RATIONALIZING
BEDS, SERVICES, AND PAYMENTS
FOR NEW JERSEY HOSPITALS

TARGETING ADDITIONAL SUPPORT TO THE NEEDIEST ESSENTIAL HOSPITALS

HENRY J. AMOROSO
TERENCE FRENCH

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With data and editorial assistance from The Urban Health Institute, Roseland, New Jersey

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Overview

In Executive Order No. 39 (See Appendix.), Governor Jon Corzine established a commission to study the availability and sustainability of hospital care in New Jersey and to recommend improvements. Included among the tasks to be performed by the Commission are: developing criteria to identify essential general acute care hospitals; recommending policies to support those hospitals, including the development of performance and operational benchmarks for such hospitals; and evaluating the effectiveness of current State policy aimed at facilitating the closure of hospitals and the re-use of closed hospital campuses. The intent of facilitating closure or conversion would be to stabilize the remaining hospitals while maintaining ready access and to help moderate the health-care costs borne by taxpayers. The Governor and others have speculated that perhaps a dozen or more of the state's 80 general acute-care hospitals could be closed, consolidated with other facilities, or converted to other health-care uses. The federal Base Realignment and Closure Commission and New York State's Commission on Healthcare Facilities for the 21st Century have been cited as models, but other approaches to rationalization may prove more practical and effective.

Any approach will represent the third time in 15 years that New Jersey has sought a cost-driven hospital rationalization solution, following earlier efforts in 1992 and 1999. If the proposed commission is authorized to require hospitals to close – as is the case in New York – New Jersey will become only the second state to force local hospitals to transition out of acute care. The New York approach involves the granting of a $1.5 billion Medicaid waiver by the federal government, which is unlikely to be duplicated elsewhere. Maryland is the only other state to have convened a statewide commission to recommend changes in the state's system, and it settled on establishing a financing mechanism — a revolving bond issue — to support the voluntary transition of hospitals out of acute care.

Summary

This paper is intended to assist the work of the commission. The paper provides an overview of the Maryland, New York, and earlier New Jersey efforts to "right-size" acute-care capacity, and it examines the recent history of hospital closures in New Jersey.

In assessing the scope of the commission's challenge, the paper recommends acknowledging three significant factors: *First*, that market-led hospital closures since 1992 have already largely rationalized the delivery of acute care in most of New Jersey's "hospital safety-net zones," leaving Essex and Hudson counties as the major areas in which additional rationalization may be required. *Second*, that a number of "regionally essential hospitals" in the state — while managed by private, nonprofit corporations — actually perform "public hospital" functions that

are supported in other states by state or local government. *Third*, that under-funding of Medicaid and charity care contributes significantly to the fragile condition of the state's urban hospitals and that the closure of some hospitals may actually increase the financial fragility of the remaining hospitals if a large portion of their new payer mix remains under-funded.

The paper concludes that a re-categorization of hospitals in New Jersey might prove of real value. This can be accomplished by establishing a "regionally essential hospital" category for those hospitals that serve for all intents and purposes as public hospitals and deserve enhanced reimbursement for their high levels of charity care, patient pay, and Medicaid services. The paper suggests that the category would be narrow and that the enhanced reimbursement can be managed without harm to other hospitals.

Previous reform efforts

State-sponsored efforts to reduce the number of general acute-care hospitals are rare, although over-bedding and duplicative facilities are common in many states. Maryland, a state with a history of strict regulatory control, took steps as far back as 1984. New Jersey has visited the issue twice — in 1992, the Department of Health identified several hospitals as closure candidates but did not insist on their closure; in 1999, the N.J. Advisory Commission on Hospitals recommended expanded close-out support for hospitals that voluntarily sought closure. New York initiated its current effort in 2005 with the legislative creation of the Commission on Health Care Facilities in the 21st Century. Scheduled to issue its final report in December 2006, this commission's work is buttressed by a Medicaid waiver that will provide $1.5 billion in additional federal funding over the next five years. The waiver requires State matching funds and the achievement of cost-reduction objectives. Elsewhere, state hospital study commissions and related groups have largely focused on examining the closure or downsizing of state mental hospitals.

1. Maryland 1984. The Governor's Task Force on Health Care Cost Containment, established to address the rapid escalation of health-care costs, identified excess hospital capacity as a major factor in rising costs. Its December 1984 report stated: "[I]f excess capacity continues, some hospitals will face slow economic starvation unless they fill beds. If they succeed in filling beds, the overall cost problem will continue. Monies used to maintain excess capacity cannot be used in other programs important to the public health …."

The Task Force suggested creating incentives for hospitals to consolidate, convert, or close, and the result was the creation of the Maryland Hospital Bond Program. The Task Force concluded that the financial disruptions caused by hospital closures should be minimized by protecting the bonded indebtedness of the closing hospitals. The Task Force found that failure to meet outstanding long-term indebtedness for closing hospitals could have a serious adverse effect on subsequent hospital bond issues and that a program to ensure the timely payment of outstanding long-term bonded indebtedness was necessary. The Task Force held that the debt should be spread among remaining hospitals, a step more feasible in Maryland than elsewhere, since hospital rates in Maryland are set by the State.

The Task Force concluded that voluntary consolidations, mergers, conversions, and closings had to be encouraged vigorously in order to reduce excess hospital capacity. The importance of reducing excess capacity was underscored by the Task Force's recommendation that state action to close hospitals be authorized if voluntary efforts proved insufficient.

Enabling 1985 legislation that established the Bond Program allows the Program to provide for the payment and refinancing of public body (bond) obligations of a closed or de-licensed hospital or a hospital converted to a limited service hospital or another health-related use if: 1) (a) the closure or conversion is in accordance with €19-123, Health-General Article of the Maryland Code; or (b) the facility is de-licensed upon the petition of the Maryland Health Care Commission (MHCC) and the Health Services Cost Review Commission (HSCRC) after efforts to encourage the hospital to reduce its excess capacity have failed; 2) there are outstanding public body obligations issued on behalf of the hospital; and 3) the hospital plan for closure, de-licensure, or conversion and the related financing or refinancing plan is acceptable to the Secretary of Health and Mental Hygiene and the Maryland Health and Higher Educational Facilities Authority (MHHEFA).

The total cost of the program is apportioned among individual hospitals according to a formula that weights the hospital's gross patient revenues as a percentage of total gross patient revenues of all Maryland hospitals. As a result, the amount assessed in each case will differ depending upon the plan approved by the MHHEFA as well as the nature and extent of the bonds involved. The bonds are limited obligations of the Authority secured by and payable solely from revenues and assets of the participating institutions. The debt is not backed in any manner by the State of Maryland or any local government.

When a hospital closes, the HSCRC analyzes whether there will be cost savings to the hospital industry in Maryland. Savings are generated when patients move from a high-cost hospital (presumably the closing hospital) to lower-cost (surviving) hospitals. It is conceivable, however, that costs could increase if the closing hospital were less costly than surviving hospitals in the same service area. Savings can also result if the HSCRC expects that there will be a net decrease in hospital utilization as a result of the closure, which might occur if a hospital permitted over-utilization to fill otherwise vacant beds.

In fact, the Maryland Hospital Bond Program has been used sparingly, with voluntary mergers and acquisitions doing more to change the landscape than the program. Bonds have been issued to support closures only four times since the program's inception in 1985. It has provided for the payment of approximately $35 million in principal of public body obligations of Maryland hospitals closed or converted in accordance with the Program. In no case, was a hospital forced to close.

Nevertheless, the Program remains in effect and is considered by Maryland officials as a useful backstop in cases of extreme need.

2. New Jersey 1992. In 1992, the N.J. Department of Health issued one in a series of State Health Plans that marked an era of extensive State regulation, including most notably strict certificate-of-need rules and a rate-setting commission that kept most hospitals whole in exchange for State oversight. The 1992 plan was marked by its publication of a list of six hospitals recommended for closure. They were St. Mary's in Passaic, Kennedy in Saddle Brook, Greenville in Jersey City, South Amboy, Montclair, and Zurbrugg-Riverside.

The plan called for involvement of local planning agencies (LABs), a Health Department "transition team" to help negotiate roadblocks, and a "transition pool" to fund the retirement of outstanding debt. None of these three elements came to pass. However, economic realities heightened by the easing of State regulations later in the 1990s led to the closure or conversion of four of the six hospitals on the list. Only St. Mary's in Passaic and Greenville in Jersey City remain acute-care hospitals, with Greenville subsumed in the Liberty HealthCare system. Similar circumstances led to other closures, most notably United Hospitals in Newark, Saint Francis Hospital in Jersey City, and Alexian Brothers and Elizabeth General in Elizabeth.

Publishing the list of hospitals identified as worthy of closure caused considerable uproar in the hospital field. Some observers suggested that their identification contributed to the elimination of State Health Plans, the closure of the LABs, and the loosening of State regulation, although those changes more likely resulted from a rising national belief in the value of competition to effect health-care change.

3. New Jersey 1999. By 1999, competition had risen sharply with the elimination of rate setting and full reimbursement for charity care, the roll-back of certificate-of-need franchise protection, and reductions in federal payments. Those changes combined to cause a steady and dramatic decline in hospital financial performance. A report completed for the N.J. Health Care Facilities Financing Authority found that profit margins for hospitals dropped from 4.4 percent in 1995 to 0.5 percent in 1998. Further, half of the state's 84 acute-care hospitals reported net losses from operations in 1998, and nearly half of the state's 30,000 licensed hospital beds were unoccupied.

The State convened a 33-member commission to recommend strategies to improve the health of New Jersey hospitals. The commission identified many factors, in addition to under-funding of Medicaid and charity care, contributing to the financial problems at New Jersey hospitals. They included excess capacity, growth of ambulatory services, reduced admissions due to new medicines and technology and widespread penetration of managed care, and discounted payments. Reduced Medicare payments and a growing number of uninsured patients were also cited.

The commission also noted that in some instances boards of trustees, hospital management, and physicians were resistant to change, did not fully understand the gravity of the financial situation, or did not act promptly on critical issues such as reducing the lengths of stay. (Analyses consistently show that the average length of stay for Medicare patients in New Jersey hospitals is 1.5 days higher than the national average. Hospitals receive no additional revenue for the longer stays under the federal fixed rate.)

A report prepared by the commission included the following recommendations:

- Establish a Hospital Asset Transformation Program to help facilities that are no longer needed or are no longer financially viable as acute-care hospitals in transitioning to other sustainable uses needed in the community.
- Establish a supplemental charity-care fund to ensure that all hospitals exceeding a threshold of charity care receive some funding.
- Establish more flexible charity-care documentation requirements to ensure that eligible patients are appropriately identified.
- Establish affordable health-insurance programs that will reduce the burden of charity care.
- Strengthen the Hospital Transition Group within the DOH to coordinate State actions to aid hospitals seeking to merge, consolidate, or create alternate services.
- Consider changes to the Medicaid reimbursement system to reflect the actual costs of current hospital operations and changes in medical practices.

Senior DOH officials said they found that small hospitals, stressed stand-alone hospitals, and hospitals from financially fragile systems were hesitant to close, either because of community resistance or because closing incurs definite costs that the hospitals hope they can avoid by staying open. These costs — which are exacerbated by a lengthy State-mandated closure process — include stranded pension costs, capital bond debt, and vendor costs. Large, healthy systems can accommodate these costs while independent hospitals and poorer systems cannot. Although more effort might have been useful in transitioning those hospitals that staff thought should be closed, such effort would have required considerable political support both locally and at the state level, as well as funds in excess of those proposed for the Hospital Asset Transformation Program. In practice, there were no state recommendations for closure, although there were successful demands for independent studies of performance at stressed hospitals.

4. New York 2006. In New York, the health and hospital commission — the Commission on Health Care Facilities in the 21st Century — was modeled in part upon the federal commission that identified military bases for closure. The New York commission, functioning with 18 statewide members and 36 members drawn from six local regions, has endured criticism for most of the nearly two years since its creation, but it has persevered and is due to report findings shortly.

The effort was prompted by federal officials concerned with Medicaid waste and fraud in New York's hospital and nursing home industries. Recommendations of the committee will be implemented with the help of an extraordinary $1 billion in state and local funds and $1.5 billion in matching federal funds that were earmarked to address the matter. These funds come on top of State funds recently used to assist hospitals in upgrading their information-technology capacity.

Although the study is not yet complete, some hospitals and systems have already submitted $250 million in requests for funds to underwrite closure and the retirement of existing debt or transition to other forms of service, such as long-term care or assisted living. The commission's report is expected to recommend the closure or down-sizing of many facilities, and the enabling legislation directs the Commissioner of Health to rescind operating certificates of hospitals identified as being unnecessary. The 18-member "Berger" commission, named for its chairman, is set to release its recommendations — which the Governor and Legislature must either accept or reject in full — on Dec. 1, 2006.

There are obvious differences between the federal base closing commission model and any state hospital commission. The federal government owns its military bases and can order them closed; apart from state and municipal institutions, hospitals are private enterprises, either not-for-profit or investor-owned, and they cannot be closed by commission fiat. Moreover, telling military personnel to move is much different from telling physicians to shift their practices or telling patients to travel greater distances for care. In addition, hospitals tend to have considerable outstanding debt that must be retired at closure, assuming due state consideration for paying back bond holders and relieving insurers of obligation.

Nevertheless, the New York initiative breaks new ground, and the results are certain to be studied by several other states where over-bedding and duplicative facilities remain concerns and by the many more states troubled by rising Medicaid and charity-care costs. Many in the hospital field in both New York and New Jersey hope the work of any commission or other authoritative body will produce higher Medicaid and charity-care payments keyed to cost-of-living or another index that ensures regular increases. Others are interested in shifting responsibility for the closure of weaker institutions to the "higher power" of the State rather than to contentious local decision-making. Still others seek guaranteed protection for selected "safety-net" urban hospitals.

The $1.5 billion in federal funding to be invested in New York's health-care reform initiatives came with conditions. Under the terms of the waiver, the State must generate Medicaid program savings in a like amount and meet significant performance milestones, which include the following actions:

- increase Medicaid fraud and abuse recoveries;
- implement the commission's recommendations;
- implement a preferred drug list for Medicaid;
- implement a program to increase the number of currently employed but uninsured New York residents with private coverage; and
- implement a single-point-of-entry for Medicaid recipients needing long-term care.

A New Initiative for New Jersey 2006

Governor Jon Corzine has proposed creating a commission to evaluate the availability and stability of acute-care services in New Jersey, with an eye toward "right-sizing" capacity and improving the financial health of surviving hospitals. The work of such a body might be facilitated by considering the recent public policy history affecting New Jersey's hospitals, by understanding the state of the field today, and by reviewing the common assumptions underlying reform efforts in New Jersey and other states.

A Summary of State Policies and Their Impact

The Hill-Burton Act of 1946 provided federal grants and federally guaranteed loans to improve and expand hospital capacity throughout the United States, particularly public county hospitals or community non-profit hospitals. The Act's objective, which was largely accomplished in the subsequent decades, was to achieve 4.5 inpatient beds per 1,000 population and/or one hospital per county across the nation.

In recent decades, advances in medical technology and practice generally reduced the lengths of stay required for medical procedures and, thus, the number of beds required. Today, the nationwide average is 2.5 inpatient beds per 1,000 population. This development, combined with population flight from cities to suburbs, left many hospitals in urban and old suburban areas of New Jersey with empty beds and poor financial performance. Certificates of need and hospital rate setting, both introduced in New Jersey in the 1970s, financially stabilized hospitals but eventually supported the creation of surplus capacity. Some estimated that by 1992, this surplus capacity was adding $1 billion per year in unnecessary costs to New Jersey's hospital system.

In 1992, amid growing recognition that New Jersey's hospitals maintained expensive overcapacity for acute-care services, the State began dismantling many of the government policies that had supported hospitals for decades.

- In 1992, the State published a health plan identifying six hospitals that should transition out of acute-care services.
- Also in 1992, the State eliminated Chapter 83, which set hospital payment rates and guaranteed that hospitals would be fully reimbursed for costs associated with the provision of uncompensated care, in part through a levy on health-care payers. Individual hospitals would now negotiate rates with individual payers, and uncompensated care was partially reimbursed through the State appropriation process.

- The elimination of Chapter 83 provided an immediate and long-term windfall for the State's health insurers. The immediate windfall was more than $1 billion payable to hospitals that was "forgiven" as part of the elimination of Chapter 83. The long-term windfall is reflected in the sound financial health of New Jersey's health-care insurers.

- Also in 1992, legislation was approved to begin exempting certain services from the State's certificate of need reviews. This began a general rollback of Certificate of Need that culminated in 1998 legislation and complemented the "market-based" philosophy underpinning the Chapter 83 rollback by eliminating State oversight of hospital financial performance and reducing the State's control of hospitals' entry into various clinical services.
- In 1995, the New Jersey Department of Health undertook regulatory reforms that further reduced Certificate of Need oversight by transitioning certain services from the competitive "full review" process to the non-competitive "expedited review" process.
- In 1998, Legislation was approved that further reduced, in three phases, the number of items subject to Certificate of Need review.
- The 1999 Advisory Commission on Hospitals echoed the concerns of the 1992 health plan when it observed that the closure of hospitals was necessary to make the remaining hospitals viable. The report recommended steps that could be taken to facilitate the closure of hospitals.
- Payment rates for Medicaid and charity care — both of which pay below cost for the services provided — remain an important factor, causing hospital closures through systemic underpayments.

Hospital Closures 1995 to Present

The purpose and effect of these and other policy changes were to force competition among hospitals in order to drive excess capacity out of the state's health-care system. The need for hospitals to close was always implicit in these policies and was sometimes explicit. Twelve of the 18 closures since the policy changes in the early 1990s were in urban areas. In several of the cases, the hospitals were transitioned to other forms of care. For example, West Hudson and Saint Mary's ceased acute care and provide only long-term care. **Table 1** presents hospital closures for the period statewide.

Table 1 — N.J. Hospital Closures, 1995 to Present

Hospital	Year Closed
Zurbrugg Hospital, Riverside	1995
United Hospitals Medical Center, Newark	1997
Roosevelt Hospital, Edison	1997
Montclair Community Hospital	1999
South Amboy Memorial Hospital	1999
St. Mary's Hospital, Orange	1999
Point Pleasant Hospital	2000
Elizabeth General, Elizabeth	2000
Boonton Hospital	2000
Virtua Health, West Jersey Hospital, Camden	2001
St. Francis Hospital, Jersey City	2002
South Jersey Healthcare, Millville	2002
Beth Israel Hospital, Passaic	2003
West Hudson Hospital, Kearny	2003
Hospital Center at Orange	2004
South Jersey Healthcare, Bridgeton	2004
South Jersey Healthcare, Newcomb	2004
Irvington General Hospital	2006

Limits of Market Discipline

Market-led closures have largely rationalized inpatient care in New Jersey. Only urban Essex and Hudson counties among New Jersey's larger urban areas contain more than two hospitals, and the New Jersey Hospital Association contends that the state's hospital industry is efficient. According to a recent study by Accenture, New Jersey maintains an average 2.47 inpatient beds per 1,000 population statewide, which is consistent with the national average of 2.54 beds per 1,000 population. Fifteen of 21 counties maintain beds at or below the national figure, and another two counties are within 0.2 percentage points.

Market-driven competition encourages a healthy, functioning marketplace but leaves behind those places where such a marketplace is unworkable. This is the nature of the competitive model. New Jersey's urban areas generally do not have the elements of a successful health-care marketplace and, therefore, fare badly in competition with well-placed suburban hospitals, despite the health-care needs of urban populations.

The absence of a healthy, functioning health-care marketplace in New Jersey's urban areas is underscored by the following characteristics:

- high proportions of under-reimbursed Medicaid care;
- high proportions of under-reimbursed charity care;
- low proportions of commercially insured patients;
- a population that is generally sicker upon admission to a hospital; and

- a population that tends to use emergency rooms for primary-care needs.

In sum, the health-care market competition shaped by policy reforms beginning in the 1990s appears to be working well in suburban New Jersey. In the state's urban areas, however, market trends threaten to force the closure of hospitals essential to ensuring that poor urban residents maintain reasonable access to top-quality health care.

Hospital Safety-net Zones

New Jersey, unlike many other states in the nation, is without a network of public hospitals. University Hospital in Newark is the single meaningful public representative. Bergen Regional Medical Center is grandfathered as an acute-care hospital, but its acute-care unit is small — approximately 100 maintained beds compared to 875 maintained beds for its behavioral-health and long-term care components — and exists almost exclusively to care for intra-hospital transfers from its two larger components.

By state policy and law, every hospital in New Jersey is obligated to provide care to all patients, regardless of the patient's ability to pay and regardless of the effect that the provision of care to the indigent might have on the financial health of the hospital. The State does, however, provide some level of reimbursement to hospitals for documented charity care, but no payments are made to physicians who provide such care in the hospitals. This discourages voluntary attending physicians and tends to force hospitals to pay physicians for care from the already stressed hospital budget.

The Relative Charity Care Percentage (RCCP) measures how much of a hospital's business is charity care. State officials use the measure as a factor in determining charity-care reimbursement levels for hospitals. **Table 2** shows the New Jersey Hospital Association's calculations for the 20 hospitals with the highest annual average RCCP for 2003 to 2005, ranging from a low of 7.16 percent to a high of 28 percent. (Bergen Regional Medical Center — at 40.23 percent — is excluded for the reasons cited above. Deborah Heart and Lung — at 8.21 percent — is also excluded, as it is licensed as a Special Hospital, which is a category not normally eligible for charity-care reimbursement.) For comparison, the 15 hospitals with the lowest RCCPs in New Jersey range from 2.52 percent to 0.92 percent.

Table 2 — Annual Average Relative Charity Care Percentage 2003 to 2005

1. Jersey City Medical Center	28.05%
2. University Hospital	23.04%
3. Trinitas Hospital	14.33%
4. East Orange General Hospital	13.58%
5. Capital Health System - Fuld Campus	13.51%
6. St. Joseph's Regional Medical Center	13.35%
7. Cathedral Healthcare	12.59%
8. AtlantiCare Medical Center City Division	11.42%
9. Raritan Bay Medical Center	11.30%
10. St. Mary's Hospital (Passaic)	11.00%
11. St. Mary Hospital (Hoboken)	10.92%
12. Greenville Hospital Campus	10.67%
13. Muhlenberg Regional Medical Center	9.17%
14. Christ Hospital	9.02%
15. Cooper Hospital	8.78%
16. Newark Beth Israel Medical Center	8.72%
17. St. Francis Medical Center	8.61%
18. Columbus Hospital	7.45%
19. Palisades Medical Center	7.17%
20. Irvington General	7.16%

As can be seen in **Table 2**, 13 of the 15 hospitals with the highest charity-care burden are in the state's major urban areas. These are Paterson-Passaic, Jersey City-Hoboken, Greater Newark, Elizabeth, Trenton, Camden, and Atlantic City. These areas, which contain the state's "safety-net hospitals," may be considered hospital safety-net zones. Seven may be so identified.

Table 3 shows the changes in licensed and maintained acute-care beds from 1992 to 2005 for individual hospitals serving the state's seven major urban areas. As illustrated in **Table 3**, since the new policy course began in 1992, a total of 10 hospitals in the state's seven major urban areas have closed (excluding Montclair, which could be considered Greater Newark). *In 2005, there were 4,590 fewer beds in service in those areas than were licensed in 1992, a reduction of 44 percent. The reduction in the Newark area was an extraordinary 51 percent.* As previously described, those closures and bed reductions were fueled in large part by changing demographics plus systematic underpayments for charity care and Medicaid payments — a problem exacerbated in urban areas because of the high proportion of self-pay, charity care, and Medicaid patients.

Table 3 — Change in Licensed and Maintained Beds for All General Hospitals Serving Safety-net Zones, 1992 to 2005

	1992 Licensed Beds	2005 Maintained Beds	
1. Paterson-Passaic			
Barnert Memorial Hospital	282	166	
Saint Joseph's Medical Center	550	480	
CLOSED Passaic Beth Israel	223	0	
Saint Mary's Hospital	226	121	
General Hospital Center at Passaic (now PBI)	303	240	
Total Paterson-Passaic	**1,584**	**1,007**	**(-577)**
2. Jersey City-Hoboken			
Jersey City Medical Center	608	274	
Christ Hospital	402	296	
St Mary's Hospital	330	200	
CLOSED St Francis Hospital	254	0	
Greenville Hospital	86	88	
Total Jersey City-Hoboken	**1,680**	**858**	**(-822)**
3. Greater Newark			
Saint Michael's Medical Center	419	223	
Saint James Hospital	189	106	
Columbus Hospital	206	175	
University Hospital	466	400	
CLOSED Irvington General Hospital	157	0	
CLOSED Hospital Center at Orange	332	0	
CLOSED West Hudson Hospital	168	0	
East Orange General Hospital	257	163	
Newark Beth Israel Medical Center	523	398	
CLOSED United Hospitals	429	0	
Clara Maass Medical Center	475	301	
Total Greater Newark	**3,621**	**1,766**	**(-1,855)**
4. Elizabeth			
CLOSED Alexian Brothers	100	0	
CLOSED Elizabeth General	352	0	
St Elizabeth (now Trinitas)	329	340	
Total Elizabeth	**781**	**340**	**(-441)**
5. Trenton			
Capital - Fuld Campus	353	269	
Capital - Mercer Campus	344	320	
St. Francis Medical Center	436	165	
Total Trenton	**1,133**	**754**	**(-379)**
6. Camden			
Cooper University Medical Center	524	400	
Our Lady of Lourdes Medical Center	325	293	
CLOSED West Jersey Hospital, Camden.	222	0	
Total Camden	**1,071**	**693**	**(-378)**
7. Atlantic City			
Atlantic City Medical Center (city and mainland)	**581**	**443**	**(-138)**
SEVEN AREA TOTALS	**10,451**	**5,861**	**(-4, 590)**

State Payments

Medicaid, Medicaid HMOs, and charity care — each a State payer that reimburses hospitals well below the cost for providing service — constitute large portions of the payer mix for urban safety-net zone hospitals. **Table 4** presents the proportion that self-pay, charity care, and Medicaid constitute for selected hospitals in New Jersey's hospital safety-net zones. In some cases, these categories constitute greater than 50 percent of a hospital's payer mix. For comparison, the selected New Jersey hospitals provide more care to charity and self-pay patients than is provided by four comparable New York City *public* hospitals presented at the bottom of the table.

Table 4 — Selected N.J. and N.Y. Hospitals
Selected Payers as Percentage of Hospital Discharges, Prelim 2005

Name	Location	% of Patient Pay (N.J.) Self-Pay (N.Y.) Indigent	% of Medicaid and Medicaid HMO	% of Bad Debt
Jersey City M.C.	Jersey City	34.9%	24.6%	7.1%
Saint James Hospital	Newark	28.8%	20.2%	20.1%
University Hospital	Newark	28.0%	16.8%	18.1%
Saint Joseph's M.C.	Paterson	19.6%	8.4%	4.3%
Saint Michael's M.C.	Newark	18.7%	11.7%	20.1%
East Orange General	East Orange	14.3%	12.8%	10.1%
Harlem Hospital Ctr.	Manhattan, N.Y.	28.7%	44.9%	NA
Metropolitan Hospital Ctr.	Manhattan, N.Y.	24.2%	53.6%	NA
Coney Island Hospital	Brooklyn, N.Y.	14.5%	37.9%	NA
Lincoln Medical	Bronx, N.Y.	13.4%	47.4%	NA

Note: Each hospital reports charity care differently. The table combines the following:

- UB 92 Data reports Patient Pay, not Self-Pay;
- SMMC and SJH list bad debt together; and
- there is no bad debt information for N.Y.C. hospitals.

Table 5 presents the hospitals in the seven urban hospital safety-net areas along with the New Jersey Hospital Association's preliminary estimated Medicaid value of the charity care provided by each hospital in calendar year 2005. (Data from the State was not yet available at the time this paper was prepared.)

Table 5 — Charity Care Provided by Hospitals in Safety-Net Zones CY2004, at Medicaid Rates

Hospital Safety Net Areas	Hospitals	Charity Care Provided CY 2005 ($M)
Paterson-Passaic	Saint Joseph's Medical Center	67.40
	Barnert Hospital	4.59
	Passaic Beth Israel Medical Center	8.31
	Saint Mary's Hospital	10.22
	Subtotal	**90.52**
Jersey City-Hoboken	Jersey City Medical Center	96.95
	Saint Mary's Hospital	14.54
	Christ Hospital	15.56
	Greenville Hospital	2.62
	Subtotal	**129.67**
Greater Newark	University Hospital	148.35
	Saint Michael's Medical Center*	36.74
	Columbus Hospital	4.37
	Newark Beth Israel Medical Center	43.20
	Irvington General	3.21
	East Orange General Hospital	9.70
	Clara Maass Medical Center	7.93
	Subtotal	**253.50**
Elizabeth	Trinitas Hospital	44.14
	Subtotal	**44.14**
Trenton	Saint Francis Medical Center	10.58
	Capital Health - Mercer	8.18
	Capital Health - Fuld	21.69
	Subtotal	**40.45**
Camden	Cooper University Medical Center	51.85
	Our Lady of Lourdes Medical Center	15.54
	Subtotal	**67.39**
Atlantic City	Atlantic City Medical Center	14.20
	Subtotal	**14.20**
	Total Charity Care in Safety Net Areas	**639.87**
	Total Charity Care Statewide	**1,076.55**

* Includes data for Saint James Hospital.

These 23 hospitals account for approximately 25 percent of all hospitals in New Jersey, but the Medicaid value of the charity-care services provided by these hospitals is nearly 60 percent of the charity care provided statewide. In effect, these seven areas constitute a "primary service area" for charity care in the state.

The amount of charity care a hospital provides is an important indicator of the degree to which a community needs the hospital. It is also a telling measure of the degree to which a hospital is under-funded. The preliminary estimates presented in **Table 5** indicate that the listed 23 hospitals provided $639.8 million in charity-care services priced at Medicaid rates during calendar year 2005. New Jersey Medicaid reimburses hospitals at about 75 percent of cost, meaning the 23 hospitals, in reality, incurred approximately $853.1 million in costs for those patients. Industry analysts maintain that hospitals require a 3 percent operating margin to be able to make necessary investments in facilities and programs. Mindful that urban safety-net hospitals are not positioned by payer mix to capture any meaningful portion of that required operating margin from commercial insurers, a total reimbursement of $878.7 million would permit the 23 hospitals to recoup the costs of providing charity care and make the 3 percent operating margin for investment in facilities and programs. In fact, total charity care reimbursement to these 23 hospitals in calendar year 2005 was $401.4 million. This is a $238.4 million shortfall of what Medicaid would have paid the hospital for the same service, reduced somewhat by Hospital Relief fund payments of $105.2 million. At full cost plus 3 percent margin, the shortfall rises to $477.3 million, less the $105.2 million in Hospital Relief funds. Similar calculations can be made for the hospital's Medicaid and Medicaid HMO books of business.

A New Category: Essential Safety-net Hospitals

Reasonable people differ about the policy merits of establishing a public hospital system in New Jersey. Although many states maintain a public hospital system to provide care to the indigent, New Jersey has chosen to make indigent charity care the responsibility of all licensed general hospitals. However, the Governor's new commission and other policymakers may soon be considering a proposal for the now-private Jersey City Medical Center, formerly a city-owned public hospital, to be joined with the public University Hospital in Newark to form a state public hospital corporation. Of course, the establishment of a public hospital corporation consisting of just these two hospitals would not address the fragile condition of the remaining 21 hospitals providing care in New Jersey's hospital safety-net zones.

When stripped bare, the central issue should be how to protect those relatively few essential hospitals that serve many charity-care and other under-insured patients in the hospital safety-net zones. Achieving financial stability in such areas — sustainability, in management terms — is exceedingly difficult. The challenge is to support those hospitals that ensure access for all and are truly vital, and to do so

without further stressing the State's already-strained budget. Either new costs must be limited, or new revenues must cover new costs.

In the search for protection, many urban hospitals in New Jersey call themselves "safety net" hospitals. While the label does have a defined regulatory meaning for purposes of charity care reimbursement, it is used more broadly by the hospital industry to describe hospitals that are in many cases large or exclusive providers of care to a community. The label as used is without any defined criteria and allows many to claim inclusion. A more restrictive and formal identification — "essential safety-net hospitals" — could be used to denote an entirely new category within the universe of hospitals operating in safety-net zones. The more restrictive status implies increased financial support to hospitals demonstrably vital to urban health.

Financial Support for Public and Essential Safety-net Hospitals

Prior to the 1992 termination of hospital rate-setting in New Jersey, health-care insurers paid to cover costs associated with indigent care and ensure hospitals' viability. With the growing recognition that Medicaid and charity care under-funding are threatening the viability of essential safety-net hospitals, it is reasonable to assume that insurers might agree or be required to include a modest add-on for certain cases at both public and essential safety-net hospitals. This argument is stronger if the benefiting hospitals are operating in a rationalized market and are themselves efficient, essential hospitals. With about 5 million commercially-covered lives in New Jersey, $100 million in additional aid could be raised for essential safety net hospitals for every $20 levied per year per covered life. This new source of funding would allow the overwhelming number of other hospitals in New Jersey — those that are neither public nor essential safety-net— to be held harmless, with their current levels of charity care and other State subsidies remaining largely undisturbed, thereby lessening the level of complaint and opposition.

Identifying Essential Safety-net Hospitals

The Essential Safety-net Hospital strategy means that the commission, and ultimately the State, would identify hospitals that must stay open, rather than following the New York State path of identifying hospitals that must close. While this paper maintains that most essential safety-net hospitals are located within the hospital safety-net zones, it is also possible that hospitals outside those zones are both essential and require additional support to be viable. The following elements could be included in the criteria for identifying these additional hospitals:

- the hospital provides care to a large number of self-pay, charity-care, and Medicaid patients or a large percentage of the patients it serves are in those payer categories;
- the State's under-funding of these payer categories is a significant factor driving the poor financial health of the hospital; and
- the closure of the hospital would create material barriers to health-care access, either because there are no other area hospitals or because other area hospitals could not accommodate the increased inpatient or emergency room volumes.

In theory, essential safety-net hospitals could be converted to full public sponsorship, but the history of public hospitals in the state is not an encouraging one. Martland Medical Center in Newark morphed into University Hospital to relieve the city of a burden and shield it from political interference, a shield that recent investigations at University suggest was flimsy. Jersey City Medical Center went bankrupt in the 1980s at least in part because of heavy political interference in its affairs. Irvington General, recently closed, was converted from public to private sponsorship to protect local taxpayers, and this proved to be a wise decision for the city.

This history, among other things, would help make an "essential safety-net" classification more practical and more acceptable to all.

Pilot in Greater Newark

The "Greater Newark" area hosts the most hospitals among the seven hospital safety-net areas, provides the largest amount of charity care of all the seven areas, trails the State in health outcomes, and maintains more beds per 1,000 population than any other part of New Jersey. As such, it would be an ideal candidate for a test of the essential safety-net hospital classification if the State were able to facilitate a rationalization of the availability and delivery of hospital care.

A commission or other evaluation group might address the following issues:

- Would one cardiac surgery center, rather than three, better serve the people of Greater Newark?
- Should the hospitals of Greater Newark partner in providing certain services, like emergency transportation, health records, the provision of primary care, and translation services?
- Would a single children's special hospital — a combined pediatric service — better serve the area's needs?
- Can insurers, many of which have developed healthy operating returns and reserves since the end of rate setting, be made into partners in ensuring that appropriate health care is available for the urban poor?
- Can current acute-care dollars be redirected to support primary care?
- Would health-care services to the community improve if the major teaching hospitals in Newark cooperated more closely?

These are questions a state-level body can address but local entities cannot. An overarching mandate for change is required.

Conclusion

Financial support of the urban health-care system in New Jersey needs to be restructured in a more rational manner — sooner rather than later if access and stability are to be maintained. This will require significant improvements in support from Medicaid and charity-care funding and – in limited areas – reductions in the duplication of services. Without change, New Jersey can expect a continuing, growing need for month-to-month and year-to-year emergency State appropriations to keep individual hospitals open. Without change, the failure of one or more hospitals vital to the urban poor is possible.

A reclassification of hospitals — public, "essential safety-net," and all others — linked to mission, payer mix, and enhanced reimbursement is an approach worthy of serious consideration.

EXECUTIVE ORDER NO. 39

WHEREAS, the 1999-2000 Advisory Commission on Hospitals identified excess hospital capacity as a major cause of the general financial distress that characterized New Jersey's general acute care hospitals at that time; and

WHEREAS, there has been no comprehensive evaluation of the financial condition of New Jersey's general acute care hospitals since the report of the 1999-2000 Advisory Commission on Hospitals; and

WHEREAS, since 1999, 10 general acute care hospitals have permanently closed in New Jersey, reducing the number of such hospitals to 80; and

WHEREAS, despite this reduction in excess hospital capacity, in 2004 New Jersey's general acute care hospitals had a median operating margin slightly above one percent, and an average operating margin of 0.4 percent, well below the national average of 4.04 percent and the Northeast region average of 2.86 percent; and

WHEREAS, in 2004, 45 percent of New Jersey's general acute care hospitals operated with a negative margin; and

WHEREAS, in 2006, one general hospital closed, two general hospitals filed for bankruptcy, and one general hospital was authorized to convert to a municipal hospital authority; and

WHEREAS, general acute care hospitals remain, despite technical advances that have shortened the length of in-patient stays and moved many services to an outpatient setting, crucial links in New Jersey's overall continuum of health care services; and

WHEREAS, all general acute care hospitals provide a wide range of health care services to New Jersey's residents that are not available from any other source; and

WHEREAS, there has been no comprehensive State planning in more than a decade to assure an ongoing appropriate correlation between hospital capacity and demand for hospital services statewide; and

WHEREAS, government and industry have a compelling interest in supporting a structured, rational assessment of in-patient capacity and primary care outcomes in order to support continued access to care and to promote better health outcomes; and

WHEREAS, the hospital industry is the fifth largest industry in the State, providing nearly 150,000 jobs; and

WHEREAS, health care workers play a crucial role in ensuring access to quality health care, and government and industry have a mutual interest in promoting and supporting an adequate and stable health care workforce; and

WHEREAS, there is a need to develop, for the benefit of the residents of New Jersey, a comprehensive Health Care Resource Allocation Plan to promote the rational use of public and private health care resources and services; and

WHEREAS, given the State's significant financial investment in existing general

acute care hospitals, there is a need for greater accountability regarding resource allocation; and

WHEREAS, given the financial distress many New Jersey hospitals face and the limited State funds available to assist hospitals, there is a need to examine whether closure is appropriate for any struggling, non-essential hospital, and whether those underutilized hospital assets can be redeployed for other health care or otherwise appropriate purposes as well; and

WHEREAS, there is no formal State policy to ensure that general acute care hospitals that are essential for access to health care, especially for low-income and medically underserved communities, will continue to operate in a fiscally sound and effective manner;

NOW, THEREFORE, I, JON S. CORZINE, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. There is hereby established the Commission on Rationalizing New Jersey's Health Care Resources ("Commission").

2. All members of the Commission shall be appointed by the Governor and shall serve at his pleasure. The Governor shall also select the chair of the Commission. All members of the Commission shall serve without compensation.

3. There shall be 11 members appointed to the Commission. The members shall be broadly representative of the health care industry with a specific emphasis on general acute care hospitals in New Jersey.

4. The Commission shall organize as soon as practicable after the appointment of a majority of its members.

5. The Commission is authorized to call upon any department, office, division or agency of this State to supply it with data and any other information, personnel or other assistance available to such agency as the Commission deems necessary to discharge its duties under this Order. Each department, office, division or agency of this State is hereby required, to the extent not inconsistent with law, to cooperate fully with the Commission within the limits of its statutory authority and to furnish it with such assistance on as timely a basis as is necessary to accomplish the purposes of this Order. The Commission may consult with experts or other knowledgeable individuals in the public or private sector on any aspect of its mission. In particular, the Health Care Facilities Financing Authority shall assist the Commission in accomplishing the purposes of this Order.

6. The Commission shall perform the following tasks:

a. Assess the financial and operating condition of New Jersey's general acute care hospitals by benchmarking them against national performance levels; compare the performance of New Jersey's general acute care hospitals to the performance of general acute care hospitals in a group of similar states; compare the array of programs and services offered by a hospital with the core mission of that hospital and the existing availability of those services at other hospitals within their region; and evaluate the effectiveness of established programs in meeting their intended objectives;

b. 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;

c. Determine appropriate geographical regions throughout New Jersey for provision of access to medical care for the residents of New Jersey, including those who are low-income and medically underserved, and assess the current and projected future demand for physician, hospital, federally qualified health center and other ambulatory care providers in each such region and compare that future demand with existing capacity;

d. 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;

e. Make recommendations for the development of State policy to support essential general acute care hospitals that are financially distressed including the development of performance and operational benchmarks for such hospitals;

f. Make recommendations on the effectiveness of current State policy concerning assistance to financially distressed hospitals that are non-essential and that seek to close but require debt relief or other assistance to enable them to do so, and make recommendations on ways to improve State policy to facilitate such closures;

g. 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;

h. Develop and publish a State Health Care Resource Allocation Plan to promote the rational use of public and private health care resources, labor, and technology and to serve as the basis for reviewing and approving the development and/or redeployment of health care assets and services around the State;

i. Review existing Certificate of Need statutes and regulations to ensure consistency with the State Health Care Resource Allocation Plan and recommend amendments and/or revisions to achieve that objective if necessary;

j. Make recommendations to strengthen State oversight and ensure greater accountability of State resources; and

k. 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.

7. The Governor at his discretion may reconvene the Commission every three years to reevaluate and update the State Health Care Resource Allocation Plan. The Department of Health and Senior Services shall, in the interim periods, continue to collect necessary data for the Commission to review if it is reconvened.

8. This Order shall take effect immediately.