delivery of services. These conditions may include reorganization of hospital boards to include additional public members, agreement to benchmarks for quality and efficiency, and other conditions.

5. Hospitals in New Jersey are going through wrenchingly difficult times. One's response to these painful circumstances, however, should not be simply to maintain the status quo. Hospitals have closed in New Jersey and the nation, and additional hospitals will no doubt close as the need for health care evolves. Rather than setting as the goal preserving current facilities in precisely their current configuration, policymakers should instead examine health care delivery trends and the needs of the people of New Jersey, and propose actions to improve access to high quality, efficiently provided care. In the short term, this perspective might be little different than that proposed by the hospitals. It may, however, call for different steps in some current circumstances, and it may well counsel different long-term steps.

The Commission looks forward to engaging in greater depth these and other issues related to the Governor's charge.

E. THE INTERIM REPORT

The Governor requested that the Commission provide in this Interim Report an assessment of the financial and operating condition of New Jersey's hospitals, and a preliminary set of criteria for assessing whether and to what extent financially distressed hospitals seeking State assistance are essential in their current configurations for maintaining appropriate access to health care services for the people of New Jersey.

The next two chapters of this Interim Report deal with a subset of the Commission's charge. Chapter 2 will present an overview of New Jersey's acute care general hospital sector and the population it serves. That chapter will end with a primer on the peculiar economics of American hospitals. Chapter 3 presents data on the financial condition of New Jersey hospitals. Finally, Chapter 4 will describe more fully the Commission's proposed framework for evaluating the relative financial viability and the relative essentiality of New Jersey hospitals.

Chapter 2

New Jersey's Acute Care Hospital Sector

A. THE POPULATION BEING SERVED

Demographics and the Economy

As is apparent from the data below, the population being served by New Jersey's health care system does not differ significantly from the overall U.S. population.

Population Distribution by Age, states (2004-2005), U.S. (2005)

	NJ #	NJ %	US #	US %
Children 18 and under	2,295,880	26	77,908,220	27
Adults 19-64	5,331,370	61	179,534,430	61
65+	1,062,220	12	35,504,790	12
65-74	516,690	6	18,553,830	6
75+	545,520	6	16,950,960	6

Population Distribution by Race/Ethnicity, states (2004-2005), U.S. (2005)

	NJ #	NJ %	US #	US %
White	5,526,770	64	195,289,750	67
Black	1,133,760	13	35,539,910	12
Hispanic	1,397,180	16	43,077,110	15
Other	631,770	7	19,040,670	6
Total	8,689,470	100	292,947,440	100

Distribution of Total Population by Federal Poverty Level, states (2004-2005), U.S. (2005)

	NJ #	NJ %	US #	US %
Under 100%	1,107,930	13	50,658,400	17
100-199%	1,246,460	14	55,241,860	19
--Low Income Subtotal	2,354,400	27	105,900,260	36
200% +	6,335,070	73	187,047,180	64
Total	8,689,470	100	292,947,440	100

Poverty Rate by Race/Ethnicity, states (2004-2005), U.S. (2005)

	NJ #	NJ %	US #	US %
White	397,290	7	22,643,440	12
Black	284,430	25	11,725,390	33
Hispanic	366,760	26	12,502,230	29
Other	NSD	NSD	3,787,350	20

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

In 2005, New Jersey's median household income ($59,989) exceeded the U.S. median ($46,037) by 30%, making New Jersey one of the wealthiest states in the U.S. State tax collections per capita in 2005 ($2,631) exceed the comparable national average ($2,191) by 20%. These taxes include all property taxes, sales and gross receipts, licenses, income taxes, and other taxes. New Jersey State per capita spending from its general fund, federal funds, other state funds, and bonds in that year ($4,769) exceeded the comparable U.S. average ($4,175) by 14.3%. In sum, New Jersey is a relatively rich state whose taxes and per capita spending exceed the national average by sizeable margins. [1]

Health Insurance Coverage

In comparison with the U.S. as a whole, New Jersey's residents have slightly better health insurance coverage, although here as elsewhere there are a large number of uninsured residents heavily concentrated in the lower income strata.

Health Insurance Coverage of the Total Population, states (2004-2005), U.S. (2005)

	NJ #	NJ %	US #	US %
Employer	5,483,960	63	158,063,050	54
Individual	239,650	3	14,253,600	5
Medicaid	676,790	8	37,838,090	13
Medicare	1,021,710	12	34,653,100	12
Other Public	34,370	0	3,325,030	1
Uninsured	1,232,980	14	44,814,570	15
Total	8,689,470	100	292,947,440	100

Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL), states (2004-2005), U.S. (2005)

	NJ #	NJ %	US #	US %
Under 100%	373,190	39	16,193,920	35
100-199%	300,090	31	13,164,730	29
--Low Income Rate	673,280	35	29,358,650	32
200% or more	534,030	9	15,006,950	9
Total	1,207,310	NA	44,365,600	NA

Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL), states (2004-2005), U.S. (2005)

	NJ #	NJ %	US #	US %
Under 100%	373,190	31	16,193,920	37
100-199%	300,090	25	13,164,730	30
--Low Income Subtotal	673,280	56	29,358,650	66
200% or more	534,030	44	15,006,950	34
Total	1,207,310	100	44,365,600	100

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

[1] The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

Although relatively more New Jersey residents obtain their health insurance coverage at the place of work than do Americans in general, the likelihood of that coverage varies by the size of the firm's workforce, here as elsewhere in the United States, as is shown in the display below. Health insurance premiums for employment-based health insurance tend to be higher than the comparable national average, although New Jersey employers appear to pay for a somewhat higher fraction of those premiums.

Percent of Private Sector Establishments That Offer Health Insurance to Employees, by Firm Size, 2003

	NJ %	US %
Firms with Fewer than 50 Employees	51.6	43.2
Firms with 50 Employees or More	94.4	95.4

Average Single Premium per Enrolled Employee For Employer-Based Health Insurance, 2004

	NJ $	NJ %	US $	US %
Employee Contribution	613	16	671	18
Employer Contribution	3,269	84	3,034	82
Total	3,882	100	3,705	100

Average Family Premium per Enrolled Employee For Employer-Based Health Insurance, 2004

	NJ $	NJ %	US $	US %
Employee Contribution	1,886	17	2,438	24
Employer Contribution	9,539	84	7,568	76
Total	11,425	100	10,006	100

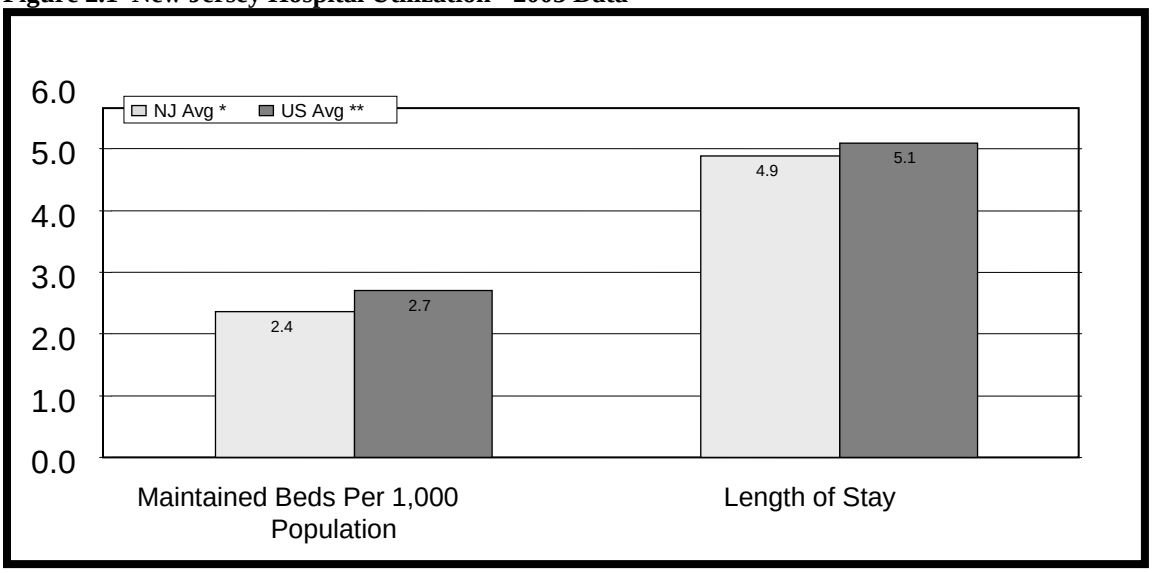
SOURCE: The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

B. NEW JERSEY'S GENERAL ACUTE CARE HOSPITALS

In 2005, New Jersey had about 25,000 licensed beds in general acute care hospitals, of which only about 20,000 were "maintained," that is, staffed for potential occupancy.[2] That endowment represents about 2.4 beds per 1,000 population, compared to the U.S. average of 2.7.

[2] Avalere Health LLC, *2006 New Jersey Health Care Almanac – Summary* (2006): Figures 1.1 and 1.2

Figure 2.1 New Jersey Hospital Utilization - 2005 Data



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

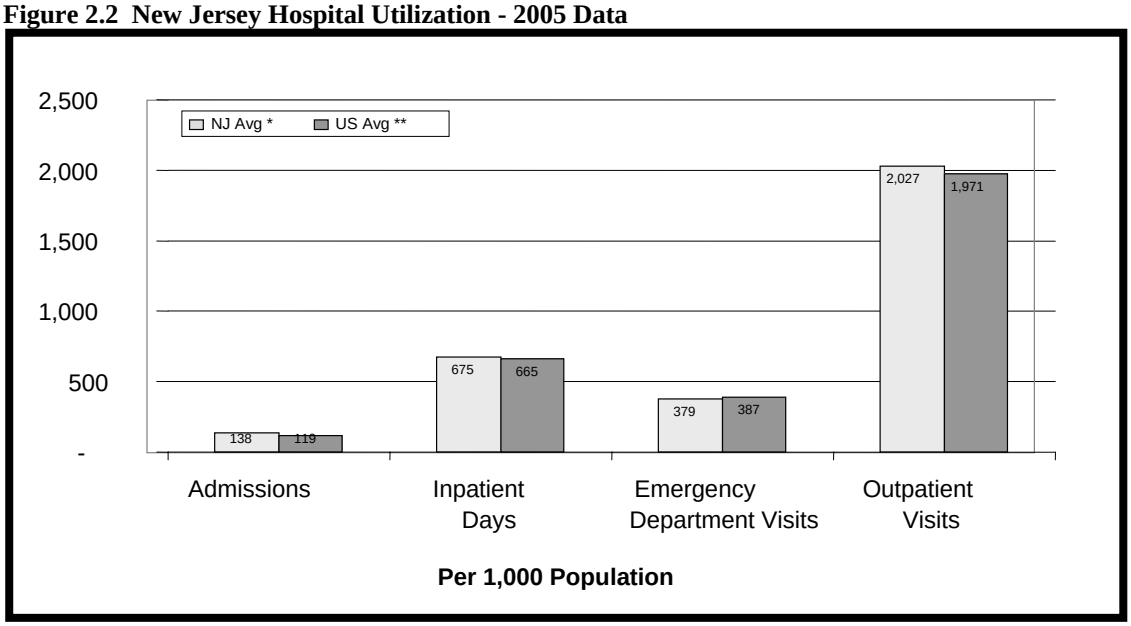
There was, however, considerable variation in this endowment across New Jersey. Essex-Union and Mercer Counties had 20% and 47% more maintained beds per capita than the state average, while Middlesex-Somerset, Cumberland-Gloucester-Salem and Warren-Hunterdon had about 25% fewer maintained beds per capita. [3]

In 2004, the average occupancy rate of maintained beds in New Jersey hospitals (74%) was only 5 percentage points below the national average (79%), and has trended up ever so gradually since 2001. That average rate, too, varies among regions in New Jersey and among hospitals within regions. In 2005, for example, the occupancy rate of maintained beds was close to 85% in Middlesex-Somerset, but only 60% or so in Mercer County.[4]

The overall average per capita utilization of New Jersey hospitals is quite similar to the U.S. average, as is shown in Figure 2.1. The use of hospital care by Medicare beneficiaries, however, appears to be very high in New Jersey relative to the U.S. as a whole.

[3] *Ibid.*: Fig. 1.3
[4] *Ibid.*: Fig. 2.11.

Figure 2.2 New Jersey Hospital Utilization - 2005 Data



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

Tables 2.1 and 2.2, based on data from the Dartmouth Atlas Project and cited in the previously referenced report by Avalere, illustrates this point. It appears that on both metrics, physician visits per beneficiary and hospital utilization per Medicare beneficiary in their last two years of life, New Jersey ranks near or at the top of the 50 states.

Table 2.1 Rank of New Jersey on Selected Characteristics of Hospital Care for Chronically Ill Medicare Beneficiaries. 1999-2003

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

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

Table 2.2 Rank of New Jersey Among All States on Selected Characteristics of Physician Care for Chronically Ill Medicare Beneficiaries. 1999-2003

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

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

Thus, it is not surprising that in 2002, the last year for which these data are conveniently available, total Medicare spending per Medicare beneficiary served in New Jersey ($8,661) was 27% higher than the national average ($6,823). The comparable number per beneficiary, served or not, was $7,834 for New Jersey, which was 25% higher than the comparable national average ($6,271).[5]

C. THE ECONOMICS OF AMERICAN HOSPITALS

As for any economic enterprise, a hospital's economic circumstances are driven by the managerial acumen of the hospital's management and by factors more or less outside the control of the hospital's management. In the hospital sector, the latter typically dominate the former.

Factors Largely Within The Hospital's Control

A hospital's degree of excess capacity (if any), its staffing patterns and issues such as supply-inventory management, work flow, patient safety and overall quality can be substantially linked to decisions by the hospital's own management.

In this regard it may be noted that managerial decisions in not-for-profit hospitals necessarily take into account goals other than purely profit-oriented ones, whereas the for-profit hospitals must deal with and address the ongoing pressure of quarterly earnings expectations.

Factors Largely Beyond the Hospital's Control

Few outsiders not intimately familiar with this nation's hospital sector appear to understand the peculiar economic structure in which American hospitals find themselves embedded. They are unique in the world.

Physician Autonomy and Hospital Costs: First, in contrast to hospital system in most other countries, in which hospital-based physicians are the hospital's full-time employees, hospital-based physicians in the United States are, for the most part, independent entrepreneurs who have the privilege, as it called, to use the facilities of the hospitals with which they are affiliated.

Practically, this means that many resource allocation decisions made by a hospital are directly affected by affiliated physicians, rather than solely under the purview of hospital management. Because physicians are the conduits through which hospitals attract revenue-yielding patients, they have significant influence over hospital management decisions.

As a result of the relationship, physicians have not historically been held economically accountable for their use of hospital resources in the treatment of patients. Neither the federal nor the state governments have so far focused on that facet of American health care. Hospital managers for their part, have only limited options for doing so, because affiliated physicians are the conduits that bring revenue to the hospital.

[5] The Henry J. Kaiser Family Foundation, www.Statehealthfacts.org

The impact of the traditional physician autonomy in their use of health-care resources has been studied for decades now by previously mentioned Dartmouth Atlas Project. Table 2.3 illustrates some of findings from the project that are relevant to New Jersey.

Table 2.3 Medicare Payments for Inpatient Care During the Last Two Years of Life of Medicare Beneficiaries
(Ratio of New Jersey Hospital's Data to Comparable U.S. Average, 1999-2003)

	Inpatient Reimbursements	Hospital Days	Reimbursements per Day	CMS Technical Quality Score
HOSPITAL A	**3.21**	**2.34**	**1.37**	**0.91**
HOSPITAL B	**2.32**	**1.26**	**1.83**	**0.95**
HOSPITAL C	**1.86**	**1.85**	**1.01**	**0.81**
HOSPITAL D	**1.83**	**1.83**	**1**	**0.59**
HOSPITAL E	**1.75**	**1.72**	**1.02**	**0.74**
HOSPITAL F	**1.58**	**1.86**	**0.85**	**0.83**
HOSPITAL G	**1.27**	**1.36**	**0.94**	**0.90**
HOSPITAL H	**1.17**	**1.26**	**0.93**	**0.94**
HOSPITAL J	**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.

As is shown in the second column of Table 2.3, in a year falling into the 1999-2003 time interval, Medicare paid Hospital A in New Jersey 3.21 times as much per decedent living in that hospital's market area during their last two years of life than the comparable average for the U.S. as a whole. By contrast, Hospital J in New Jersey was paid by Medicare an amount fairly close to the average. The third and fourth columns in Table 2.3 show the composition of the overall Medicare payment into the number of hospital days and Medicare reimbursement per day. Thus, Medicare beneficiaries living in their last two years of life in the market area of Hospital A had 2.34 times as many hospital days as the national average, and Hospital A was paid 37% more per day by Medicare than the comparable national average.

It is hard to imagine that the high variance in resource use displayed in Table 2.3 reflects commensurate variations in the demographic composition of Medicare beneficiaries in their last two years of life or in their health status. In any event, the findings from the Dartmouth Atlas Project are statistically adjusted for such differences.

Additionally, there is no evidence that these differences in resource use are reflected in commensurate differences in the quality of health care and in the patients' quality of life. There now exists a sizeable body of research indicating that there is not a statistically detectable difference in the quality of care and quality of life of patients in the high-cost regions and the low-cost regions of the United States. Indeed, one study has found the correlation

between resource use and quality of care to be negative[6]. As is shown in the right-most column of Table 2.3, the spending differences in New Jersey do not seem to be correlated at all to the Technical Quality Index developed and published on a hospital-by-hospital basis by the Centers of Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services.

So far, the chief explanation proffered by health services researchers is that the observed spending differential reflects in part, the preferred practice style of physicians. In any event, physicians find themselves increasingly challenged to defend these spending variations. They will be forced to do so in future years by the confluence of two trends: first, the emergence of ever more sophisticated software that can track every physician's order entry by input ordered by medical case, and, second, health-care spending trends that drive employers, governments and individual families into fiscal distress.

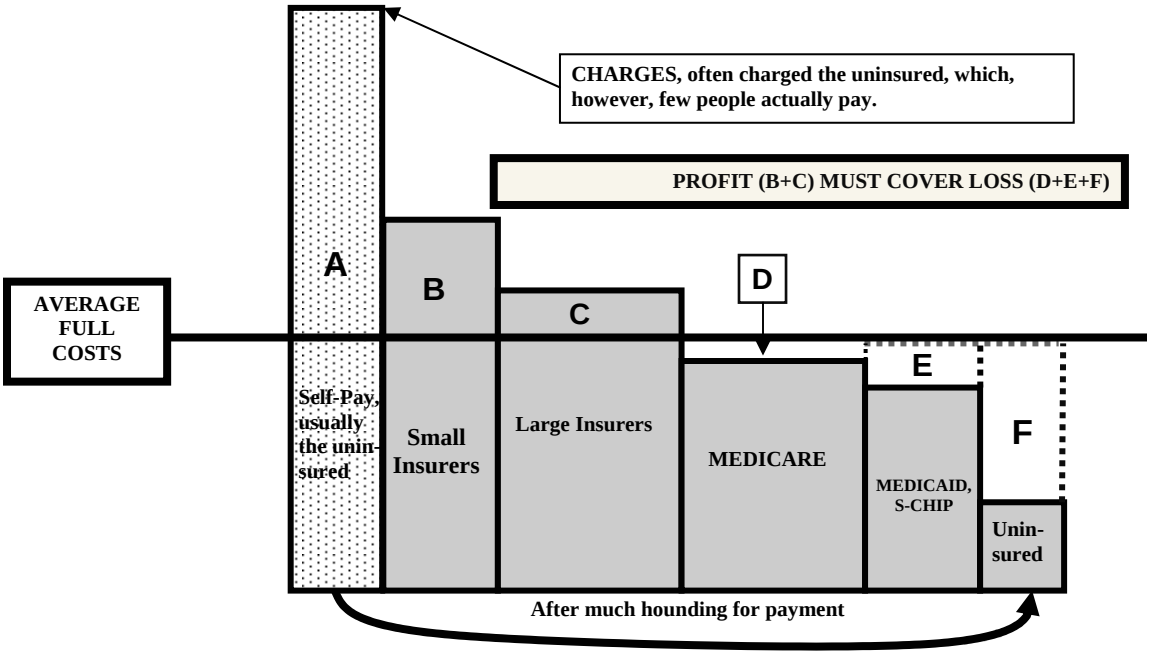
During its deliberations, the Commission heard a presentation by a New Jersey-based consulting firm that has developed sophisticated software capable of tracking physician order entries. The Commission learned from that presentation that there appear to be large variances in resource use by physicians for identical, severity-adjusted cases even within the same hospital. The Commission will pursue the potential of such software, available from other sources as well, through its subcommittees on *Infrastructure and Health Care Delivery (including IT)* and *Hospital/Physician Relations and Practice Efficiency*.

Although the actual names of the hospitals represented in Table 2.3 are known to the Commission, no present purpose is served by revealing them in this Interim Report. The Commission recommends, however, that such data become routinely available to the public. Only on the basis of such transparency can the State's residents know that their health spending is cost-effective.

Pervasive Price Discrimination: A second, uniquely American feature of the hospital sector is pervasive price discrimination, which effectively makes American hospitals an hydraulic financial system, as illustrated in Figure 2.3.

[6] Katherine Baicker and Amitabh Chandra, "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Car**e,"** *Health Affairs* Web Exclusive, April 7, 2004.

FIGURE 2.3 THE U.S. HOSPITAL AS A HYDRAULIC FISCAL SYSTEM



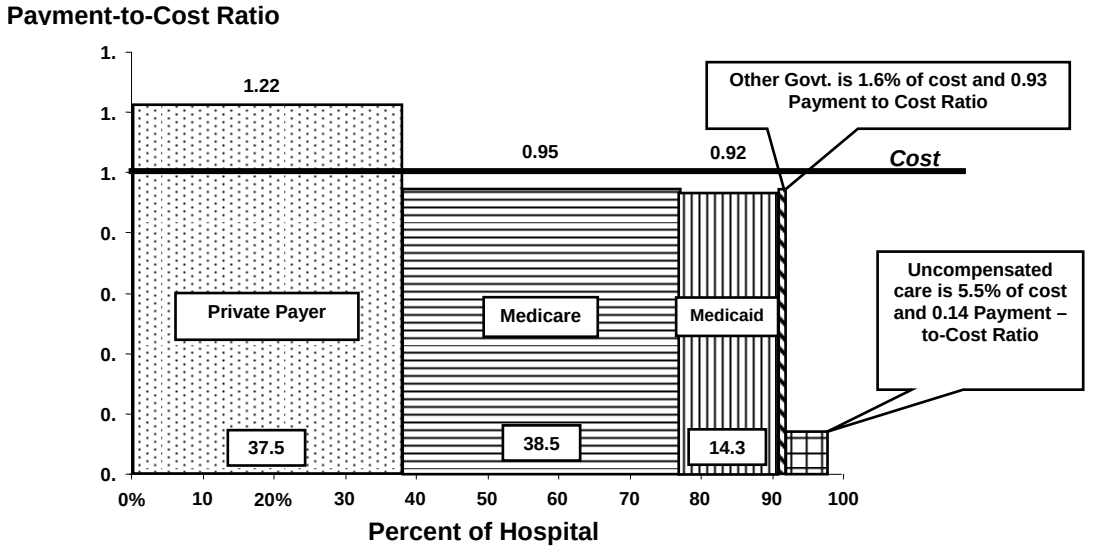
SOURCE: Adapted from a design by Larry Lewin.

In that hydraulic financial system, some insurers (notably the federal Medicare program for the elderly and the federal/state Medicaid program for the poor) pay the hospital prices much below the cost of caring for patients covered by these insurers. The hospital must then somehow cover this payment shortfall by charging private insurers and self-paying (uninsured) patients prices that are considerably above the cost of caring for these patients.

In Figure 2.3, areas B and C must cover the deficits D+E+F. Although many hospitals charge uninsured patients the highest markups over costs (see column A of Figure 2.3), few patients actually pay those charges, as the uninsured typically either default on their debt altogether or negotiate with hospitals for discounts off the high charges.

Figure 2.4 illustrates the hydraulic cost-shift described above with real numbers from the year 2005, albeit for the United States acute care hospital sector as a whole. Here it must be noted that the Medicaid shortfall, which in 2004 was 8% for the nation as a whole, had been much larger. In its previously cited report *New Jersey Acute Care Hospitals Financial Status* (October 3, 2006), the consulting firm Accenture reports states that the 2004 Medicaid payment-to-cost ratio for inpatient hospital services was only about 0.73, up from 0.70 in 2002. (It should be noted, however, that Medicaid reimburses hospital costs, minus a nominal discount (5.8%), for outpatient hospital services. Hence, the blended cost coverage for all hospital services in 2004 was approximately 81%.) This could partially explain why the premiums for employment-based health insurance in New Jersey are higher that the national average.

FIGURE 2.4 The Cost-Shift as a Payment Hydraulic – United States Averages, 2004



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

In the current pricing system, different payers compete with one another in their effort to shift responsibility for covering a hospital's cost to other payers – with Medicare and Medicaid in the lead as cost shifters.

One economic impact of the cost shifting may be that hospitals, which are unable to charge private payers high enough mark-ups over cost, can easily slide into financial distress.

The ethical problems triggered by these policies lie in their impact on low-income, uninsured residents. As a result of state and federal legislation, as well as contracts with commercial insurers, hospitals typically charge uninsured, self paying patients higher prices than are paid by private insurers.

It may be noted in passing that, according to the Henry J. Kaiser Family Foundation, payment ratios for New Jersey physicians are even lower than those for hospitals, as is shown below.

Medicaid Physician Fee Index, 2003

	NJ #	US #
All Services	0.56	1.00
Primary Care	0.61	1.00
Obstetric Care	0.41	1.00
Other Services	0.65	1.00

Medicaid-to-Medicare Fee Index, 2003		
	NJ #	US #
All Services	0.35	0.69
Primary Care	0.34	0.62
Obstetric Care	0.31	0.84
Other Services	0.43	0.73

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

Economists teach their students that relative prices signal relative social valuations. Thus, when the New Jersey Medicaid program pays physicians significantly less than the commercial market for the identical service, the implication is that their care for low-income children is not as socially valuable as care provided to a child of better means. This implied message may account for the fact that so many physicians refuse to treat Medicaid patients. While hospitals are bound by law not to differentiate in their treatment of patients by level of payment for their care, physicians are not so constrained. In recognition of this unintended implication, Governor Corzine's State Fiscal Year 2008 recommended budget includes $5 million in State dollars to increase Medicaid reimbursement rates for services to children, effective January 2008. Resultantly, on an annualized basis, an additional $20 million will be available in State and federal funds combined. This will bring Medicaid reimbursement rates from approximately 40% to about 80% of what Medicare pays on average.

The Uninsured and Underinsured: A third economic factor beyond hospitals' control is the number of uninsured or underinsured patients looking to them for health care.

Although no American federal or state legislator has ever argued that the problem of the homeless should be dealt with by mandating hotels to offer rooms free of charge to the homeless, American policymakers at all levels of government have mandated hospitals to function in effect as an informal catastrophic health insurance system for uninsured Americans. This is done by mandating hospitals to care for the uninsured and then to recover the cost of that care from other payers or from governments in the form of sundry subsidies. The economic and ethical implications of that policy have already been explored above.

To be sure, federal and state governments have tried to deal with that problem through a variety of direct and indirect financing, details of which for New Jersey are presented below under the headings "Subsidy Payments" and "Contract and Line Item Appropriations."

As is illustrated in Table 2.4, the State of New Jersey will pay over $3.7 billion in State Fiscal Year 2007 to the acute care hospitals operating within the State. This represents approximately 23% of the reported $16.2 billion in total hospital net patient revenue. This level of State spending is up nearly 45% from just four years ago. State Fiscal Year 2007 Medicaid payments of over $1.7 billion account for 48% of the state support and have grown by 33% since 2003, while $850 million in State Health Benefits payments, $786 million in subsidy payments and $300 million in contract and line item appropriations make up 23%, 21% and 8% respectively of State payments to the industry. The largest growth percentage in State expenditures over the last four years has occurred in State contracts and line item appropriations. The 176% growth is most attributable to the annual escalation of executive and legislative enhanced support for hospitals which occurs through the State budget process.

For presentation in Table 2.4, State spending has been categorized into four separate payment categories: State Health Benefits; Medicaid; Subsidies; and Contracts and Line Item Appropriations.

1) State Health Benefits are medical payments for qualified public employees, retirees and their eligible dependents.

2) Medicaid payments are inclusive of expenditures made for both the “traditional” Medicaid population (low-income parents, children and people who are blind or disabled), as well as for those enrolled in the State’s NJ FamilyCare program (health coverage for children whose family's incomes are too high for them to qualify for "traditional" New Jersey Medicaid but not high enough to be able to afford private health insurance). Graduate Medical Education payments provide funding to hospitals which serve a large proportion of Medicaid patients and are distributed to eligible hospitals based upon the number of residents in relation to other qualified hospitals.

3) Subsidy payments are comprised of:

    a. Charity Care payments made to acute care hospitals to subsidize the cost of uncompensated care provided to low income persons. Distribution follows the statutory formula and is based on a proportion of a hospital’s documented charity care provided to low income persons discounted with a profitability factor;

    b. Hospital Relief Subsidy Fund payments that provide additional reimbursement to disproportionate share hospitals which serve a large proportion of low income persons and have a high volume of target services which are most commonly used by low income persons; and

    c. The Hospital Relief Subsidy Fund for Mentally Ill and Developmentally Disabled Clients that provides additional reimbursement to disproportionate share hospitals which serve a large number of low income mentally ill or developmentally disabled clients. The distribution of the fund is based upon recommendations by the Division of Mental Health and Hospitals with particular attention paid to those hospitals essential to preserve the fragile network of mental health providers in the State.

4) Contract and Grant Payments are other State expenditures paid to hospitals through individual contracts for specific services and for executive and legislative support to specific facilities.

Table 2.4 Five-Year Summary of State Payments to NJ Acute Care Hospitals

	Est. SFY2007	SFY2006	SFY2005	SFY2004	SFY2003
State Health Benefit Payments [1]	$ 849,900,000	$ 803,300,000	$ 737,500,000	$ 588,300,000	$ 538,800,000
Medicaid Payments:					
Managed Care [2]	$ 808,800,000	$ 690,000,000	$ 557,700,000	$ 521,700,000	$ 507,500,000
Fee For Service [3]	$ 925,200,000	$ 841,500,000	$ 799,200,000	$ 749,500,000	$ 788,700,000
Graduate Medical Education [4]	$ 20,000,000	$ 20,000,000	$ 20,000,000	$ 20,000,000	$ 20,000,000
Sub-Total:	$ 1,754,000,000	$ 1,551,500,000	$ 1,376,900,000	$ 1,291,200,000	$ 1,316,200,000
Subsidy Payments:					
Charity Care [5]	$ 583,400,000	$ 583,400,000	$ 583,400,000	$ 381,232,000	$ 381,232,000
Hospital Relief Subsidy Fund [6]	$ 183,000,000	$ 183,000,000	$ 183,000,000	$ 183,000,000	$ 183,000,000
Hospital Relief Subsidy Fund for Mental Health [7]	$ 20,000,000	$ 20,000,000	$ 20,000,000	$ 20,000,000	$ 20,000,000
Sub-Total:	$ 786,400,000	$ 786,400,000	$ 786,400,000	$ 584,232,000	$ 584,232,000
Contract & Grant Payments:					
State Agency Contracts [8]	$ 153,900,000	$ 152,000,000	$ 80,000,000	$ 86,000,000	$ 81,700,000
Line Item Appropriations (including Hosp. Asst. Grants) [9]	$ 145,700,000	$ 123,500,000	$ 60,200,000	$ 43,000,000	$ 27,000,000
Sub-Total:	$ 299,600,000	$ 275,500,000	$ 140,200,000	$ 129,000,000	$ 108,700,000
TOTAL:	**$ 3,689,000,000**	**$ 3,416,700,000**	**$ 3,041,000,000**	**$ 2,592,732,000**	**$ 2,547,932,000**
Annual Growth from Previous Year:	8.0%	12.4%	17.3%	1.8%	
Aggregate 4 Year Growth:	44.8%				
TOTAL HOSPITAL NET PATIENT REVENUE [10]	**$ 16,200,000,000**	**$ 15,700,000,000**	**$ 14,800,000,000**	**$13,900,000,000**	**$ 13,200,000,000**
State Payments as Percent to Total Revenue	22.8%	21.8%	20.5%	18.7%	19.3%

SOURCES:

(1) Data from the State Health Benefits Administration, CYs 2002 through 2006. Available data represented approximately 93% of the total membership, thus completion factors applied.

(2) Data from the Governor's Annual Budget - Medicaid Evaluation Data and the Annual Medicaid Managed Care Rate Cell Calculation sheets.

(3) Data from the Governor's Annual Budget - Medicaid Evaluation Data.

(4,5,6,7,9) Data from the Annual State Appropriations Handbook.

(8) Data from the New Jersey State Accounting System.

(10) Data from CYs 2002 through 2005 Audited Financial Statements. Calendar Year 2006 based on submitted, but unaudited, data.

D. SUMMARY

The purpose of this chapter has been to provide a brief overview of the New Jersey hospital sector, along with a demographic and economic portrait of the population the sector serves. In most respects, averages for New Jersey resemble fairly closely comparable averages for the nation as a whole, including health statistical variables (not included in this chapter, but available on www.statehealthfacts.org). New Jersey hospitals are outliers in some respects, however. For example, they are at or near the top of the ranking for utilization of services by patients near the end of life. New Jersey stands out, however, as one of the wealthiest states in the Union. One might surmise accordingly that this State could afford a world-class health care system.

The second part of the chapter presented a small primer on the economics of the American hospital sector. It was noted that many important factors affecting hospital quality and financial status are within the power of hospital managers and boards, and that they are properly accountable for the results of their decisions. It was also noted, however, that managers of American hospitals – New Jersey's included – face many important challenges beyond their ability to control. They often face unilateral actions by payers restricting their access to resources, confront a system in which payers attempt to shift the responsibility for costs to other payers, and are left to fulfill the responsibility of serving as provider of last resort for New Jersey's uninsured while struggling to extract payment for those services in a shifting and uncertain landscape. This convoluted system of financing care for the poor is not found elsewhere in the world.

Chapter 3

The Financial Condition of New Jersey Hospitals

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

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

- operating margin;
- total margin;
- days cash on hand;
- current ratio;
- debt service coverage;
- long-term debt to capitalization; and
- average age of plant.

This chapter discusses the role of these financial indicators in the financial analysis of enterprises and their magnitudes in New Jersey hospitals. The Commission used three data sources to analyze the financial condition of New Jersey hospitals – Medicare Cost Reports, Audited Financial Statements, and Unaudited Financial Statements (2006 only). Appendix 3 describes in more detail each of the data sources and their relative strengths and weaknesses. In general, we used Medicare Cost Report data to analyze long-term trends and for comparisons of New Jersey results to other states. Audited financial statements were used for hospital-specific assessments, for more detailed analysis of the range of values for each ratio, and for comparisons to financial benchmarks available from the major rating agencies. Unaudited financial statements were used to provide a preliminary picture of 2006 financial results. Note that for several reasons – notably differences in classification of financial items and the number of hospitals reporting – medians calculated from the different data bases will likely differ.

A. THE FINANCIAL CONDITION OF NEW JERSEY HOSPITALS

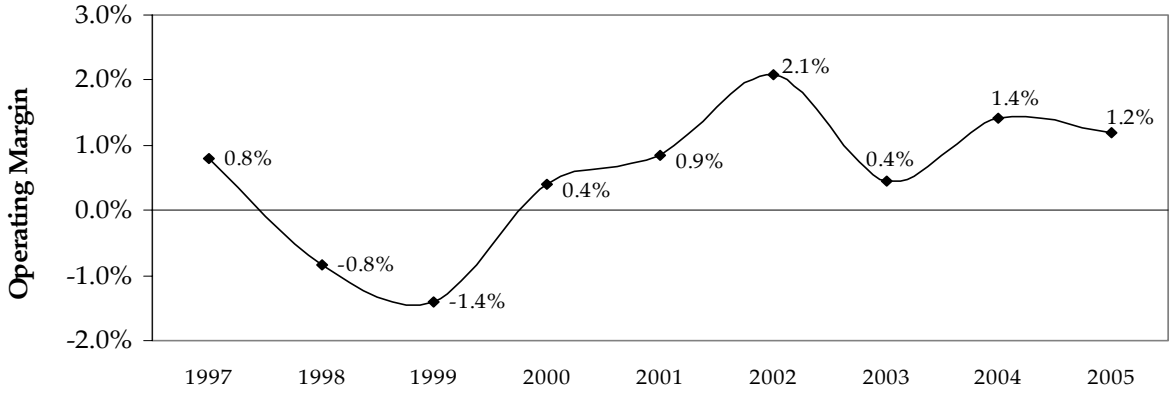
As noted above, to get a sense of the financial condition of New Jersey's hospitals, the Commission directed Navigant Consulting to examine a series of standard financial indicators widely used for that purpose. In what follows these indicators are defined, their use in financial analysis is explained, and their magnitudes for New Jersey hospitals are assessed.

Operating Margin

This metric is defined as income (or loss) from patient operations divided by net patient revenues (i.e., not patient revenues billed but patient revenues actually received or expected to be received by hospitals). It excludes non-operating items such as fundraising or gains or losses on the sale of assets. Thus, this metric measures a hospital's net income strictly from operations. A negative margin indicates that the hospital could not meet its financial obligations for patient care from operating revenues alone. In the short and medium term, a hospital can bridge such operating shortfalls with funds from the issuance of debt, from cash reserves or with State assistance. A sustained negative operating margin, however, can push a hospital into bankruptcy.

Despite some differences in the calculation of operating margin in Medicare Cost Reports and audited financial statements (explained in Appendix 3), the operating margin trend obtained from Medicare Cost Reports is both valid and informative. As Figure 3.1 illustrates, the *median*[7] operating margin for New Jersey hospitals has ranged from a low of negative 1.4 percent in 1999 to a high of 2.1 in 2002. The recent trend has been negative, with margins declining steadily since 2002. Unaudited data for 2006 show a median of negative .04%, indicating that more than half of the State's hospitals lost money from operations.

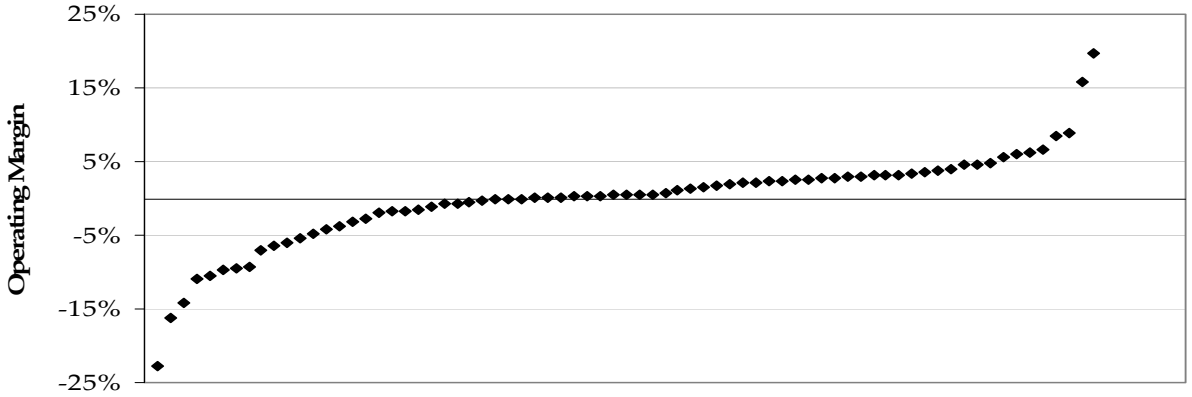
Figure 3.1 Trend in Median Operating Margins for New Jersey Hospitals, 1997 - 2005



A *median*, like its cousin, the *average*, however, is merely a measure of central tendency that obscures from view the dispersion of values about those central tendencies. Figure 3.2 describes the nature of the dispersion of the operating margin of New Jersey hospitals using 2005 audited financial statements. Each dot represents an individual hospital's operating margin. Operating margins ranged from -23 percent to nearly 20 percent, with the large majority of hospitals falling within the negative 5.0 percent to positive 5.0 percent range. As noted in a subsequent discussion, the average operating margin for acute care hospitals in the entire nation is approximately 3.3 percent. The graph makes it clear how treacherous it is to describe an entire economic sector by the medians or averages of descriptive variables, such as financial indicators.

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

Figure 3.2 Distribution of New Jersey Hospitals' FY 2005 Operating Margins based on Audited Financial Statements

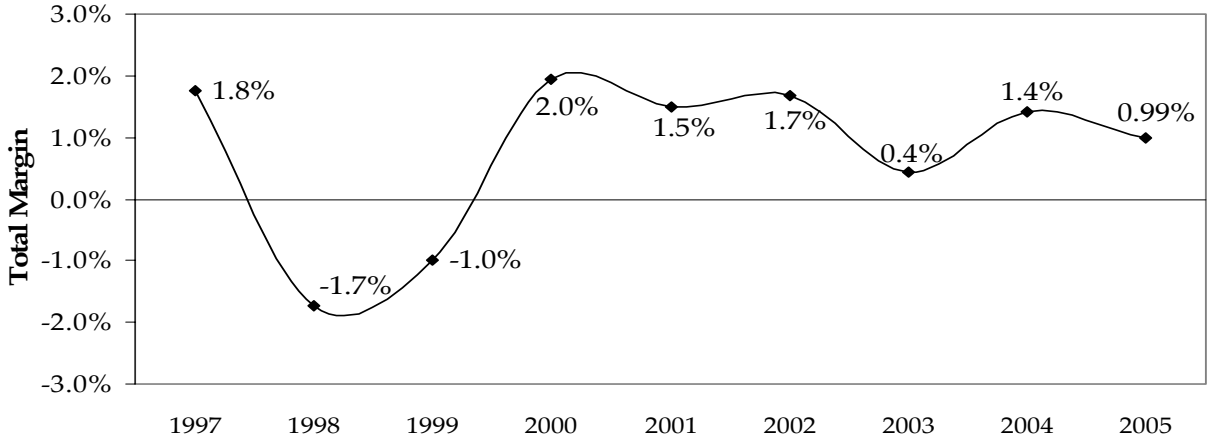


Total Margin

Total margin is defined as income (or losses) from all sources divided by net revenues. Most industry analysts indicate that maintenance of a positive total margin is critical to a hospital's survival. A positive total margin provides funding for equipment and facility replacement in excess of historical depreciation. Hospitals that fail to generate consistent positive total margins are unlikely to meet their financial obligations in the long run. The median total margin for all acute care hospitals in the United States in 2005 was 3.6 percent.

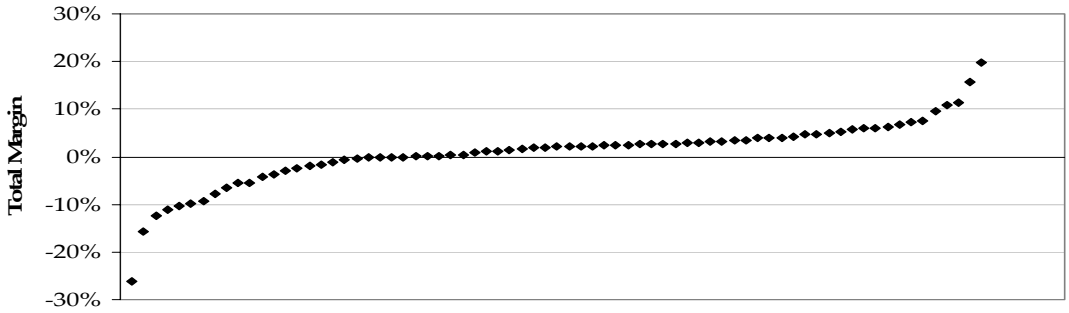
As is illustrated in Figure 3.3, according to Medicare Cost Report data for the time period of this study, the median total margin for New Jersey hospitals was at its lowest level since 1998 and reached its highest level in 2000. Since 2000, the median total margin for New Jersey hospitals has fluctuated between 0.4 percent and 1.7 percent, markedly below the national median.

Figure 3.3 Trend in Median Total Margins for New Jersey Hospitals, 1997 - 2005



Analysis of FY 2005 audited financial statements showed hospital total margins ranged from -26 percent to nearly 20 percent with a median of 2.1 percent. Data for 2006 based on unaudited financial statements shows a marked decline in the median total margin as it fell to .66 percent. Figure 3.4 illustrates the distribution of hospitals' total margins based on FY 2005 audited financial statements. The large majority of hospitals fall within the -1.0 percent to 8.0 percent range. Most importantly, more than two-thirds of New Jersey hospitals had total margins below the national median.

Figure 3.4 Distribution of New Jersey Hospitals' FY 2005 Total Margins based on Audited Financial Statements

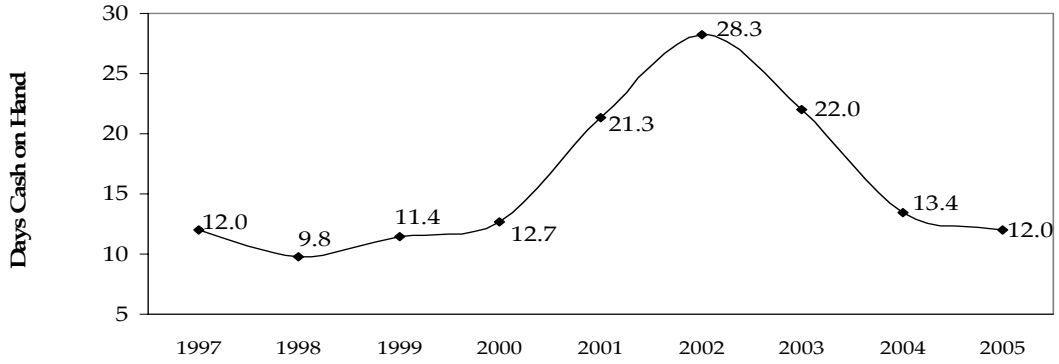


Days Cash on Hand

This metric is defined as cash and highly liquid assets (e.g., marketable securities or money-market funds) on hand divided by the hospital's average daily cash outflow to support operations, which means it excludes depreciation, a non-cash expense. In plainer English, it measures a hospital's cash reserves in terms of the number of days the hospital could continue to meet daily operating expenses even if no cash revenues were to come in. The lower the number, the more vulnerable a hospital is to disruptions in revenues (e.g., problems with reimbursement from third party payers) or expenses (e.g., sharp increases in supply costs). A very low number may signal that the hospital may not be able to meet payroll.

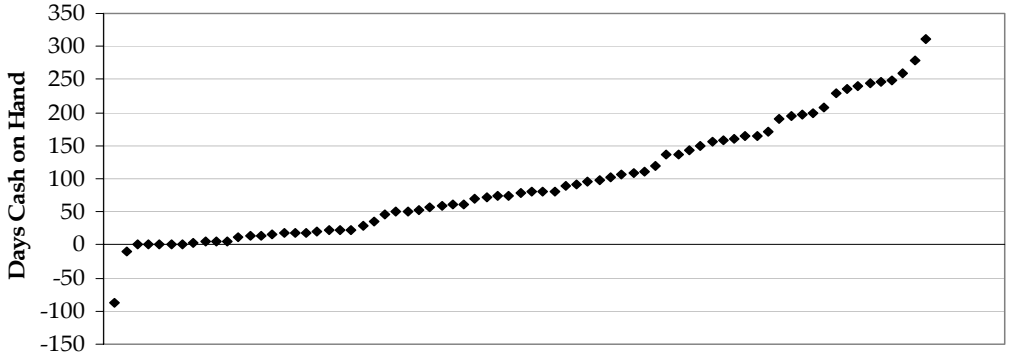
As illustrated in Figure 3.5, median days of cash on hand for New Jersey hospitals, as calculated from Medicare Cost Reports, was relatively constant from 1997 to 2000, then rose to its high in 2002 and for 2005 returned to its pre-2000 level.

Figure 3.5 Trend in Median Days Cash On Hand for New Jersey Hospitals, 1997 – 2005



However, as is explained further in Appendix 3, there is data limitation in Medicare Cost Reports that results in understatement of hospitals' days cash on hand. Because of this, we used Medicare Cost Reports to examine historical trends in the hospitals' days cash on hand indicator, but relied on hospitals' FY 2005 audited financial statement data that include board-designated funds to assess hospitals' more current days cash on hand positions. Figure 3.6 illustrates the distribution of hospitals' days cash on hand based on FY 2005 audited financial statements which include board-designated funds. In FY 2005, days cash on hand ranged from -87 (overdraft) to 311, with a median of 80 days. In 2005, the median days cash on hand, including board-designated funds that are available for immediate use if needed, for all hospitals in the nation was 160 days. In other words, the median for New Jersey hospitals was half of the median for all hospitals in the nation. More importantly, approximately one-third of New Jersey hospitals had less than 50 days cash on hand in FY 2005. Unaudited data for 2006 show a further decline in median days cash on hand down to 69 days.

Figure 3.6 Distribution of New Jersey Hospitals' FY 2005 Days Cash On Hand based on Audited Financial Statements

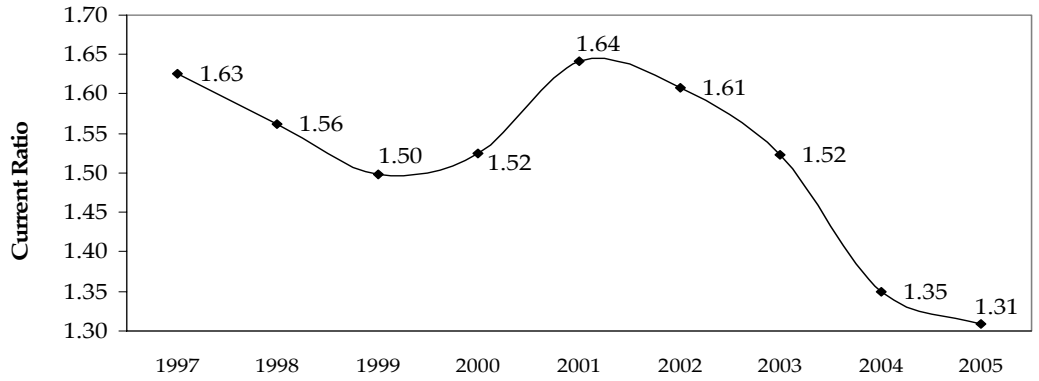


Current Ratio

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

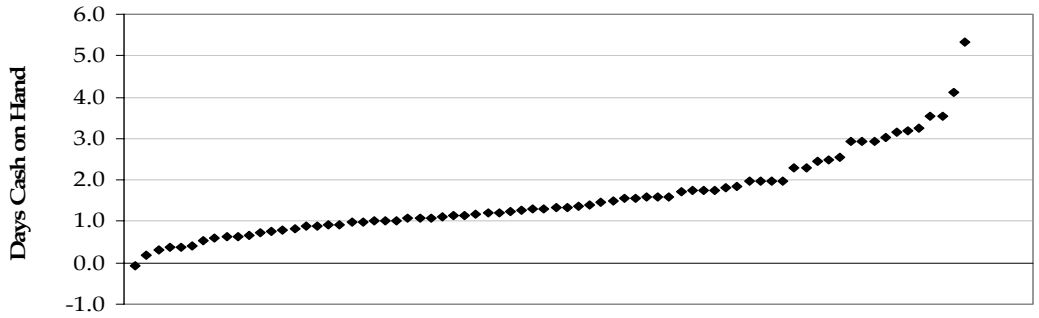
As illustrated in Figure 3.7, with the exception of the period from 1999 to 2001, the median current ratio for New Jersey hospitals has declined. Hospitals' median current ratio reached its highest point in 2001 and was at its lowest point over the study time period in 2005. Unaudited data for 2006 indicate continued decline, with the median current ratio falling to 1.27.

Figure 3.7 Trend in Median Current Ratios for New Jersey Hospitals, 1997 – 2005



As Figure 3.8 illustrates, approximately three-fourths of New Jersey hospitals had current ratios below 2.0 in FY 2005. Liquidity problems are, therefore, systemic for the industry in the State and are not only affecting some hospitals.

Figure 3.8 Distribution of New Jersey Hospitals' FY 2005 Current Ratios Based on Audited Financial Statements



Debt Service Coverage

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

As Figure 3.9 illustrates, the median debt service coverage ratio for New Jersey hospitals was at its lowest point in 1998, increased over the next three years and has stabilized since 2003. A stable debt service coverage ratio is normally the result of fairly low variation in operating income and low variation in the amount of debt. As will be discussed in the next section, New Jersey hospitals have an exceptionally high average age of plant, which suggests hospitals have incurred relatively less new debt in recent years. It is important to highlight that, although New Jersey hospitals' debt service coverage has been stable in recent years, hospital plants are not

being replaced and the State's debt service coverage ratio of 2.43 is substantially below the average of 3.98 for all hospitals in the United States.

Figure 3.9 Trend in Median Debt Service Coverage for New Jersey Hospitals, 1997 - 2005

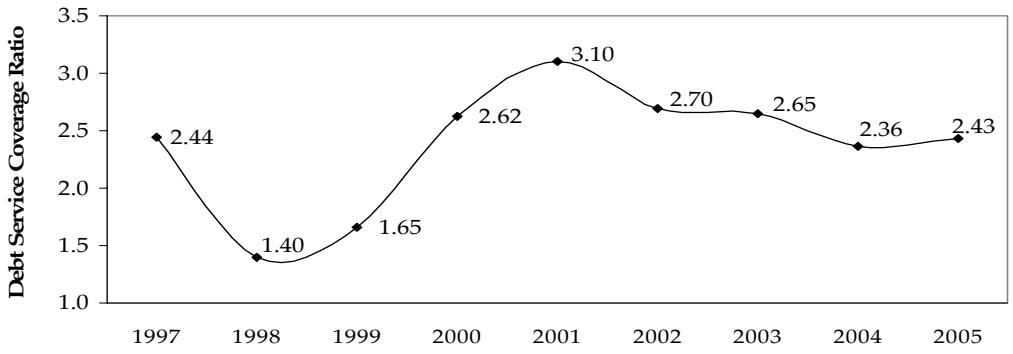
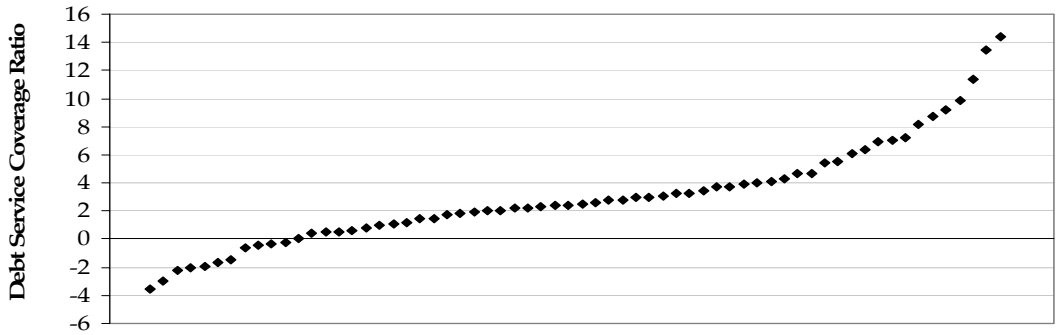


Figure 3.10 illustrates the distribution of individual New Jersey hospitals' debt service coverage ratios based on FY 2005 audited financial statements. Values ranged from -3.5 to 14.4 with a median of 2.71. Particularly troubling is the number of hospitals with coverage ratios less than 1.0, an indication of potential problems in meeting debt service. Also, the median for 2006 based on unaudited financial statements shows further decline to 2.42.

Figure 3.10 Distribution of New Jersey Hospitals' FY 2005 Debt Service Coverage based on Audited Financial Statements



Long-Term Debt to Capitalization

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

As illustrated in Figure 3.11, New Jersey hospitals' median long-term debt to capitalization ratio reached its highest level in 2002 and has decreased each year since then. While the trend has been in the right direction, the overall level is of concern. The median long-term debt to capitalization for all hospitals in the nation is 38.6 percent, indicating that the majority of the median hospital's resources are derived from equity rather than debt.

Figure 3.11 Trend in Median Ratios of Long-Term Debt to Capitalization for New Jersey Hospitals, 1997 – 2005

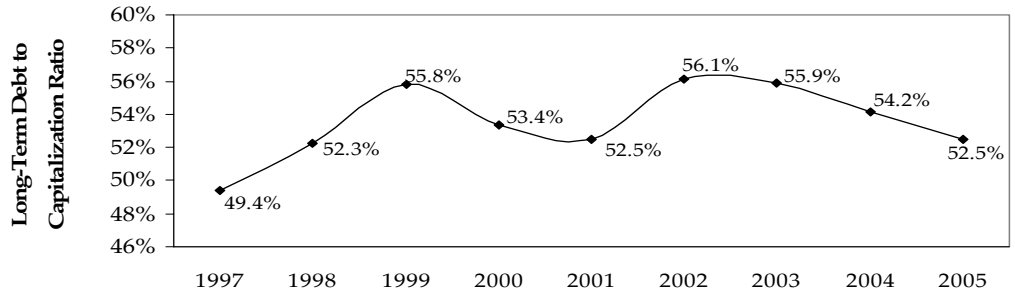
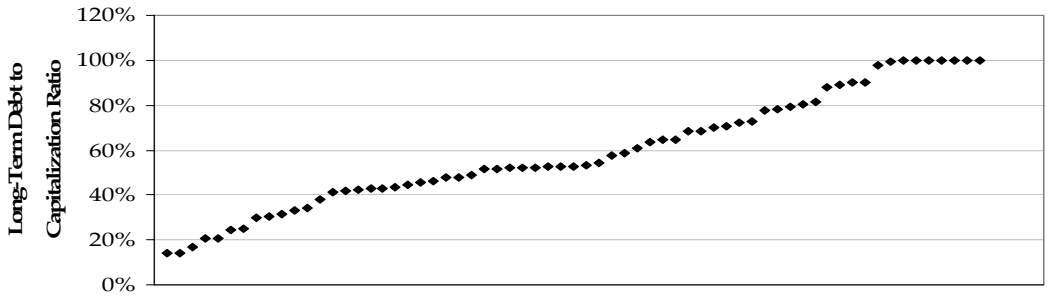


Figure 3.12 illustrates the distribution of individual hospitals' long-term debt to capitalization ratios based on their audited financial statements. These ratios ranged from 14 percent to 100 percent with a median of 46%. As shown in the graph, seven New Jersey hospitals have long-term debt to capitalization ratios of 100 percent, which means that their activities are entirely funded by debt. Unaudited data for 2006 indicate a decline in the median but this appears to be attributable to reclassification of debt at several hospitals rather than an actual improvement in fund balances or debt levels.

Figure 3.12 Distribution of FY 2005 Long-Term Debt to Capitalization for New Jersey Hospitals based on Audited Financial Statements*



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

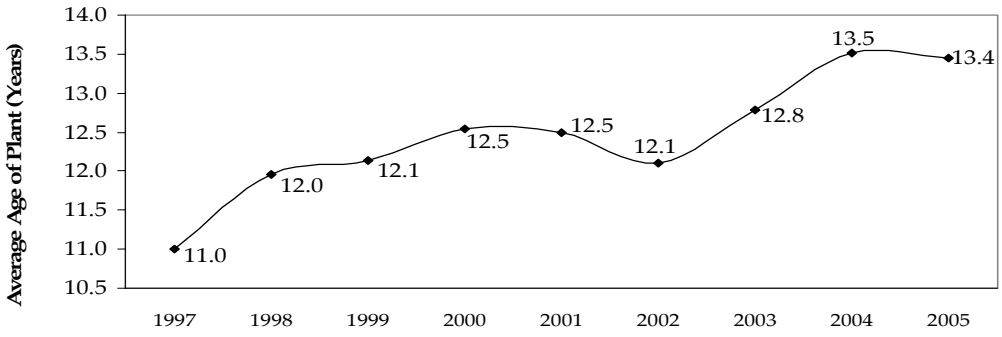
Average Age of Plant

In the eyes of economists and financial analysts, the average age of plant of an enterprise is a significant statistic for two reasons. First, new technology, for its utilization, often requires new capital outlays for structures and equipment. In the case of hospitals, an old plant may make it difficult or impossible to attain the highly efficient, modern patient-focused health care that is now being sought around the globe. Patient-centered care, for example, involves moving

diagnostic equipment closer to the patient's bedside, instead of moving patients on gurneys from bedside to diagnostic equipment that may be housed on other floors. Newer structures in general allow superior patient flows, scheduling of operating rooms, and so on. They also are less costly for climate control and maintenance.

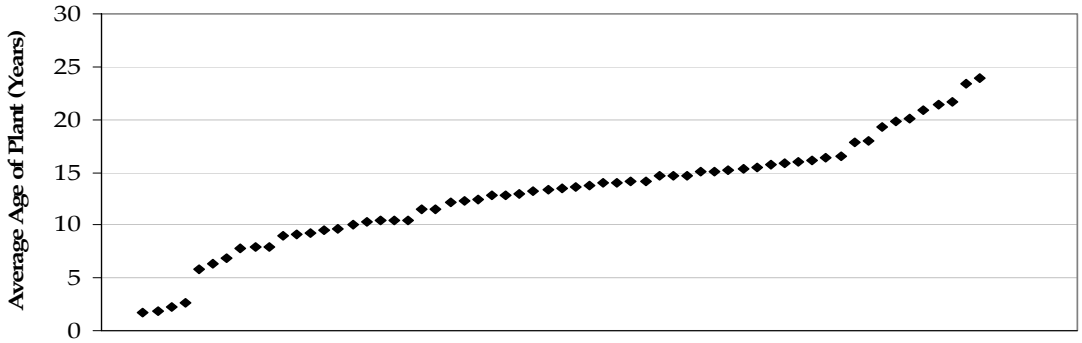
The median value for New Jersey hospitals' average age of plant has increased nearly every year since 1997 as illustrated in Figure 3.13, and in FY 2005 was 13.4 years. The significance of this troubling trend cannot be overstated; New Jersey hospitals' average age of plant of 13.4 in FY 2005 was more than 30 percent higher than the 10.2 median value for all hospitals in the nation in 2005.

Figure 3.13 Trend in Median Average Age of Plan for New Jersey Hospitals, 1997 - 2005



Looking at data for individual hospitals calculated from audited financial statements (Figure 3.14), we can see that one-third of the State's hospitals had an average plant age of 15 years or older, and less than one-fourth had a plant age equal to or below the national median. It suggests that, to keep New Jersey hospitals abreast of modern trends in technology and patient care, sizeable capital outlays for the replacement of old plant will be needed in due course. The median for 2006, calculated using unaudited financial statements, shows continued aging of the State's hospital infrastructure.

Figure 3.14 Distribution of FY 2005 Average Age of Plant for New Jersey Hospitals based on Audited Financial Statements



B. COMPARISON OF MEDIAN FINANCIAL INDICATORS FOR NEW JERSEY HOSPITALS AND OTHER STATES AND CREDIT RATING AGENCIES' VALUES

We completed similar analyses for hospitals in New Jersey's "neighboring" states. These states included Connecticut, Maryland, New York, and Pennsylvania. With the exception of New York, hospitals in each of the comparison states had higher operating margins than New Jersey hospitals. New Jersey hospitals had a more significant debt load, relative to the other states, again with the exception of New York. Lastly, New Jersey hospital facilities have the oldest plants relative to the comparison group of states. Exhibit 3.1 below presents these comparisons. In addition to the comparison states, we also provide medians for the United States, as a whole.

Exhibit 3.1 Comparison of Key Financial Indicators' Median Values – Hospitals in New Jersey, Neighboring States and the United States, 2005

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

Source: 2005 Medicare Cost Reports

It is also useful to compare the profitability, liquidity and financial structure indicators for New Jersey hospitals to the expectations that credit rating agencies have when they evaluate a hospital that is seeking to enter the bond market. Median values for several financial indicators for different bond ratings calculated by Standard & Poor's, one of the major bond rating agencies, are compared to New Jersey hospitals' indicators in Exhibit 3.2. The Exhibit clearly indicates that, for most of the ratios, New Jersey medians fall between the medians for BBB- hospitals (the lowest rating category above speculative grade) and the medians for speculative grade ratings. To highlight one example, the median cash on hand for BBB- hospitals was 103 days compared to 80 days for New Jersey hospitals. In other words, the financial performance of a large majority of New Jersey hospitals does not meet the expectations for a typical BBB- hospital. A lower bond rating, especially a speculative grade bond, means that it will be difficult for a hospital to obtain bond financing, and the financing that is obtained will be accompanied by higher interest rates.

Exhibit 3.2 Comparison of Key Financial Indicators – New Jersey Hospitals to Various Rating Levels, 2005

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

Sources:

(1) Standard & Poor's Rating Services, Public Finance: Stand-Alone Hospital Medians; July 2006

(2) Data for New Jersey are based on audited financial statements

* Note: All data are 2005 medians

To provide additional perspective on New Jersey hospitals, we compared the State's medians to three specific bond rating levels: "A-", "BBB+", and "BBB-". Exhibits 3.3 through 3.5 present these comparisons. As the data in the Exhibits show, New Jersey hospital medians are lower than the medians for all hospitals in the United States, even for BBB- rated bonds.

Exhibit 3.3 Comparison of Key Financial Indicators – New Jersey Hospitals to Median Values for BBB- Credit Ratings, 2005

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

Sources

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

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

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

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

Exhibit 3.4 Comparison of Key Financial Indicators – New Jersey Hospitals to Median Values for BBB+ Credit Ratings, 2005

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

Sources:

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

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

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

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

Exhibit 3.5: Comparison of Key Financial Indicators – New Jersey Hospitals to Median Values for A- Credit Ratings, 2005

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

Sources:

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

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

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

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

C. SUMMARY

Based on the preceding metrics, the Commission concludes that:

1) the financial condition of New Jersey hospitals has been deteriorating for the last several years. Currently New Jersey hospitals are showing, on average, poor profitability, limited cash reserves and high levels of debt, although some hospitals are much worse off than others; and

2) on average, the financial performance of New Jersey hospitals is worse than is the average performance of its counterparts nationwide, and it is not favorable when compared to financial benchmarks commonly used in the industry and by financial rating agencies who assess the quality of a hospital's debt instruments.

It was noted, however, that there is a wide dispersion of values for these financial metrics across New Jersey hospitals. Some hospitals are considerably more distressed than these averages or medians indicate, while others are in very good financial condition, even by national standards.

Overall, however, it can be said that New Jersey's hospitals do not form a financially solid sector of the economy. Low margins and low levels of cash on hand threaten a hospital's ability to meet both short- and long-term debt obligations. Furthermore, New Jersey hospitals' capital structure is highly leveraged with a median long-term debt to capitalization ratio of 52.5 percent. When considered in their entirety, these factors significantly inhibit the ability of the State's hospitals to invest in their infrastructure, which has resulted in an exceptionally high average plant age.

Chapter 4

An Analytic Framework for Evaluating Hospitals: "Essentiality" and Financial Viability

This chapter describes the Commission's approach to developing criteria for identifying hospitals that provide essential services in their region but are in financial distress and may warrant financial assistance from the State, depending upon availability of funds for that purpose.

A. DEVELOPMENT OF FRAMEWORK FOR EVALUATING HOSPITALS

The purpose of developing criteria to identify essential hospitals and a method for scoring or ranking hospitals using the criteria, is to provide a framework for evaluating which financially distressed hospitals are essential to maintaining access to hospital care and which are not.

Based on discussions with members of the Commission, Navigant Consulting developed the following approach to evaluate acute care hospitals in New Jersey:

1. identify suitable criteria for identifying "essential" hospitals and score hospitals using the criteria;

2. identify metrics that portray a hospital's "financial viability" and score hospitals using these metrics; and

3. combine the results of the first two analyses to determine whether a financially distressed hospital at risk of closure is essential in its market area for maintaining access to hospital care.

Figure 4.1 illustrates the analytical framework of this approach. The potential implications for policy are discussed in connection with Figure 4.2.

The Commission proposes to map a variety of selected metrics on a hospital's essentiality" into one overall weighted score that can be located on the horizontal axis of Figure 4.1. Similarly, the Commission proposes to map several metrics on the "financial viability" into one overall weighted score that can be located on the vertical axis of Figure 4.1. In the end, then, every New Jersey hospital can be represented as a point in the grid, reflecting both its "essentiality" and its "financial viability."

Figure 4.1 has 4 quadrants, each with its own interpretation. Hospitals in poor financial conditions that are, however, not "essential" in the sense that their services could be delivered by other hospitals in the area, would fall into the lower left quadrant of the grid. Similarly, financially distressed hospitals judged (on the basis of the metrics and other non-metric qualitative considerations) to be "essential" would be located on the lower right quadrant. Hospitals that are judged to be "financially viable" and not "essential" to their market area would fall into the upper left quadrant. Finally, hospitals judged to be "essential" but in good financial condition would fall into the upper right quadrant.

Figure 4.1: Framework for Evaluating Hospitals

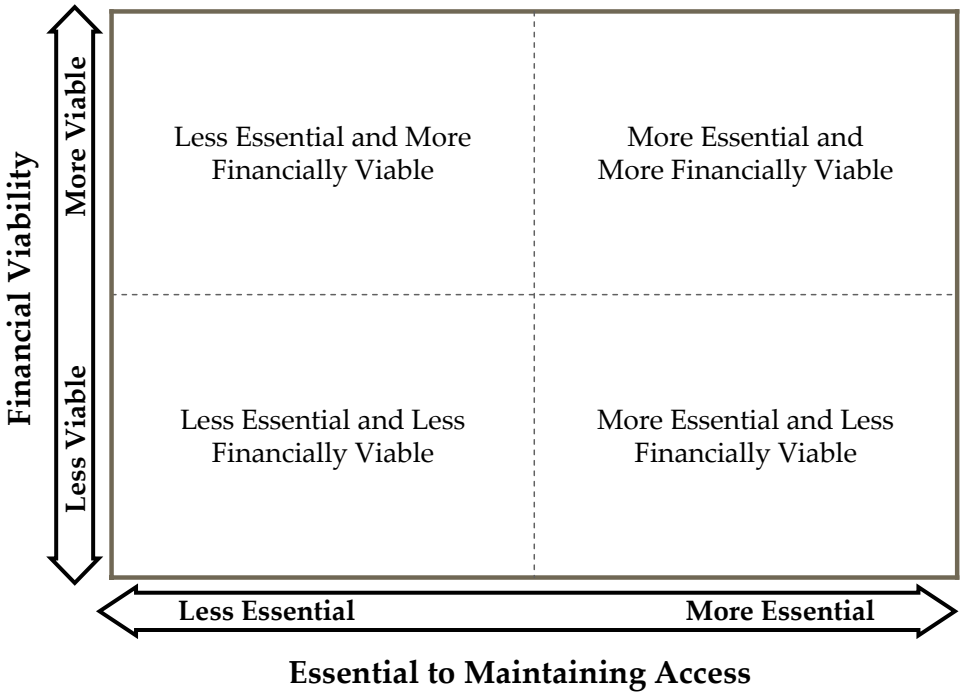


Figure 4.1 has the virtue of not just classifying hospitals into the preceding four categories, but of locating them in a geometric space that can indicate degrees of "essentiality" and "financial viability." This is particularly helpful when there are not sufficient funds to assist all hospitals judged to be "essential" and in poor financial condition.

The metrics on "essentiality" and "financial viability" selected for the implementation of this analytic framework are discussed further on in this chapter.

B. HOSPITAL MARKET AREAS

In scoring hospitals in terms of their "essentiality," it is necessary to compare hospitals within reasonable geographic areas that reflect the population's travel patterns for hospital services. Instead of using for that purpose governmental or political unit boundaries such as cities or counties as some studies have, the Commission decided to use as a starting point the Dartmouth Atlas Project's *Hospital Service Areas and Hospital Referral Regions,* which have been carefully developed by these researchers over the years and have found the confidence of the health-services research community.

The Dartmouth Atlas Project's work is based on analysis of Medicare patients' use of local and regional hospital services, using the patient's residence (zip codes) as a basis. Dartmouth Atlas researchers identified 67 Hospital Service Areas in New Jersey which they further aggregated to ten Hospital Referral Regions based on Medicare patients' patterns of use of cardiovascular surgical and neurosurgery services. (See Appendix 4 for an illustration of the Dartmouth Atlas-defined Hospital Referral Regions for the New Jersey area.)

In a few of the Dartmouth Atlas-defined Hospital Referral Regions, the referral hospital or hospitals most often used by New Jersey residents of the region are in neighboring states. Thus, to form market areas that are entirely within the State of New Jersey's boundaries, the Commission reassigned New Jersey areas that are in a Dartmouth Atlas-defined Hospital Referral Region of a city in a neighboring state to a region in New Jersey. We made these reassignments based on analysis of where patients from the zip codes that comprise these areas were hospitalized, using 2005 UB-92 patient discharge data for patients in all payer categories discharged from New Jersey acute care hospitals.

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

Appendix 5 provides a summary of the adjustments to the Dartmouth Atlas-defined Hospital Referral Regions the Commission made in forming market areas for purposes of the evaluating New Jersey hospitals in terms of essentiality.

These adjustments resulted in eight hospital market areas that represent reasonable geographic areas and hospital concentrations. Figure 4.2 illustrates these hospital market areas.

Table 4.1 provides discharges and patient origin information for each of the hospital market areas. (See Appendix 6 for a listing of acute care hospitals by market area.) As the percentages in the last column in the Table 4.1 indicate, the hospital market areas reflect fairly well the population's travel patterns for hospital services. It is seen that the vast majority of New Jersey residents who remain in-state for their inpatient hospital care actually are hospitalized in the hospital market area in which they live. The data give the Commission confidence in the market areas it has chosen for its analysis.

The hospital market areas have a dual purpose. First, they are the relevant areas within which hospitals can be compared in terms of their essentiality[8], and second, they are the areas for which we will project future demand for hospital and physician services in a later phase of the Commission's work. The next sections discuss development of criteria for identifying essential hospitals and the methodology for comparing hospitals.

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

Figure 4.2 New Jersey Hospital Market Areas

Table 4.1: Acute Care Hospitals, Discharges and Market Share by Market Area

Hospital Market Area	Number of Acute Care Hospitals	2005 Discharges from Acute Care Hospitals in Market Area[9]	Percent of Patients Hospitalized in the Market Area in which They Reside[10]
Atlantic City	9	90,875	86%
Camden	11	150,114	96%
Hackensack, Ridgewood & Paterson	15[11]	219,657	92%
Morristown	9	108,360	76%
New Brunswick	8	139,561	85%
Newark/Jersey City	16	224,403	85%
Toms River	8	145,218	89%
Trenton	4	42,325	87%

C. CRITERIA FOR IDENTIFYING *ESSENTIAL* HOSPITALS IN NEW JERSEY

As a starting point for identifying essential hospitals, the Commission considered the criteria New York's *Commission on Health Care Facilities in the 21st Century* used for identifying candidates for closure or conversion by the New York Commission (though the New Jersey Commission is not a hospital-closing commission). After extensive discussions and deliberation, the Commission agreed on the quantifiable criteria and metrics for identifying essential hospitals shown in Table 4.2.

The first criterion, *care for financially vulnerable populations*, is important in identifying hospitals that are essential to maintaining access to care because they serve large numbers of indigent patients. We are using three separate metrics for this criterion because each measures something different:

- Medicaid and uninsured discharges measure a hospital's role in caring for indigent patients on an inpatient basis;
- Medicaid and uninsured emergency department visits also measure the role a hospital may play as a source of primary care for patients who do not have an ongoing relationship with a primary care physician; and
- Medicare disproportionate share hospitals' ratio of inpatients days attributable to Medicare patients who are also eligible for Medicaid to total Medicare days measures a hospital's role in caring for poor Medicare patients.

[9] Source: Analysis of New Jersey Department of Health & Senior Services 2005 UB-92 Patient Discharge Data; includes discharges of New Jersey and out-of-state residents. Also includes discharges from two hospitals, South Jersey Healthcare, Bridgeton and Irvington General, which have since closed.
[10] This analysis is based on New Jersey residents who are hospitalized in New Jersey hospitals only and does not include New Jersey residents who are hospitalized in other states.
[11] PBI Regional and St. Mary's Hospital Passaic are each counted separately.

The second criterion, *provision of essential services as measured by trauma center designation*, is important because trauma centers are regional resources that provide critical, time-sensitive care.

The third criterion, *utilization*, is important in identifying hospitals that are essential to maintaining access to care by virtue of the size of their patient care activity.

- A hospital's emergency department visits as a percent of the hospital service market area's total emergency department visits measures its relative importance as a provider of emergency services in a geographic area that considers access to time-sensitive emergency services.

- Total patient days plus emergency department visits are an overall indicator of the size of a hospital's patient care activity. While total outpatient visits may be the best indicator of the size of a hospital's ambulatory care activity, in the absence of a standardized source of data that allows for meaningful comparison across hospitals, we are using emergency department visits as a proxy.

- Inpatient occupancy rate on the number of maintained beds reported by hospitals measures a hospital's volume of inpatient care relative to its capacity.

Table 4.2 Quantifiable Criteria and Metrics for Identifying Essential Hospitals

Criterion / Metric	Data Source
Care for Financially Vulnerable Populations	
Medicaid and Uninsured Discharges	2005 UB-92 Patient Discharge Data from New Jersey Department of Health & Senior Services
Medicaid and Uninsured ER Visits	2005 UB-92 Emergency Department Data from New Jersey Department of Health & Senior Services
Medicare Disproportionate Share Hospitals' ratio of patient days for Medicare dual eligible patients to total Medicare patient days[12]	2005 Medicare Cost Reports
Provision of Essential Services	
Trauma Center Designation	New Jersey Department of Health and Senior Services
Utilization	
Percent of Hospital Service Area's Total ER Visits	Analysis of 2005 UB-92 Emergency Department Data from New Jersey Department of Health & Senior Services
Inpatient Occupancy	Analysis of Acute Care Maintained Beds and Patient Days from 2005 B2 Reports submitted by hospitals to the New Jersey Department of Health & Senior Services
Total Patient Days and ER Visits	2005 B2 Reports for Patient Days and 2005 UB-92 Emergency Department Data from New Jersey Department of Health & Senior Services for ER Visits

[12] To qualify for as a Medicare Disproportionate Share Hospital (DSH) and receive the payment adjustment, a hospital's DSH patient percentage – the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare and Medicaid and the percentage of total inpatient days attributable to Medicaid patients not also eligible for Medicare – must be at least 15 percent.

D. CRITERIA FOR IDENTIFYING HOSPITAL *FINANCIAL VIABILITY*

The criteria for evaluating hospitals' financial viability are a subset of the financial indicators we reviewed in our overall assessment of the financial condition of the State's hospitals in Chapter 3 of this report. After analyzing a variety of financial indicators, the Commission selected, in consultation with staff of the New Jersey Health Care Facilities Financing Authority, three key measures of hospital financial viability[13] – (1) profitability, (2) liquidity, and (3) capital structure – and the metrics for each.

We selected the operating margin (as a percent of net revenue) as the measure of profitability because it is a clear indicator of the profitability of patient operations in abstraction from the way a hospital is financed and in abstraction from non-patient revenue, such as income from investments. Although non-operating income and expenses can have a substantial impact on overall profitability, they vary from year to year and do not reflect the results of operating activities. No measure other than operating margin better reflects a hospital's capacity to generate a profit from patient care on a consistent basis.

To measure *liquidity*, we analyzed hospitals' days cash on hand and current ratios and selected days cash on hand because of the importance of cash to maintaining current level of operations. Moreover, New Jersey hospitals have relatively low levels of cash on hand and so this measure reflects the immediate financial distress that many are experiencing.

We selected *long-term debt to capitalization* to measure the relationship between debt and equity or total capitalization. As the data presented in Chapter 3 of this report show, debt comprises a greater portion of New Jersey hospitals' overall capital structures compared with hospitals in other states.

Table 4.3 presents the criteria and metrics for assessing hospital financial viability along with the 2005 statewide average for each metric.

Table 4.3 Criteria and Metrics for Identifying Hospital Financial Viability

Criterion	Metric	2005 Statewide Average for Metric
Profitability	Operating Margin	0.7%
Liquidity	Days Cash on Hand	121
Capital Structure	Long-term Debt to Capitalization[14]	49.8%

We used hospitals' FY 2005 audited financial statements provided by the New Jersey Health Care Facilities Financing Authority to calculate each hospital's value for each metric. For hospitals that are members of hospital systems that are financially responsible for them, we used the hospital systems' value for each metric, calculated from the hospital systems' FY 2005

[13] The Commission considered using times interest earned ratios, but decided not to because these ratios do not add anything to the distinctions the Commission seeks to make among hospitals over and above the Long-term Debt to Capitalization ratio.
[14] Several hospitals' Long-term Debt to Capitalization values were greater than 100 percent or were negative. We set these hospitals' Long-term Debt to Capitalization values at 100 percent for the financial viability analysis.

audited financial statements. The rationale for using hospital system financials is that when a system of hospitals jointly borrows under a master indenture as an obligated group, all the hospitals in the obligated group are financially bound together. In these cases the system's, rather than individual hospital members', financial indicators are the relevant measures for lenders and credit rating agencies and the resources of the system are available to support individual hospitals in the system.

We scored each hospital on these three financial viability metrics in the same way as was done for the essential hospital metrics[15], except that we compared all hospitals in the State against the statewide average for the metric rather than against the average for the market area in which the hospital is located. The reason for using the statewide average is to identify hospitals in the State that are in financial jeopardy, not necessarily to identify some hospitals in each market area based on their financial performance relative to the others in the same market area. For example, if all hospitals in a market area are performing better financially than the statewide average, the Commission's efforts should not be focused there.

The FY 2005 statewide averages for these financial viability metrics are between the medium and lowest investment grade ranges of Standard & Poor's and Moody's credit ratings for hospitals. The purpose of using the statewide averages for evaluating individual hospital's relative financial condition is to prioritize the hospitals on which the Commission and State should focus efforts, not as benchmarks for financial viability.

The next section provides an explanation of how the Commission compared hospitals using the criteria and metrics for essentiality and financial viability.

E. METHOD FOR COMPARING HOSPITALS: STANDARDIZED METRICS

Broadly speaking, the method for comparing hospitals is benchmarked on the average for each metric for all hospitals in the market area. For each metric, each hospital's score is based on how far above or below the average it is for each metric.

It will be noted from Tables 4.2 and 4.3 that the various metrics for each hospital used in this analysis have different dimensions. Some are percentages, some are numbers. Furthermore, we know that each of these metrics has a different degree of dispersion of hospital values around the average. Both circumstances make it impossible to collapse such metrics meaningfully into an overall score of "essentiality" and "financial viability."

A widely applied solution to this problem is to "standardize" all of the metrics which, in effect, converts them to variables that have the same dimension and the same degree of dispersion. The method of standardizing variables is described in Appendix 7 for the interested reader.

Suffice it to say here that, after standardizing each metric for "essentiality," the individual standardized scores are collapsed into an overall weighted score for "essentiality," assigning equal weights to all metrics. With this method, a positive score indicates a hospital is more

[15] Since higher values of Long-term Debt to Capitalization put a hospital at greater risk, we inverted the score for that metric so that values above the average yield negative scores. Doing this allowed us to sum the scores to arrive at an overall score of each hospital's financial viability relative to other hospitals in the State.

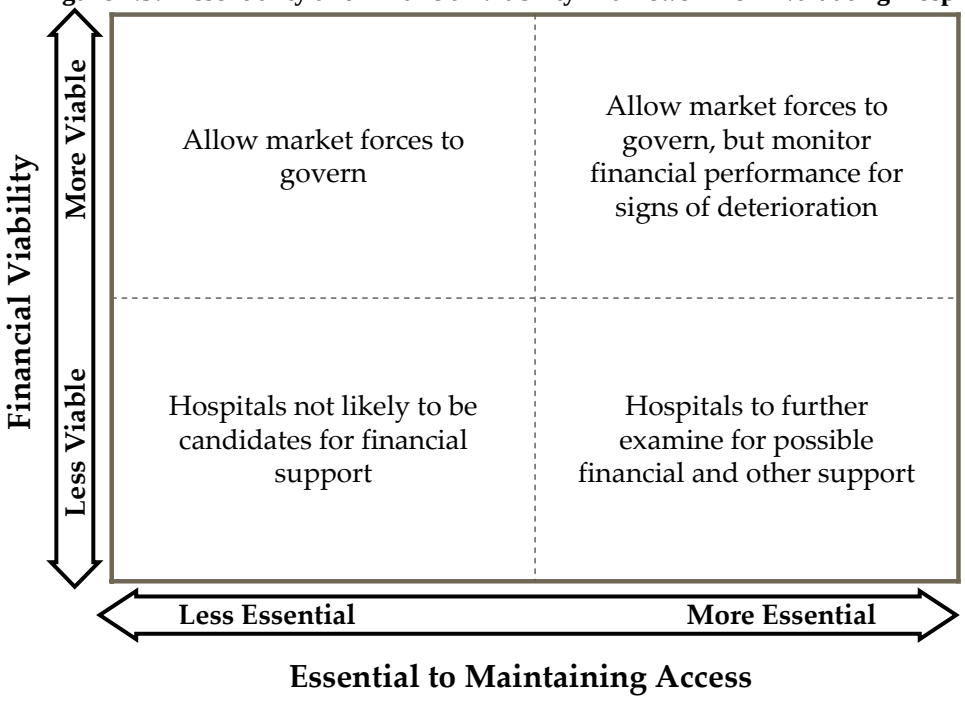
essential than the average for all hospitals in the area and a negative score indicates a hospital is less essential than the average. Each hospital's overall essentiality score is relative only to the other hospitals in its market area; it is not valid to compare hospitals' essentiality scores across different market areas.

The metrics for "financial viability" are similarly transformed and collapsed into an overall weighted score.

F. COMBINING "ESSENTIALITY" AND "FINANCIAL VIABILITY"

Combining the results of the essential hospital and financial viability analyses enables the Commission to group hospitals, by market area, into one of the four quadrants illustrated in Figure 4.3, benchmarked on the intersection of the average "essentiality" score and the average "financial viability" score. The idea is for the State to use this framework as a first step in evaluating whether a hospital warrants financial assistance from the limited funds available for that purpose.

Figure 4.3: Essentiality and Financial Viability Framework for Evaluating Hospitals



G. SUMMARY

The objective of this chapter has been to explain to the reader the Commission's general analytic approach to identifying which financially distressed hospitals in New Jersey are potential candidates for financial assistance from the State. The discussion has stressed the quantitative aspect of the Commission's approach because there lies the most challenging methodological issues in such an analysis.

It bears emphasis that the analytic framework represented by Figure 4.3 necessarily is based only on strictly quantifiable metrics. As such, it cannot possibly address all of the social, economic and geographic issues that must be examined by government in determining which financially distressed hospitals the State should support to maintain access to care. The Commission's quantitative analytic framework, therefore, must be supplemented by an assessment of non-quantifiable factors and the knowledge among policy analysts and policy makers of local conditions. In the end, mere numbers cannot take the place of sound judgment; they can only guide that judgment.

Among the non-quantitative issues that the Commission and State need to consider in determining which financially distressed hospitals are essential to maintaining access to hospital care are:

- whether all services are accessible elsewhere in the market area or region;
- impact on travel time for hospital care in the event of a hospital's closure;
- whether a hospital is part of a system which has financial responsibility for it;
- public transportation alterations or other transportation solutions that may be necessary to maintain access to care in the event of a hospital's closure;
- quality of care and efficiency improvements that may be necessary in financially distressed, essential hospitals;
- potential access to care implications for particular racial and ethnic groups;
- impact on access to clinic and other key ambulatory services; and
- impact on employment in the market area.

Other considerations not included in this list surely will come under consideration as well.

Appendix 1

Commission Membership

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The James Madison Professor of Political Economy
Professor of Economics and Public Affairs
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Fred M. Jacobs, M.D., J.D. – EX-OFFICIO
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Steven M. Goldman, J.D., L.L.M. – EX-OFFICIO
Commissioner
Department of Banking and Insurance

Jennifer G. Velez, J.D. – EX-OFFICIO
Commissioner
Department of Human Services

Michele K. Guhl
Executive Director
Department of Health & Senior Services

Appendix 2

Data Sources for Chapter 2

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

Avalere Health LLC, 206 New Jersey and Health Care Almanac – Summary (2006): Figures 1.1, 1.2, 1.3, and 2.11

NJ Department of Health and Senior Services Quarterly Hospital Utilization Data and Kaiser State Health Facts

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

Katherine Baicker and Amitabh Chandara, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," Health Affairs We Exclusive, April 7, 2004

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

Appendix 3

Data Sources for Chapter 3

The Commission used two primary data sources to provide current and historical financial data: the Medicare Cost Report (Worksheet G), and audited financial statements.

The Medicare Cost Report is an annual report submitted to the Centers for Medicare and Medicaid Services (CMS) by all Medicare providers (any hospital that receives federal Medicare/Medicaid funds). The report is comprehensive – hospitals report total costs, not just Medicare costs – and requires information on administrative structure, staffing and utilization of services, as well as financial data. Medicare Cost Reports are maintained in the Healthcare Cost Report Information System (HCRIS), a national data reporting system. Currently, the most recent data available is for FY 2005.

The New Jersey Health Care Facilities Financing Authority (NJHCFFA), the State's primary issuer of municipal bonds for New Jersey's health care organizations, provided hospitals and hospital systems' audited financial statements. During its 35-year history, the NJHCFFA has issued more than $13 billion in bonds on behalf of over 140 health care organizations throughout the State. New Jersey hospitals submit audited financial statements to NJHCFFA for review and inclusion in a database used for on-going monitoring and analysis. Although FY 2005 is the most current year for which NJHCFFA has a complete set of audited reports, most hospitals have submitted their FY 2006 unaudited financial data to NJHCFFA.

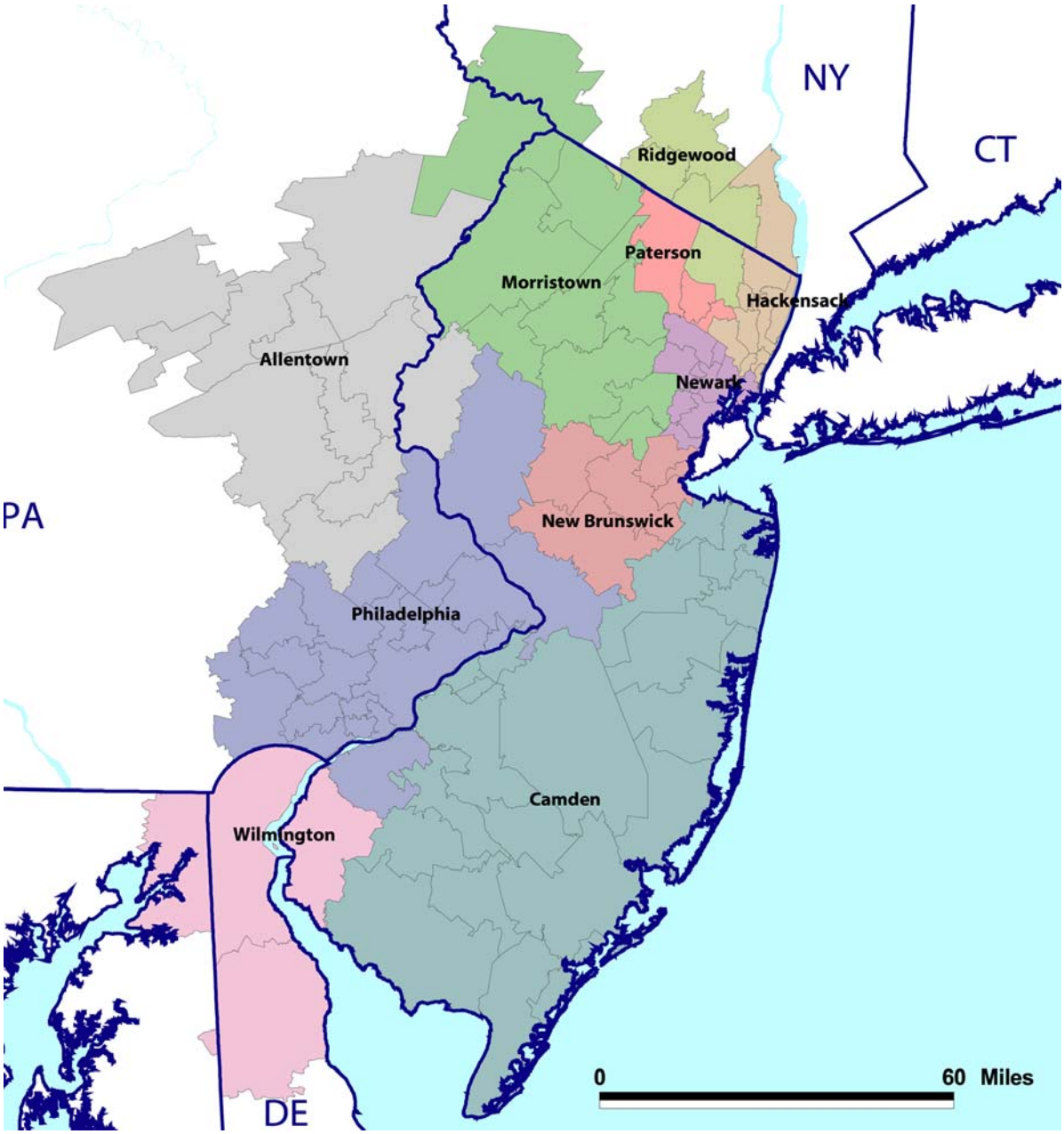
The Medicare Cost Reports have the advantage of providing a national data base, collected through a standardized form, which allows for state-by-state comparisons. However, the reports are not reviewed by an independent party. Further, inconsistent or incomplete reporting of certain financial elements limits the ability to calculate key financial rations. For example, reporting non-operating gains and losses is not consistent across hospitals, which limits the ability to compare operating and total margins from facility to facility. In addition, this will cause the operating margin to be equal to or greater than the total margin. As another example, the Medicare Cost Report does not include a line item for board-designated funds; without this element, days cash on hand as conventionally defined cannot be calculated.

Audited financial statements are reviewed by an independent third party. Further, the requirement that the statements be prepared in accordance with Generally Accepted Accounting Principles (GAAP) reduces the inconsistency in reporting of financial elements from hospital to hospital. However, with few exceptions, it is difficult to get state-by-state data based on audited financial statements.

The primary value of unaudited statements is that they are usually available within 45 to 60 days from the end of a period. In contrast, audited financial statements are not usually available until 120 to 150 days after the fiscal year ends; cost reports are usually not available until six or more months after the year ends. Thus, unaudited statements will typically provide the most current picture of a hospital's financial condition. The primary disadvantage of unaudited statements is that they have not been reviewed by an independent outside party. In some cases, there may be material differences between the unaudited and audited statements based on the findings of that outside review. Therefore, unaudited statements should be analyzed with caution.

Appendix 4

Dartmouth Atlas-Defined Hospital Referral Regions for New Jersey Area



Appendix 5

Adjustments to Dartmouth Atlas-defined Hospital Referral Regions to Form New Jersey Hospital Market Areas

Dartmouth Atlas-defined Hospital Service Area	Dartmouth Atlas-defined Hospital Referral Region	Adjustments
Phillipsburg	Allentown, Pennsylvania	Reassigned from Allentown to Morristown Hospital Referral Region
Flemington	Philadelphia, Pennsylvania	Reassigned from Philadelphia to New Brunswick Hospital Referral Region
Trenton	Philadelphia, Pennsylvania	Treated as its own hospital market area
Twenty Hospital Service Areas in central and southern New Jersey	Camden, New Jersey	Divided into three market areas: • Toms River • Atlantic City • Camden
Woodbury	Philadelphia, Pennsylvania	Reassigned from Philadelphia to Camden market area
Salem	Wilmington, Delaware	Reassigned from Wilmington to the Atlantic City market area
Ridgewood	Ridgewood, New Jersey	Combined with Hackensack and Paterson Hospital Referral Regions
Paterson	Paterson, New Jersey	Combined with Hackensack and Ridgewood Hospital Referral Regions
Newark	Newark, New Jersey	None

Appendix 6

New Jersey Acute Care Hospitals by Hospital Market Area

Hospital	Hospital Market Area
Bayonne Medical Center	Newark/Jersey City
Christ Hospital	Newark/Jersey City
Clara Maass Medical Center	Newark/Jersey City
Columbus Hospital	Newark/Jersey City
East Orange General Hospital	Newark/Jersey City
Greenville Hospital	Newark/Jersey City
Jersey City Medical Center	Newark/Jersey City
Mountainside Hospital	Newark/Jersey City
Newark Beth Israel Medical Center	Newark/Jersey City
RWJU at Rahway	Newark/Jersey City
Saint Barnabas Medical Center	Newark/Jersey City
Saint James Hospital	Newark/Jersey City
Saint Michael's Medical Center	Newark/Jersey City
Trinitas Hospital - Williamson Street Campus	Newark/Jersey City
UMDNJ-University Hospital	Newark/Jersey City
Union Hospital	Newark/Jersey City
Barnert Hospital	Hackensack, Ridgewood & Paterson
Bergen Regional Medical Center	Hackensack, Ridgewood & Paterson
Chilton Memorial Hospital	Hackensack, Ridgewood & Paterson
Englewood Hospital and Medical Center	Hackensack, Ridgewood & Paterson
Hackensack University Medical Center	Hackensack, Ridgewood & Paterson
Holy Name Hospital	Hackensack, Ridgewood & Paterson
Meadowlands Hospital Medical Center	Hackensack, Ridgewood & Paterson
Palisades Medical Center of New York	Hackensack, Ridgewood & Paterson
Pascack Valley Hospital	Hackensack, Ridgewood & Paterson
PBI Regional Medical Center	Hackensack, Ridgewood & Paterson
St. Joseph's Hospital and Medical Center	Hackensack, Ridgewood & Paterson
St. Joseph's Wayne Hospital	Hackensack, Ridgewood & Paterson
St. Mary Hospital Hoboken	Hackensack, Ridgewood & Paterson
St. Mary's Hospital	Hackensack, Ridgewood & Paterson
The Valley Hospital	Hackensack, Ridgewood & Paterson
Hackettstown Regional Medical Center	Morristown
Morristown Memorial Hospital	Morristown
Muhlenberg Regional Medical Center, Inc.	Morristown
Newton Memorial Hospital	Morristown
Overlook Hospital	Morristown
Saint Clare's Hospital/Denville Campus	Morristown
Saint Clare's Hospital/Dover General	Morristown
Saint Clare's Hospital/Sussex	Morristown
Warren Hospital	Morristown
Hunterdon Medical Center	New Brunswick
JFK Medical Center	New Brunswick
Raritan Bay Medical Center - Old Bridge Division	New Brunswick
Raritan Bay Medical Center - Perth Amboy Division	New Brunswick
Robert Wood Johnson University Hospital	New Brunswick
Saint Peter's University Hospital	New Brunswick

Hospital	Hospital Market Area
Somerset Medical Center	New Brunswick
University Medical Center at Princeton	New Brunswick
Bayshore Community Hospital	Toms River
CentraState Medical Center	Toms River
Community Medical Center	Toms River
Jersey Shore University Medical Center	Toms River
Kimball Medical Center	Toms River
Monmouth Medical Center	Toms River
Ocean Medical Center	Toms River
Riverview Medical Center	Toms River
Capital Health System at Fuld	Trenton
Capital Health System at Mercer	Trenton
Robert Wood Johnson University Hospital at Hamilton	Trenton
St. Francis Medical Center	Trenton
Cooper Hospital/University Medical Center	Camden
Kennedy Memorial Hospitals-University Medical Center, Cherry Hill	Camden
Kennedy Memorial Hospitals-University Medical Center, Stratford	Camden
Kennedy Memorial Hospitals-University Medical Center, Turnersville	Camden
Lourdes Medical Center of Burlington County	Camden
Our Lady of Lourdes Medical Center	Camden
Underwood-Memorial Hospital	Camden
Virtua-Memorial Hospital of Burlington County, Inc.	Camden
Virtua-West Jersey Hospital Berlin	Camden
Virtua-West Jersey Hospital Marlton	Camden
Virtua-West Jersey Hospital Voorhees	Camden
AtlantiCare Regional Medical Center, Inc.	Atlantic City
AtlantiCare Regional Medical Center, Inc.	Atlantic City
Burdette Tomlin Memorial Hospital, Inc.	Atlantic City
Shore Memorial Hospital	Atlantic City
South Jersey Healthcare Regional Medical Center	Atlantic City
South Jersey Hospital - Elmer	Atlantic City
Southern Ocean County Hospital	Atlantic City
The Memorial Hospital of Salem County	Atlantic City
William B. Kessler Memorial Hospital, Inc.	Atlantic City

Appendix 7

Methodology for Comparing Hospitals

The methodology for comparing hospitals is based on the average for each metric for all hospitals in the hospital's market area.

We established a score equal to the number of standard deviations away from the average for each hospital. A positive score indicates a hospital is more essential than the average for all hospitals in the area and a negative score indicates a hospital is less essential than the average.

The formula used for converting a hospital's metric on a certain variable (e.g., number of Medicaid and uninsured discharges and ER visit, occupancy rate, etc) into its equivalent standardized value is as follows:

$$\text{Standardized Score} = \frac{\text{(Individual Hospital Metric Value – Average for All Hospitals in the Market Area)}}{\text{Standard Deviation of the Metric for the Area}}$$

By subtracting the average of the metric for the relevant hospital market area from the observed value of the metric for a given hospital and then by dividing it by that metric's dispersion (standard deviation) across hospitals in that area, one arrives at a new variable whose average across the area must, by construction, be 0 and whose measure of dispersion (standard deviation) is 1.

If this is done for every metric, then, regardless of the size and dimension of each metric, all standardized metrics will have an across-market-area average of 0 and a dispersion (standard deviation) of 1. Because these standardized variables are now similar, one can add them up, by weighting each, to arrive at an overall weighted average score that may reflect many distinct metrics.

Below are examples of this method for standardizing two of the essentiality metrics, one that is numbers (number of Medicaid and uninsured ER visits) and one that is percentages (occupancy rate).

Method for Standardizing Metrics Example: Medicaid and Uninsured ER Visits

Hospital	Observed Value for Number of Medicaid and Uninsured ER Visits	Average Number of Medicaid and Uninsured ER Visits for Market Area	Observed Value less Average	Standard Deviation	Standardized Score
	A	**B**	**C = A - B**	**D**	**E = C/D**
A	5,562	13,827	-8,265	9,935	-0.83
B	5,732	13,827	-8,095	9,935	-0.81
C	6,231	13,827	-7,596	9,935	-0.76
D	6,281	13,827	-7,546	9,935	-0.76
E	7,951	13,827	-5,876	9,935	-0.59
D	9,159	13,827	-4,668	9,935	-0.47
F	11,484	13,827	-2,343	9,935	-0.24
G	12,028	13,827	-1,799	9,935	-0.18
H	15,333	13,827	1,507	9,935	0.15
I	20,500	13,827	6,674	9,935	**0.67**
J	31,550	13,827	17,724	9,935	1.78
K	34,107	13,827	20,281	9,935	2.04
Average	**13,827**				**0.00**
Standard Dev.	**9,935**				**1.00**

Method for Standardizing Metrics Example: Inpatient Occupancy Rates

Hospital	Observed Value for Occupancy Rate	Average Occupancy Rate	Observed Value less Average	Standard Deviation	Standardized Score
	A	**B**	**C = A - B**	**D**	**E = C/D**
A	47%	72%	-25%	11%	-2.33
B	59%	72%	-13%	11%	-1.25
C	68%	72%	-4%	11%	-0.39
D	70%	72%	-2%	11%	-0.19
E	70%	72%	-2%	11%	-0.15
D	74%	72%	2%	11%	0.19
F	76%	72%	4%	11%	0.36
G	78%	72%	6%	11%	0.59
H	79%	72%	7%	11%	**0.67**
I	82%	72%	10%	11%	0.95
J	82%	72%	10%	11%	0.96
K	83%	72%	11%	11%	1.03
Average	**72%**				**0.00**
Standard Dev.	**11%**				**1.00**

As these two example show, the variation in the observed values is very different for the two metrics: for the number of Medicaid and uninsured ER visits, the dispersion (standard deviation) is 9,935, while the dispersion for occupancy rates is 11%. However, the standardized scores in Column E account for these different dispersions in the observed values for the metrics. For example, Hospital I has 6,674 more Medicaid and uninsured ER visits than the average for all the hospitals in the market area and this yields a standardized score of .67. For the occupancy rate metric, Hospital H's occupancy rate is 7 percent greater than the average occupancy rate for all hospitals in the market area, and its standardized score is also .67. In standardized terms, both Hospital I and Hospital K are 0.67 above the average for these two different metrics. Standardizing allows for hospitals' observed values to become "unit free", thus enabling them to be added across all the essentiality metrics.

Under this method, each hospital's overall essentiality score is relative only to the other hospitals in its market area; it is not valid to compare hospitals' essentiality scores across different market areas.

The Commission used the same methodology for scoring each hospital on the three financial viability metrics, except that it compared all hospitals in the State against the statewide average for the metric rather than against the average for the market area. Since higher values of Long-term Debt to Capitalization put a hospital at greater risk, we inverted the score for that metric so that values above the average yield negative scores. Doing this allowed us to sum the scores to arrive at an overall score of each hospital's financial viability relative to other hospitals in the State.

Appendix 8

Public Comment on the Proposed Criteria

COMMENTS FROM VALLEY HOSPITAL

It appears that the determination of whether or not a hospital would be deemed essential is based predominantly on the socioeconomic status of the population served. If this is the intent, then perhaps it would be more appropriate to refer to these hospitals as "safety net" rather than "essential." The current implication is that only this type of hospital is essential when there are hospitals such as Valley, the second busiest hospital in the state based on admissions that are meeting the health care needs of a large population. If this was not the Commission's intent, then the definition of what makes a hospital essential needs to be much broader than payer mix and the availability of Trauma Services.

It is interesting to note that all three state-designated Level I Trauma Centers are in the same cities where the Medicaid population is highest. With the exception of Morristown, all the Level 2 Trauma Centers are in densely populated urban locations. If the Commission is considering the availability of specialty services as a criterion for being deemed essential, we would suggest that services in addition to trauma be considered. Other essential services to consider include cardiac surgery, comprehensive cancer services, obstetrics, pediatric and neonatal intensive care, chronic dialysis, neurosurgery and other surgical specialties. Absent any expansion of the criteria, all "essential" hospitals will be located in urban areas with a significant Medicaid and charity care population. Again, if this is the intent then the hospitals should be designated "safety net" rather than referring to them as "essential."

It is difficult to comment on how the proposed revisions to the market areas will impact the industry as it is unclear how these will function. The Commission is proposing to condense the ten Dartmouth designated Hospital Referral Regions (HRR) into eight. It appears that the size of the regions vary significantly and in some cases may be either too large or too small. I will comment specifically on the region that includes Valley Hospital in Ridgewood. It has been proposed that the Ridgewood and Paterson regions be combined with the Hackensack HRR creating a region that produces nearly 200,000 discharges and covers a population of 1.4 million people, which seems overly large. In addition, many of the major roadways in our area run north and south rather than east and west, which significantly increases travel time further challenging the proposed combination.

On a final note, it appears that the Commission is working with Navigant from the materials that were distributed. Navigant has and is currently providing management services at a number of New Jersey hospitals. How is the Commission addressing what could be perceived as a potential conflict of interest?

We applaud Governor Corzine and the Commission's commitment to improving the health care system in New Jersey. I am certain that the Commission recognizes that the health care system is far broader than just the State's acute care hospitals and that any course of action must include all aspects of the system.

Thank you again for your candidness and the opportunity to participate in the process.

COMMENTS FROM SOMERSET MEDICAL CENTER

Michele K. Guhl
Executive Director
Commission on Rationalizing Health Care Resources
New Jersey Department of Health & Senior Services

Dear Ms. Guhl:

We wish to suggest additional factors for identifying "essential hospitals." Few can dispute "travel time to next nearest hospital", a factor which the commission has already noted, but we believe an additional measure of geographical accessibility is vital. The fact is that there are five hospitals in the state that are sole providers in their respective counties. They are essential to their communities, not only for lower income and elderly persons, but for all. Traveling longer distances for all in an increasingly urbanized and high-traffic state renders sole-provider hospitals in Cape May, Cumberland, Somerset, Hunterdon and Sussex Counties "essential hospitals." The absence of these institutions would cause unwarranted hardship for the 813,000 (2000 Census) people residing in these areas.

We respectively request that this measure – sole provider-- be added, perhaps under "Other Factors to Consider."

A second important criterion worthy of consideration is recognition of hospitals that serve as Medical Coordination Centers (MCC). Such hospitals are part of a state-wide system of crisis response and they have invested heavily in facilities, communications equipment and training, both with their own funds and additional state support. They serve a critical function in enabling the state to deal with biological or other overwhelming area crises. Hospitals serving in this capacity are certainly essential.

Vincent L. D'Elia

Vice President – Strategic Planning & Legislative Affairs
Somerset Medical Center

COMMENTS FROM MERIDIAN HEALTH

The Commission does not appear to specifically include a hospital's status as a teaching institution with regard to its calculus for "essentialness". On behalf of Meridian Health, I respectfully request that the Commission give serious consideration to adding the teaching status of a hospital as a key consideration. New Jersey has lagged behind other states in our region in the development of medical education, having come upon an integrated medical education system quite late (UMDNJ having begun in early '70s). Physician practices have remained small, community hospitals have flourished, and the growth of medical research, until recently, has been muted.

The costs for sustaining a vibrant teaching role are quite high. The adoption of residency caps by the federal government has strained New Jersey teaching hospitals and we see many examples where institutions are carrying residencies that are not reimbursed by the federal government. For example, Jersey Shore University Medical Center has some 110 residents and fellows in its program yet receives funding for only 84 slots. The hospital also rotates between one-third and one-half of all medical students at UMDNJ-Robert Wood Johnson Medical School, yet receives no compensation at all for this training.

Although other elements of the calculus for "essentialness" may already be viewed as those provided by teaching institutions, and hence an argument could be raised that there is no need for a specific category, we believe a specific element is necessary. This would allow for a more appropriate comparison between financially unstable hospitals: where one is a teaching institution and one is not.

Of course, not all teaching hospitals are alike. Simply having a small residency program should not weigh heavily on the comparison, especially where a number of hospitals have quite small teaching operations. For example, 42 hospitals currently have approved residency programs (as of 2004). However, only 18 hospitals have total approved residencies of 40 or more slots. At a minimum, I suggest that the Commission look at major teaching institutions using the guidelines crafted by the Association of American Medical Colleges (AAMC): a major teaching hospital is one that is affiliated with a medical school and has at least four residency programs with at least two in the six core specialties: family medicine, medicine, surgery, ob-gyn, psychiatry and pediatrics. The extra costs for operation of these facilities should be considered in any determination of essentialness. Clearly, the long-term impact of cutting back on teaching hospitals in New Jersey is quite different from the long-term impact of cutting non-teaching hospitals.

Thanks again for this opportunity to comment.

Regards,

Russ Molloy, Esq.
Vice President of Government Relations
Meridian Health

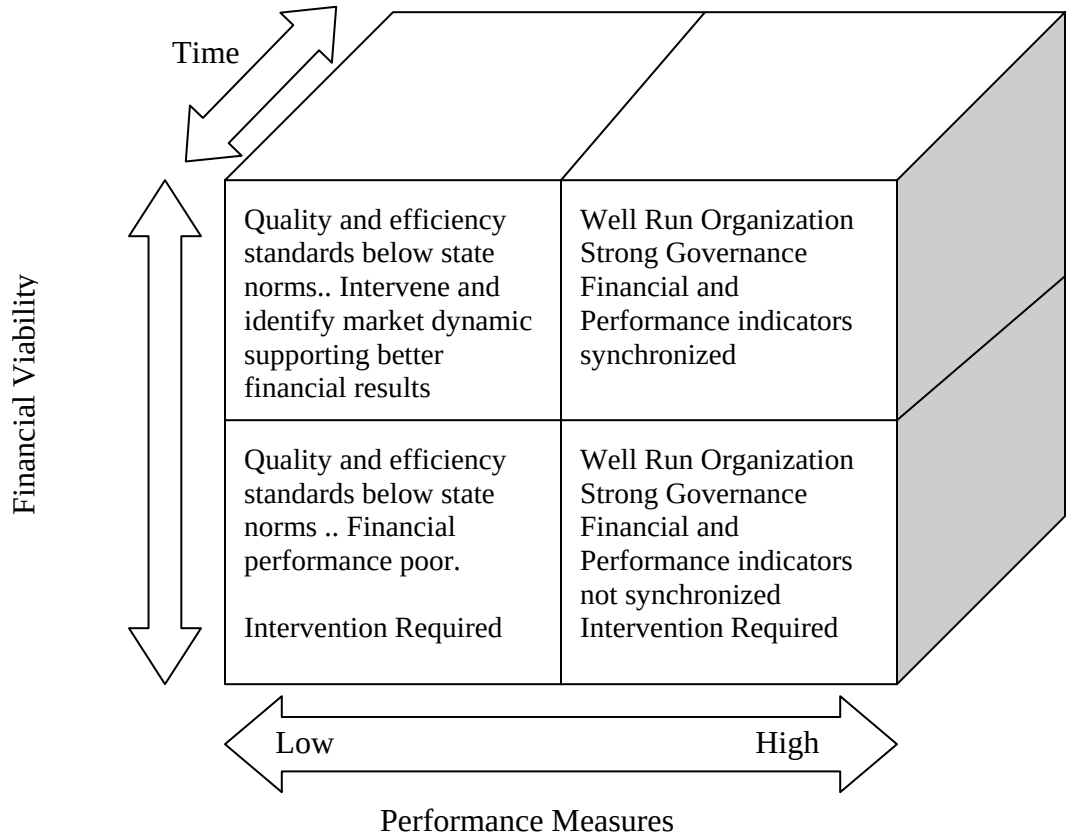
Comments from the Catholic Healthcare Partnership Regarding:

Proposed Framework for Evaluating Hospitals' Essentiality and Financial Viability

A little over a decade ago the New Jersey Department of Health attempted to modify the planning process by defining certain hospitals as the necessary franchises within a given market area. This attempt at controlled biased planning clearly did not work in the best interests of New Jersey citizens and its healthcare infrastructure. One key deficiency in this process was the use of a static view of the market that was never revisited or updated to reflect the dynamics of an ever moving environment. We believe many of the problems we are facing today in fact were born out of that strategy.

The single biggest factor that needs to be evaluated in the equation is time. Time needs to be considered on two fronts, first the static or short term horizon, identifying where organizations fall today and what interventions need to be considered immediately to stem any further erosion. Second, a long term view (clearly more complex) projecting demand as well as other interventions to achieve a model organization of high performance and high financial viability. It is impossible to forecast the required interventions when we don't know the underlying cause of either poor performance or financial viability.

We feel it is better to define the X axis of the grid as hospital performance. Performance measured against financial viability will provide a better roadmap to direct effort and resources.



Performance Indicators:

- **Quality Measures:**
  - "Real" quality measures, not documentation measures
  - Innovation
  - Infection Rates
  - Re-admission Rates
  - Medical Staff Measures (age, Board Certification etc.)
- **Efficiency Measures:**
  - FTE's per occupied bed
  - Operating Costs net of Bad debts per admission and "standardized" adjusted admission.
  - Occupancy Rates
  - LOS
  - Case Mix / Acuity Measures
  - Throughput measures
- **Other Measures:**
  - Care for the vulnerable populations is a vital criterion for the process.
  - Satisfaction measures
  - Payer Mix

Financial indicators:

- Liquidity ratios
- Debt coverage ratios
- NOT operating margins (too much manipulation)

Hospital Alliance of New Jersey

"Celebrating 10 Years as the Voice of New Jersey's Urban Hospitals"

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May 11, 2007

Uwe Reinhardt, Ph.D., Chairman
Commission on Rationalizing Health Care Resources
Department of Health and Senior Services
P.O. Box 360
Trenton, New Jersey 08625-0360

Dear Chairman Reinhardt:

Thank you for the opportunity to comment on the Commission on Rationalizing Health Care Resources' draft metric for evaluating "essential" hospitals in New Jersey.

When reviewing this metric, the first point that appears unusual is the inclusion of a "burn unit" as a requirement to be considered essential. While we do not disagree that this is certainly an important service, we feel it is inappropriate to include this in the comparison metric since with only one designated burn center in New Jersey, it provides for much too narrow of a measurement tool. That being said, we feel some more work needs to be done on the availability of other key services in your metric such as mental health and dialysis, especially for Medicaid and charity care patients.

In our analysis of your metric, we have compared it to New York's own definition of an essential hospital and also with aspects of New York's "Financially Distressed Hospital" program. We agree with your criteria listed for "Care for Vulnerable Populations" but have two additional suggestions. In addition to Medicaid and charity care discharges, the Commission should also look to the degree of self-pay and bad debt burden that the hospital experiences. It is unclear as to whether this would all fall under the "Uninsured Discharges" in your draft metric. We note that New York's Financially Distressed Hospital program included considering losses from bad debt. Bad debt is often higher in urban areas because patients that would qualify for charity care are often non-compliant with the application process.

We also feel that as an access exercise, it is important to understand what the percentage of Medicaid and charity care discharges are in a global service area to be able to evaluate whether the closure of the hospital would result in material barriers to care. We also feel that more study should be placed on population density in being able to deliver services. Another consideration is not just looking at distance between facilities "as the crow flies" - although hospitals can be geographically close, there can be a great deal of difficulty for the poor and elderly to have access to certain facilities. In addition, in New York's definition of essential hospital, the percent of Medicare discharges is also included. Since this is an important factor in assessing the services provided to the elderly in an area, we feel that the Commission should consider adding this criterion to its evaluation.

The financial viability metrics that you reference are very basic and need some further analysis. For instance, a metric that looks at long-term debt to capitalization can be

misleading because a hospital could have taken on existing debt from closed facilities in its service area during a consolidation. We believe that hospitals that have helped to reduce excess capacity through consolidations/closures of other acute care hospitals should be eligible for special funding considerations. Also, the inclusion of "days cash on hand" in your evaluation cannot be looked at alone without also looking at the amount of days a facility takes to pay vendors – as the amount of cash available is directly tied to what bills the hospital has outstanding. Also, in any study of a facilities' long-term financial health, a hospital's pension liability must be taken into consideration. In addition, NJ policymakers should monitor the likelihood of potential changes in federal DSH reimbursement to hospitals.

As we discussed with you during our testimony on April 30th, urban hospitals are victims of location with poor payer mixes. Most likely the financial vulnerability they are experiencing is not a red flag that the hospital had inefficient management; on the contrary, we believe that challenged hospital executives that are operating hospitals with such vulnerable positions are more likely to be more proficient in their performance. However, we certainly understand Commissioner Jacobs' point that any additional monies that the State dolls out to help distressed hospitals need to be spent wisely. We also note that under New York's Financially Distressed Hospital program, hospitals that received funds from the pool were required to deliver services to the medically indigent in a more efficient and economical manner. Hospital Alliance feels that whatever benchmarks are put in place, they should be applied evenly to all New Jersey hospitals.

As we mentioned to you in our testimony, even when all of your comparison metrics regarding the populations served and availability of services are complete, it does not answer the complete question of whether or not that hospital is essential. As most likely the number one employer in its area, the closure of a hospital hits the economy very hard in the impacted area. Because of this, we suggest that you add "the economic benefit to the community" that the hospital provides to your metric of evaluation.

It is also interesting to note that in New York, distressed hospitals were not eligible for additional funds if they had filed for bankruptcy. We believe that it makes sense for New Jersey to consider adding this recommendation to its metric.

As you know, currently many urban hospitals are experiencing high volumes but are seeing "red" because a hospital cannot lose money on almost every patient and survive. The persistent problem with HMOs and insurance companies not paying adequate rates and inappropriately denying payment for services has greatly contributed to hospitals' financial distress. Most importantly, we believe that the pervasive and ongoing deficiency in reimbursement for Medicaid and charity care services is the root cause of the financial problems at urban hospitals. To be able to objectively assess this, we suggest that New Jersey perform a five-year historical review of the facilities' financial predicament like New York did under its Financially Distressed Hospital program. Specifically, we believe it would be a very worthwhile exercise to compare what the facility received in charity care reimbursement for the past five years as compared to the actual documented charity care for those corresponding years.

Which brings us to our most important comment: the principal statement that we'd like to make involves the State's responsibility to "reimburse hospitals for charity care provided." While the concept of "distressed funds" going to "less financially viable essential hospitals" may be good public policy, it should not be at the expense of funds being appropriated for charity care. It is critical that the 2005 literal charity care base year be fully funded FIRST before any additional funds are given out under the Commission's distressed hospital criteria. Otherwise, the Commission's action will further deteriorate NJ hospitals by contributing to the inadequate reimbursement that has plagued hospitals in our state for many years. As the charity care formula distributes funds fairly by an objective method (by basing a hospital's percentage of reimbursement on its percentage of charity care business related to its total business), it is logical and good public policy to reimburse NJ hospitals through a fully funded formula before any additional appropriations are made.

We'd like to reiterate that no matter what metrics are used that they have limitations. Because of this, we ask that you use them simply as a guideline. We ask that you bring your years of real world experience in healthcare to your understanding of these serious problems and in devising solutions to strengthen the very hospitals that are meeting their missions of providing healthcare to the poor and uninsured in New Jersey.

Sincerely,

Suzanne Ianni

Suzanne Ianni
President and CEO

c: Gary Horan, Chairman, Hospital Alliance of New Jersey

SOLARIS HEALTH SYSTEM℠

May 11, 2007

Members, New Jersey Commission on Rationalizing Health Care Resources
C/O Michele Guhl, Executive Director
Department of Health and Senior Services
P. O. Box 360
Trenton, NJ 08625-0360

Re: Proposed Framework and Criteria for Determining Essential and Financially Distressed Hospitals

Dear Chairman Reinhardt and Esteemed Commission Members:

Thank you for the opportunity comment on the Commission's "Proposed Framework and Criteria for Determining Essential and Financially Distressed Hospitals". As President and CEO of one of the state's largest health systems, I do not envy your mission to develop policy recommendations that may ultimately lead to the downsizing of one of the state's largest and most critical resources – its hospital system.

Please allow me to preface my comments by expressing frustration that I and other members of the public were not provided ample time to prepare our thoughts on this important proposal. I was not made aware of your proposal and May 11 comment deadline until Executive Director Michele Guhl made a presentation to a meeting at the New Jersey Hospital Association on May 10. I would also like to express frustration that I and other members of the public were only provided a short bullet-point synopsis of the Commission's proposal on which to comment. The lack of detail contained in the proposal leaves many essential questions unanswered, for example:

- How will the Commission weight the proposed metrics to develop its recommendations for essential and less viable hospitals?
- How does the Commission propose that the Administration and the Legislature use this material during the SFY 2008 budget process?
- How will the Commission determine and quantify factors such as:
    - Impact on area employment?
    - Impact on service delivery and access to care for racial and ethnic groups?
    - Travel time to other hospitals?
    - What constitutes 'comprehensive services'?

Recommendations

Identifying an essential hospital is an impossible task, because I believe that all of the state's hospitals are essential to their patients, communities and staffs. However, the Commission has done a good job at identifying some of the criteria that help identify facilities that serve vulnerable populations and are underreimbursed for the care that they provide to these families. I would like to make a few recommendations to add to the Commission's report.

Care for Vulnerable Populations
In addition to the criteria identified by the Commission, I would add another metric to measure care provided to undocumented immigrants, one of the state's most vulnerable populations that do not show up under the metrics identified in the Commission's proposal.

Availability of Services
In addition to the criteria identified by the Commission, teaching programs – both graduate medical education and nursing and allied health training programs – should be included under the umbrella of essential services. For example, Muhlenberg Regional Medical Center is not only a teaching hospital, with residencies in internal medical and colon and rectal surgery, but it also hosts one of the area's only nursing and allied health schools.

In addition to providing comprehensive services (such as OB and inpatient mental health), the Commission should also consider unique services offered by hospitals in each region. The Commission seems to have touched on this concept by adding trauma and burn units to this category; however other specialty services and programs should also be considered to ensure that a hospital closure does not deprive a region of critical services. CN regulated services, such as elective angioplasty, should be added to this metric. Centers of excellence, such as the Diabetes Center of New Jersey at Muhlenberg Regional Medical Center, should also be included in the proposal.

Other Factors to Consider
The Commission recognizes that "quality" is an important factor in identifying an essential hospital. I recommend that this critical metric be weighted heavily when identifying which hospitals would qualify for additional state support. Improving health care quality must be the top priority of every hospital in the state regardless of financial performance. Factors to consider for quantifying quality include:

- Performance under the NJ Hospital Performance Report;
- Active participation in nationally and state recognized quality improvement programs, such as the Protecting Five Million Lives From Harm campaign, and the NJHA ICU Collaborative; and
- Investments in technology and capital programs to improve quality and efficiency and reduce medical errors.

Thank you for the opportunity to comment on this proposal. I look forward to providing additional feedback to the Commission as you continue your work and ask that you please do not hesitate to contact me at (732) 744-5822 if I can be of some assistance to you.

Sincerely,

Adam Beder,
Director, Government Affairs

Cc: John P. McGee, President & CEO, Solaris Health System

HPAE
110 Kinderkamack Road
Emerson, NJ 07630
www.hpae.org

To: Commission on the Rationalization of Healthcare Services in NJ
From: Health Professionals and Allied Employees (HPAE), AFT, AFL-CIO
Re: Proposed Financial Viability Metrics, Essentiality Criteria and Framework for Evaluating Hospitals for State Support

HPAE represents 12,000 nursing and other health professionals in healthcare facilities throughout New Jersey, including 13 of the state's general acute care hospitals. We are submitting these comments in response to a request for feedback posted on the Commission's website on April 20th.

Proposed Financial Viability Metrics

The Commission's consultant proposes using operating margin, days cash on hand and ratio of long-term debt to capitalization to measure the financial viability of NJ hospitals.

HPAE Concerns:

1. *The source of the data*. The information posted on the Commission website doesn't indicate the source of the data for the financial metrics. We understand that the data will be cross-checked with data from the NJHCFFA. We support use of NJHCFFA data, as their calculations are based on their own review and analysis of hospital audited financial statements. We would be concerned if these metrics were based on the NJHA FAST (Financial and Statistical Trends) report data. Our experience is that these reports are not reliable. For example, the December 2005 NJHA FAST report indicated that Bayonne Medical Center had an operating margin of 4.4%, the 6th highest in the state. Examination of their audited financials showed an operating margin of 0.3%, a figure that itself has turned out to be inaccurate.
2. *Three year trend*. We would expect that financial measures for each hospital would be looked at over at least a 3-year period to reveal trends and account for unusual variations due to changes in leadership or unique events.
3. *Role of mismanagement and the need for transparency and accountability*. Poor financial and operational decisions, including bad billing practices by hospital leadership, along with inadequate governance are responsible for much of the financial fragility of many of NJ's vulnerable hospitals. The proposed criteria do not address this issue and our concern is that hospitals will be labeled "less viable" because of poor management and governance rather than because of any inherent inability of the hospital to thrive financially. We would hope that as part of its deliberations, the Commission would

consider recommendations linking a hospital's receipt of *any* state funds, including charity care, Medicaid, and bond financing, to critical review of its finances and governance structures.

Proposed Criteria for Identifying Essential Hospitals

The Commission's consultants propose a variety of criteria for determining "essentiality. We're pleased that these criteria include the impact on employment, and the need to address the needs of particular racial and ethnic groups and transportation concerns.

HPAE concerns:

The criteria do not address:

1. unique services provided by a hospital,
2. hospital's role in serving immigrant and undocumented populations,
3. measures of a community's health status, or
4. indicators of unmet needs of the communities served by a hospital
5. anticipated growth and future demographic changes and health needs of the served communities.

Proposed Framework for Evaluating Essentiality and Financial Viability

It appears that where a hospital lands on the essentiality and viability axes will determine whether a hospital is a candidate for financial and other support from the state. The following do not appear to be included in the framework:

- Unmet health care needs of the community;
- Leadership, governance and accountability concerns (waste, mismanagement, self-dealing etc);

For example, a hospital could be very financially vulnerable as a result of significant debt associated with unnecessary building expansion and a failure to accurately assess the health care needs of the surrounding communities. This same hospital might appear to be redundant and therefore non-essential because it is offering the same services as nearby hospitals. However, an analysis of unmet needs in the hospital's service area might reveal populations not being served at all and/or services needed but not currently available.

In addition, we would urge that the framework consider the following:

- An option for levels of support from the state, based on the nature and degree of financial vulnerability of a hospital, including bridge loans and grants;
- Creation of "early warning" and "early intervention" systems that would enable the health department, perhaps along with the NJHCFFA, to monitor hospitals' financial condition and intervene in leadership and governance when appropriate in order to prevent the crises that several NJ hospitals currently face.

NJHA
NEW JERSEY HOSPITAL ASSOCIATION

May 11, 2007

Uwe Reinhardt, Ph.D., Chairman
Commission on Rationalizing Health Care Resources
Department of Health and Senior Services
P.O. Box 360
Trenton, NJ 08625-0360

Re: Comments on Draft Metric for Evaluating Essential Hospitals

Dear Chairman Reinhardt:

The following are NJHA's comments to the draft metric for evaluating "essential" hospitals in New Jersey distributed by the Commission on Rationalizing Health Care Resources:

Proposed Framework for Evaluating Hospitals Essentiality and Financial Viability

- The grid appears to focus in on hospitals in crisis. Given that we are being told this is not a "closure commission" shouldn't the State be looking at the entire system, beyond just acute care hospitals, to plan for the future? A hospital might be "essential" to its community, but operating well. The terminology seems inappropriate.
- The proposed framework needs to be grounded in comprehensive statewide health planning. At present, it lacks that context. The framework needs a statewide health plan for all healthcare services (not just acute care) in order to make sense. It must examine and address the proliferation of ambulatory care centers. Such a plan must include the projected demand for healthcare services by "baby boomers." According to a report recently released by the American Hospital Association, the number of U.S. residents over age 65 will nearly triple between 1980 and 2030 as America's "baby boomers" age, placing new demands on the nation's healthcare system. The report estimates that six in 10 boomers – more than 37 million people – will be managing more than one chronic condition by 2030. The report may be found at www.aha.org/aha/content/2007/pdf/070508-boomerreport.pdf.
- The grid fails to address reimbursement issues. As we pointed out in our testimony, the current system in New Jersey pushes the uninsured and Medicaid population to the state's acute care hospitals for services. We are left with the non-paying or poor-paying patient populations, while ambulatory care centers often "cherry pick" paying patients. The woeful Medicaid rate for physicians and hospitals is left unaddressed, and hospitals fight annually for adequate charity care funding. These issues must be addressed and accounted for in the grid.
- NJHA agrees with the comments submitted by the Catholic Healthcare Partnership regarding the grid's failure to factor in hospital performance in terms of quality and

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Tel 609-275-4000

efficiency. The grid considered by the Catholic Healthcare Partnership should be examined.

Proposed Criteria for Identifying Essential Hospitals (Criteria for Comparing Hospitals)

- The criteria must include the percent of charity care provided, along with the care provided to undocumented immigrants. These factors should be included, along with the percent of Medicare discharges. Along with Medicaid, Medicare fails to cover hospital costs. Charity care fails to cover hospital costs and does not pay anything for physician costs. Almost no funding is provided for undocumented immigrants.
- The criteria must also include geographic isolation. Certain facilities are the only acute care provider in their region, and that factor must be considered.
- When examining "inpatient occupancy" we suggest you examine "staffed beds" versus "licensed beds" because that is a more accurate representation of the work that the hospital is doing. Looking at the occupancy rate of a hospital based upon licensed beds presents a distorted picture.

Proposed Criteria for Identifying Essential Hospitals (Other Factors to Consider)

- Impact on employment in the area will be a factor when it comes to closing any hospital in the state. Hospitals are normally the largest employer in the town they are located in, and closures have a devastating impact upon that community, along with surrounding areas.
- We suggest "Impact on ambulatory service delivery" be changed to "Impact on ambulatory service availability." When a hospital closes, will the ambulatory care centers in the area step up to the plate to provide care for those previously seen in hospitals, who may not have the ability to pay, or may be covered by Medicaid – a less-than-cost payer? Will they take all comers?
- We do not understand "Hospital system solutions" and what that phrase means. The idea that a healthy hospital system should become involved in running a hospital in financial trouble raises many troubling questions. First, the system may be healthy precisely because it was able to consolidate and close a financially troubled hospital. It may have had too much capacity. Second, the idea that a viable hospital system should run a hospital in financial distress presumes geographic proximity, which may not exist. Third, the premise ignores the obligation of the state of New Jersey to properly reimburse all hospitals for services provided to charity care and Medicaid patients, which would alleviate the pressures felt by all hospitals.
- We suggest adding a factor that examines the quality of care, including (1) length of stay, and (2) physician utilization.

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- We suggest that a factor be added that examines the graduate medical education component of the hospital. Given that all experts project a physician shortage in coming years, the training component of individual hospitals must be a factor. According to the N.J. State Physician Census conducted by the Center of State Health Policy at Rutgers, New Jersey has seen a decline in the number of patient care physicians from 2001-2003 of 4.4 percent. The Association of American Medical Colleges has called for a 30 percent increase in medical school enrollment to deal with the projective shortfall in the workforce.
- We suggest adding a factor that looks at CEO turnover, which may have contributed to the problems at the facility, along with governance.
- We suggest adding a factor that examines "surge capacity." Hospitals are expected to be ready for disaster preparedness by the State of New Jersey, so this factor must be included.

Proposed Criteria for Measuring Hospital Financial Viability

We think the three factors identified are good ones, but some essential factors are missing, including:

- Occupancy levels
- Accounts receivable
- Average payment period
- Evaluation of managed care contracts, denial rates and delayed payments by managed care companies
- Operating margin
- Age of plant

Thank you for the opportunity to comment.

Very truly yours,

Gary S. Carter
President & CEO

c: Michele Guhl

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Appendix 9

Commission's Initial Responses to Public Comment

Framework for Evaluating Hospitals and Various Policy Issues

- The Commission received several comments that it should be considering the State's entire healthcare system, not just acute care hospitals.

Response: The Commission's charge from the Governor is to focus on the State's general acute care hospitals, and in assessing alternative sources of care, to consider the demand for and supply of physicians, and ambulatory care facilities such as federally qualified health centers.

- The Commission received a comment that the short-term assessment and interventions to assist financially distressed hospitals in immediate need must be separated from the long-term goal of how to achieve a model hospital system in the State.

Response: The Commission's charge includes advising on both short-term and long-term issues. To date, the Commission has focused on the assessment of the financial and operating condition of New Jersey's hospitals, and the development of criteria for assessing whether and to what extent financially distressed hospitals seeking State assistance are essential in their current configurations for maintaining appropriate access to health care services for the people of New Jersey. For the short-term, the Commission focused on the likelihood that the most strained of New Jersey hospitals will seek State aid to help them cope with their financial difficulties. For the long-term, the charge of the Commission is not to create a centralized, prescriptive plan for the provision of health care in New Jersey. That project is beyond the Governor's charge, and would fit uncomfortably in today's context of governmental and market influences on health care delivery. Instead, the Commission will provide advice on the means by which New Jersey might take steps as a purchaser, grantor, and regulator to improve the health of New Jersey's hospitals for the benefit of the people of New Jersey. The Commission's complete analysis and suggested long-term responses to these conditions will be provided in its final report.

- The Commission received comments that the framework fails to address Medicaid reimbursement issues for hospitals and physicians and the annual battle for adequate charity care funding.

Response: The purpose of the framework is to differentiate hospitals in terms of their essentiality and financial viability. Medicaid reimbursement and charity care funding issues affect all hospitals, but by varying degrees depending on their Medicaid and uninsured patient volume. The essentiality criteria, by including hospitals' inpatient and emergency department volume of Medicaid and uninsured patients, indirectly consider Medicaid payment issues and the charity care burden.

The Commission recognizes that changes in Medicaid reimbursement and charity care funding may be necessary to address the needs of essential, financially distressed hospitals. Its *Reimbursement/Payers Subcommittee* will be studying this and other related payment issues.

- The Commission received a comment suggesting that whatever benchmarks are put into place should be applied evenly to all New Jersey hospitals.

Response: The Commission's analytic framework is based on quantifiable criteria and metrics using routinely reported, standardized sources of data for identifying hospitals' essentiality and financial viability. As such, the framework applies the criteria equally to all New Jersey hospitals. But quantifiable criteria cannot possibly address all of the social, economic and geographic issues that must be examined by government in determining which financially distressed hospitals the State should support to maintain access to care. The Commission's quantitative analytic framework, therefore, must be supplemented by an assessment of non-quantifiable factors and the knowledge among policy analysts and policy makers of local conditions. In the end, mere numbers cannot take the place of sound judgment; they can only guide that judgment.

- One commenter suggested that hospitals that have helped to reduce excess capacity through consolidations/closures of other acute care hospitals should be eligible for special funding considerations.

Response: The Commission will consider this suggestion as it develops recommendations for ways to assist financially distressed hospitals.

- One commenter suggested that the Commission recommend that financially distressed hospitals not be eligible for additional State funds if they have filed for bankruptcy.

Response: The Commission will consider this suggestion as it develops recommendations for ways to assist financially distressed hospitals that are essential to maintaining access to care.

- One commenter asked how the Commission proposes its analytic framework be used by the Administration and Legislature during the SFY 2008 budget process.

Response: As noted earlier, the Commission's analytic framework uses quantifiable criteria and metrics for identifying hospitals' essentiality and financial viability. But quantifiable criteria cannot possibly address all of the social, economic and geographic issues that must be examined by government in determining which financially distressed hospitals the State should support to maintain access to care. Therefore, the Commission proposes that for the SFY 2008 budget process, as well as in future years, its quantitative analytic framework be supplemented by an assessment of non-quantifiable factors and the knowledge among policy analysts and policy makers of local conditions.

- One commenter asked that the Commission examine "surge capacity".

Response: One the Commission's tasks is to project future demand for hospital services. These projections are being made at the market area level and will factor in the size of the projected population and the effect of projected changes in the population's age composition

in each area. The Commission understands the importance of this issue but does not believe it to be within the scope of its work at this time.

Proposed Criteria for Identifying Hospitals Essential to Maintaining Access to Care

- The Commission received several comments that the criteria should include self-pay patients and patients who are undocumented immigrants.

Response: In identifying hospitals' provision of care to financially vulnerable populations who have few other sources of care, the Commission used each hospital's Medicaid and uninsured discharges and emergency department visits from the Department of Health & Senior Services 2005 UB 92 Database. The following payer codes were used to identify Medicaid and uninsured patients:

Payer	**Payer Code Description**	**Payer Code**
Medicaid	Title XIX (Medicaid)	012
	Medicaid HMO	083
	Americaid Inc. HMO	032
Uninsured	Patient: Direct	031
	Miscellaneous Indigent	095
	Patient: Other Source of Patient Pay	039

We think that self-pay patients and patients who are undocumented immigrants are accounted for in the three payer codes used to identify uninsured patients.

- One commenter asked how the Commission will weight the essentiality and financial viability criteria metrics.

Response: Each metric is equally weighted.

- One commenter noted that it is important to understand what the percentage of Medicaid and charity care discharges are in a global service area to be able to evaluate whether the closure of a hospital would result in material barriers to care.

Response: The Commission's framework for evaluating hospitals' essentiality considers each hospital's "share" of the market area's Medicaid and uninsured discharges and emergency department visits. The methodology for comparing hospitals on each essentiality metric is based on the average for each metric all the hospitals in the market area. Thus each

hospital's total volume of Medicaid and uninsured discharges and emergency department visits is compared to the average for all the hospitals in the area. The results of this comparison would not differ if each hospital's percentage the market area's total Medicaid and uninsured volume were used instead of the total number of Medicaid and uninsured patients. The Commission considered using the proportion that Medicaid and uninsured patients' comprise of each hospital's total patients, but decided that the total volume of indigent patients a hospital cares for is the better metric for evaluating its essentiality to maintaining access to care for financially vulnerable patients.

- One commenter noted that population density should be studied in evaluating hospitals ability to deliver services.

Response: One of the Commission's tasks is to project future demand for hospital services. These projections are being made at the market area level and will factor in the size of the projected population and the effect of projected changes in the population's age composition in each area.

- One commenter noted that hospitals' Medicare discharges should be an essentiality metric.

Response: The Commission did not include hospitals' Medicare discharges because members thought that it is not a measure of service to financially vulnerable populations. However, one of the metrics for service to financially viable hospitals – Medicare Disproportionate Share Hospitals' ratio of patient days for Medicare dual eligible patients to total Medicare patient days – measures of hospitals' service to the portion of Medicare population that is financially vulnerable, that is, the segment that is poor and thus also eligible for Medicaid.

- Some commenters urged the Commission to measure inpatient occupancy on hospitals staffed beds rather than licensed beds.

Response: The Commission measured inpatient occupancy on the number of maintained beds as reported by hospitals on the B2 Reports they submit to the Department of Health and Senior Services.

- Some commenters questioned the appropriateness of the term essential and wondered whether the term "safety net" would be more appropriate given the criteria being used.

Response: The Governor's Executive Order charged the Commission with developing criteria for identifying hospitals that are essential to maintaining access to care. The Commission has chosen to include in the criteria, several metrics for identifying hospitals' service to financially vulnerable populations because these people are likely to have few other sources for care. These metrics do identify "safety net" hospitals. The other criteria for identifying hospitals essential to maintaining access to care include three metrics that measure the intensity of a hospital's use compared to others in the market area and one that recognizes the high-level emergency care resource that trauma center designation connotes.

- The Commission received several comments about including a variety of other metrics to the essentiality and financial viability criteria, including: hospital efficiency and quality measures; the availability of specialty and unique services beyond high level emergency services; impact on area employment and economic benefit a hospital provides; impact on access to care for racial and ethnic groups; distance and travel time between hospitals; and geographic isolation when a hospital is the only acute care provider in its county or region.

Response: The Commission thinks that its recommended criteria for the "essentiality" and "financial viability" of hospitals are a good starting point in assessing the relative urgency and advisability of providing additional state funding to distressed hospitals. In addition to the purely quantitative metrics, there are important qualitative variables, not easily quantified, that the State will wish to consider in individual cases. These qualitative variables include an individual hospital's quality of care performance and consideration of whether all services, including specialty or unique services, are accessible elsewhere in the region should a troubled hospital in need of additional State financing cease to operate. Other qualitative variables to be considered include travel time to other facilities and the number of hospital employees. Policy analysts' and policy makers' knowledge of local conditions is necessary to assess these non-quantifiable factors in individual cases.

In addition, the Commission will consider the extent to which extraordinary assistance should be provided only when a hospital agrees, where appropriate, to specific steps assuring responsible governance, high quality care, and efficient delivery of services. These conditions may include reorganization of hospital boards to include additional public members, agreement to benchmarks for quality and efficiency, and other conditions.

- The Commission received several comments about including graduate medical education as a criterion for identifying hospitals essential to maintaining access to care.

Response: The Commission discussed including graduate medical education but decided to not include it because its charge and focus is on patient care and because analysis indicated that there was a high correlation between the hospitals with graduate medical education programs and hospitals that scored highly on the essentiality criteria the Commission is using.

- One commenter suggested including a factor in the analytic framework for CEO turnover and governance.

Response: The Commission does not think that these are quantifiable metrics that should be used to compare hospitals in terms of their essentiality to maintaining access to care. However, as noted earlier, the Commission will consider the extent to which extraordinary assistance should be provided only when a hospital agrees, where appropriate, to specific steps assuring responsible governance, high quality care, and efficient delivery of services. These conditions may include reorganization of hospital boards to include additional public members, agreement to benchmarks for quality and efficiency, and other conditions.

- One commenter questioned combining the Ridgewood and Paterson area with Hackensack into one hospital market area.

Response: Analysis of patients' travel patterns for inpatient hospital care indicates that 72 percent of the patients who live in the Dartmouth Atlas-defined Paterson Market Area go to hospitals in their own market area. While this is a reasonable percentage for defining a hospital market area, it is the lowest of all the market areas and hospitals one other market area, Hackensack and Ridgewood, care for a sizeable share – 20 percent – of Paterson's patients. Combining the areas results in a single market area where 92 percent of the patients who live there go to hospitals there. Based on this analysis the Commission decided to combine these areas.

Proposed Criteria for Measuring Hospital Financial Viability

- One commenter suggested that the financial viability analysis include 2006 data and be based on hospitals' financial metrics over a three-year period to reveal trends and account for unusual variations due to changes in leadership or unique events.

Response: Most hospitals have submitted their unaudited financial statements for 2006, but audited 2006 financial statements are not yet available. While unaudited financial statements will typically provide the most current picture of a hospital's financial condition, unlike audited statements, they have not been reviewed by an independent outside party. In some cases, there may be material differences between the unaudited and audited statements based on the findings of that outside review. Therefore, unaudited statements should be analyzed with caution.

A further advantage of basing the financial viability analysis on audited statements instead of unaudited statements, is the requirement that they be prepared in accordance with Generally Accepted Accounting Principles (GAAP). This requirement reduces the inconsistency in reporting of financial elements from hospital to hospital.

Regarding the suggestion about using financial metrics over a three-year period, the Commission may consider recommending that the financial viability analysis in the future use a three-year moving average for each of the financial metrics.

- One commenter noted that the number of days a hospital takes to pay vendors should be included with the financial indicator, days cash on hand.

Response: The volume of payments owed to vendors could affect a hospital's cash position. However, even after adjusting each hospital's days cash on hand based on how much it was above or below the state median days in accounts payable, we see little difference in the relative cash position of each hospital. The major differences were concentrated among hospitals that one would conclude had poor liquidity to begin with. In other words, adding

accounts payable as a criterion would have little impact on the conclusions regarding financial viability.

- One commenter noted that operating margin should not be used as a metric for financial viability because it is subject to manipulation.

***Response*:** All the financial elements used in calculating ratios are affected by the decisions of management. The Commission opted for operating margin over the debt service coverage ratio because it evaluates operating income in relation to all expenses, not just debt service.

- One commenter noted that occupancy levels, operating margin, age of plant, accounts receivable, average payment period, evaluation of managed care contracts, denial rates and delayed payments by managed care companies should be included as metrics for hospitals' financial viability.

***Response*:** Occupancy levels may affect financial results but are not an indicator of financial performance; further, they are already included as a criterion for identifying essential hospitals. Problems with accounts receivable will be reflected in a lower days cash on hand figure. As noted above, adjusting for average payment period would not have a major impact on conclusions regarding financial viability. There is no consistent data source for measuring managed care contracts or denial rates and delays in payments by managed care companies; further, problems in these areas will be reflected in poor operating margins and/or low days cash on hand. Operating margin is included as a criterion for assessing financial viability. A high age of plant figure is unlikely to be an indicator of financial distress unless it is combined with poor profitability and/or low liquidity and/or high leverage.

- One commenter noted that hospitals' pension liabilities must be considered in evaluating hospitals' long-term financial health.

Response: The Commission recognizes that pension liability is a very current accounting issue; however, this information is not currently available on hospitals' financial statements. Public companies were required to report pension liabilities beginning in 2006, but non-public companies do not have to report pension information until the end of 2007. Hospitals will need to report overall status of pension funds as a footnote in financial statements published after December 15, 2007, but are not required to report pension liabilities in their financial statements until after December 15, 2008.