

Examining the State of Our Healthcare System: The Unique Challenges Facing Urban Hospitals and Their Importance in Our State

**Hospital Alliance of New Jersey
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EXECUTIVE SUMMARY

Compelling data shows that New Jersey's "Safety Net" hospitals are a vital component of the state's healthcare delivery system. The populations they serve are the state's neediest and those least likely or able to leave their cities to seek subsidized care in inaccessible suburbs. Yet despite their lack of healthcare insurance, these "at risk" patients are being well cared for at the cost of ever diminishing hospital reserves due to the imbalance in the state's hospital reimbursement policy. Continuing such a policy will soon result in essential services being denied the most needy, as "Safety Net" hospitals are financially drained into oblivion.

While it is true that change may be on the way with the impending formation of a commission to examine hospitals, much can be done immediately to change the way hospitals are subsidized if state policymakers will differentiate between "essential" hospitals that serve the most "at risk" populations, and others having a more salutary payer mix. By making sound healthcare policy decisions in the near term that will help safety net hospitals become healthier entities, the Corzine Administration and the state Legislature will actually save taxpayer dollars and benefit those most in need at the same time.

In review, we ask that our Governor and Legislature focus on the following steps that can be taken NOW:

- **The State should reimburse charity care fairly by updating the base year used in the formula or reimburse hospitals on an actual claims basis.**
- **An increase in Medicaid rates should be approved immediately to recognize the critical priority of "Safety Net" care and nurturing the financial health of the hospitals that provide it.**
- **The current Certificate of Need program needs to redirect existing healthcare resources to "Safety Net" hospitals to attract a better payer mix toward urban institutions.**
- **State officials should be empowered to force Medicaid HMOs to greatly reduce delays and denials and improve physician availability through increased rates and ensure that hospitals are being reimbursed adequately for Graduate Medical Education (GME) and disproportionate share (DSH).**
- **The existing New Jersey Asset Transformation Act should be amended to facilitate mergers and consolidations within the hospital community, empowering the state HCFFA to assume debt service payments, refinance, pay off or pay down debt of institutions whose planned or recent mergers resulted in a closure of a redundant institution. Also, the State HCFFA should apply judicious relief upon application in cases where debt reduction will result in long-term survival of a hospital or enhancement of needed services to urban residents. This can be done via a "safety net" bond issue approved by the Legislature and state voters.**

We look forward to working with the Corzine Administration and the Legislature to implement the above recommendations with the guiding principle of ensuring healthcare access for New Jersey's most vulnerable citizens.

Introduction

Recently there has been attention given to the topic of examining New Jersey hospitals and their provision of healthcare services in this state. This is on the heels of two hospitals that in recent budget deliberations were given additional state funds to be “bailed out” of financial distress. Our State leaders are inquiring, “When faced with a hospital in severe financial distress that wants to remain open, should the State bail it out or let it close?” These decisions have historically been made on a political basis and it is the intention of our state leaders to begin to rationalize these decisions by setting broad standards to determine if a hospital is “essential.” The end goal is to save New Jersey money, decrease duplication and increase efficiencies.

The simple answer to this question is that hospital closures do not in and of themselves save the State money. Over the past decade numerous hospitals have voluntarily closed but the price tag to our State in terms of reimbursement to our safety net hospitals has continued to increase. One must look deeper to understand what makes sense for the delivery of healthcare to New Jersey citizens, which includes over 1.3 million uninsured.

The longer answer is that since the implementation of the Health Care Reform Act of 1992, which dismantled our rate setting system, and the chipping away of our Certificate of Need program and the shift from indemnity insurance to managed care, healthcare policy in New Jersey has moved away from one of regulation to one of market forces. But there is a fatal flaw in this policy: the market does not compete for patients with no insurance or ability to pay for their care. It is ironic, however, that a major determinant of an “essential” hospital, one upon which the community critically depends, is the amount of free care the hospital provides in charity care and bad debt.

It is the purpose of this paper to address some of the unique challenges facing urban hospitals in this deregulated market and to begin to address healthcare policy avenues that could be pursued to strike more of a balance, which would not only more appropriately reimburse safety net providers but also funnel more dollars from the healthcare system to the hospitals providing the care.

The policy recommendations made in this paper are the result of longstanding experience on numerous Governors’ task forces including, but not limited to, the 1999 Advisory Commission on Hospitals and the 2004 Governor’s Uninsured Workgroup and countless legislative and departmental committees over the past thirteen years. But this paper is just the tip of the iceberg; Hospital Alliance looks forward to continuing to work with our state leaders to make healthcare policy decisions that make sense for our State and the people it serves.

Data Sources

As stated in the prologue, all hospitals are experiencing downward financial trends but those hospitals in urban areas face the greatest challenges due to the large volumes of uninsured and Medicaid patients that they serve.

The Hospital Alliance of New Jersey is a coalition of safety-net providers that serve a significant portion of the State's indigent patients. Its goal is to improve and advance healthcare for New Jersey's most vulnerable populations. Members of the Alliance continue to be alarmed by a financial erosion taking place within the State's urban hospitals, which will jeopardize their ability to continue to provide needed services.

At several sections in this report, differences are highlighted between "Safety Net" and "Other" hospitals regarding their provision of healthcare services and the financial pressures they face while fulfilling their mission to provide quality care to all.

For the purposes of this report, the following hospitals are referred to as "Safety Net" hospitals. These hospitals are either current or former participating HANJ members.

Barnert Hospital (Paterson)	Newark Beth Israel Medical Center (Newark)
Bergen Regional Med. Ctr. (Paramus)	Our Lady of Lourdes Med. Ctr. (Camden)
Capital Health System (Trenton)	Palisades Medical Center (North Bergen)
Cathedral Healthcare System (Newark)	PBI Regional Medical Center (Passaic)
Christ Hospital (Jersey City)	St. Clare's Health Services (Morris/Sussex)
Cooper Health System (Camden)	St. Francis Medical Center (Trenton)
East Orange General Hosp. (E. Orange)	St. Joseph's Hospital and Med. Ctr. (Paterson)
Greenville Hospital (Jersey City)	St. Mary's Hospital (Hoboken)
Jersey City Med. Ctr. (Jersey City)	St. Mary's Hospital (Passaic)
Meadowlands Hospital (Secaucus)	Trinitas Hospital (Elizabeth)
Meridian Health System (Mon/Ocean)	University Hospital (Newark)
Muhlenberg Regional Med. Ctr. (Plainfield)	

The data reflected in this report was provided by the New Jersey Health Care Facilities Financing Authority's Apollo program, with the exception of the charity care, and Hospital Relief Fund information, which was obtained from the Department of Health and Senior Services and the Department of Human Services. Charity care documentation numbers for 2005 were prepared by Besler and Company since no formal release of these numbers occurred from the Department.

Data regarding the number of uninsured was obtained from the Center for Health Statistics website that reports the Census Bureau's Current Population Survey (CPS).

SOME FACTS ABOUT NJ'S UNINSURED AND CHARITY CARE

New Jersey's Center for Health Statistics reports that over 1.3 million (or 15%) of New Jersey's population have no health insurance. This number has been increasing steadily – and hospitals are now providing more charity care services than ever.

The provision of charity care services has increased dramatically over the past few years with documented charity care at Medicaid rates going from \$778 million in 2002 to nearly \$1.2 billion in 2005.

WHO IS BEING SERVED BY SAFETY NET HOSPITALS?

The answer to this question is our most vulnerable citizens are being served by New Jersey's safety net.

They are the over 560,000 Medicaid recipients and the 1.3 million uninsured.

As stated above, more than 15% of New Jersey's population does not have health insurance, yet over 760,000 of the uninsured represent full-time workers and their families. They are hard working people who are too "rich" for Medicaid and too young for Medicare who simply do not receive health insurance as a benefit of employment. And nearly 180,000 of these folks work for companies with 1000 or more employees.

We understand that New Jersey is looking to study universal healthcare objectives so that more of our citizens have health insurance coverage. Hospital Alliance requests to be a part of this important endeavor as it moves forward.

Safety net hospitals in this report provide the lion's share of care to the uninsured.

In fact, even though these hospitals represent only one-third of the State's hospitals, they are responsible for two-thirds of all documented charity care. Below are figures representing hospitals' 2005 documented charity care at Medicaid rates:

Safety Net Hospitals	\$ 780.6 million
Others	<u>\$ 409.2 million</u>
Total Charity Care	\$ 1.1898 billion

Unfortunately, for the fourth year in a row a base year of 2002 was used to distribute charity care reimbursement. The level of funds remained constant at \$583.4 million, however, Hospital Assistance Grants amounting to over \$70 million were also allocated in the FY 2007 Budget.

DISTRIBUTION OF CHARITY CARE REIMBURSEMENT

From a policy perspective, the current formula used to distribute limited charity care funding makes sense. It bases the percentage of funds (cents on the dollar reimbursement) that a hospital receives upon its percentage of charity care business related to its total business. However, for the past several years, the State Budget dictated that the distribution be based on a 2002 base year and not on the most recent available documented data as was originally intended by the drafters of the formula.

Because it has not been based on hospitals' actual experience, the distribution of charity care dollars in recent years has been unjust and inaccurate. Our state leaders who believe that urban hospitals have been reimbursed at high levels for charity care do not understand this serious problem.

For example, because of its proportion of charity care delivery to its entire book of business, University Hospital ranks in the top reimbursement tier where hospitals are reimbursed 96-cents on the dollar of their documented charity care at Medicaid rates. Because 2002 data was used again instead of the most recent available 2005 data, University Hospital only received 51 cents on the dollar – not the 96% that the formula prescribes. Even including University's Hospital Assistance Grant (included in the budget as \$8 million but reduced by Governor Corzine's line item veto to \$7.2 million), University was only reimbursed just over 55 cents on the dollar. Because charity care is based on Medicaid rates and Medicaid rates only cover 70-75% of what it costs the hospital to treat these patients, the actual dollar reimbursement to University Hospital was even lower than 55 cents on the dollar for the charity care they provide. (New Jersey's Medicaid rates are abysmally low and do not adequately reimburse providers.)

And this injustice did not just occur to 96-cent hospitals or those in the middle of the pack. Even hospitals that are considered "floor" hospitals, such as Jersey Shore University Medical Center, were severely hurt by the use of old data. Because their actual delivery of charity care increased, funding them at 43 cents of 2002 data only reimbursed them at 27% of the Medicaid rate for their actual delivery of care in 2005.

Using old data also inappropriately reimbursed some hospitals more than they were entitled to. It is critical that charity care reimbursement be based on actual delivery of care so that the dollars "follow the patients."

POLICY RECOMMENDATION: It is incumbent upon our state leaders to reimburse charity care based on actual experience by updating the base year used in the formula or reimburse hospitals on an actual claims basis.

Hospital Alliance has always advocated that with limited charity care subsidies the dollars should flow to the hospitals that need them the most. If our state leaders do not appropriate enough dollars to fully fund the industry-wide supported charity care formula, then consideration must be given to applying additional screens to the formula, (for example, a profitability screen) in order to concentrate existing dollars to those hospitals that need them the most and have limited resources for which to cross subsidize the free care given at their institution.

Mission Versus Market: If the Market Does Not Compete for Uninsured Patients, With Decreasing Reimbursements from All Payers, How Do Hospitals Survive?

Hospitals use high value services to subsidize less profitable services that are valuable to the community. In addition to reducing duplication and ensuring volume for distinct healthcare services, one of the Certificate of Need (CN) program's express purposes was to ensure that paying, insured patients frequented the urban centers to bring needed funding to the cities. CN is supposed to guard against excess capacity in a region and prevent increased costs, but elimination of CN for some services has exposed hospitals to more market pressures. A market driven competitive approach dilutes the number of patients traveling to the urban centers for care leaving those hospitals to treat mainly patients that are Medicaid or charity care.

Additionally, with hospitals in survival mode to obtain profitable services, relaxed certificate of need requirements allow for a "race" among providers to get the most up-to-date technologies and specialties to provide high-end services that generally have higher reimbursement rates. In the end, this can result in unnecessary duplication of services and unnecessary costs for the healthcare system.

Hospitals are also experiencing a problem of the outmigration of services to independent ambulatory surgery centers (ASC). These centers are "cherry-picking" patients leaving hospitals not only with a disproportionate amount of complex and high risk patients which are more costly, but also since the ASC's are not subject to the same regulatory requirements to treat all comers, they skim off the paying patients leaving hospitals in the precarious position of treating patients for which reimbursement is limited.

Also, the move from indemnity insurance to a managed care market of "best price" and "price transparency" limits the ability of providers to cost shift. Medicaid's move from fee-for-service payments to managed care has hurt providers due to increased delays and denials and through tough payer negotiations that do not compensate for Graduate Medical Education (GME) and disproportionate share (DSH).

POLICY RECOMMENDATION: An add-on to the Medicaid rates should occur to recognize the proportion of a hospital's caseload that represents safety net care. We understand this is currently being considered by the Administration.

POLICY RECOMMENDATION: Need to examine the current CN program to see if policy changes could occur to funnel existing healthcare resources to hospitals. Included in this study should be an examination of the current distribution of health services to see where consolidations or partnerships could be warranted.

POLICY RECOMMENDATION: Medicaid should continue its work with HMOs and hospitals to tackle issues such as network adequacy, delays and denials, physician availability and to ensure that hospitals are being reimbursed adequately for GME and DSH, possibly through special carve outs. Physician rates must be increased because Medicaid reimbursement is abysmally low. Doctors have been looking to hospitals to pay them to treat Medicaid patients. This is yet another burden that falls disproportionately upon urban hospitals.

WHY HOSPITALS ARE DIFFERENT

Hospitals provide 24 hour, seven days a week care. And unlike other providers, they are obligated to treat all patients whether or not they can pay for this care. New Jersey has a longstanding public policy commitment to provide healthcare to all of its citizens regardless of their ability to pay and its regulations are even tougher than federal standards. As partners with the State, New Jersey's non-profit hospitals consistently meet their end of this partnership by ensuring that every New Jersey resident has access to a full continuum of healthcare services.

Hospitals are integral to disaster preparedness. They, like no other healthcare entity, need to be at the ready if a natural epidemic or terrorist threat strikes. In the past few years, hospitals have worked more closely with public health and emergency management officials to improve coordination. Hospitals need sufficient funding to acquire new equipment and to improve technological capabilities. One of the most important aspects to hospitals regarding disaster preparedness is their ability to have surge capacity, if necessary.

Hospitals' contribution to New Jersey's economy is vital. Hospitals impact the economy directly by being one of the largest employers in New Jersey and also indirectly through the purchase of services such as contracted labor, utilities, pharmaceutical drugs, dietary, laundry and building supplies. These services provide money and jobs to many citizens of New Jersey.

Hospitals provide enormous public goods to their communities from meals on wheels to cancer screenings. These programs that are now financed from patient care revenues, gifts or grants are the first type of programs eliminated when faced with financial difficulty. Underpayment for treatment of charity care, self-insured (bad debt) and other patients has a huge ripple effect on what services the hospital can offer to its community.

SAFETY NET HOSPITALS PROVIDE A HIGH VOLUME OF NEEDED SERVICES:

	<u>2004</u>	<u>2005</u>
Admissions	339,716	338,850
Patient Days	1,956,558	1,932,990
Same Day Surgeries	120,298	117,382
Emergency Room Visits	863,096	895,745

There are only a few sources of reimbursement available to hospitals for this care: insurance, government (through Medicaid or Medicare), self-pay and charity care. Safety net hospitals typically have poor payer mixes with a large concentration of patients being either covered by charity care, Medicaid or self-pay.

BECOMING MORE EFFICIENT

There has been much talk about hospitals' need to increase efficiencies in order to survive the marketplace. Hospitals continue to strive for new efficiencies by reducing their rate of growth in costs to below rate of revenues. There are several strategies for increasing efficiencies including cutting staff, working to reducing length of stays, reducing resources per case (by examining if local consolidations or partnerships makes sense) and unfortunately, by reducing investments required to maintain their physical plant, modernize and advance new technologies.

But the easiest way to become more efficient is to be selective about which patients you serve and only treat those for which you will receive proper payment. This "efficiency" option is not open to hospitals, which makes them very different than other healthcare providers. We cannot emphasize enough that the scope of the financial problems of hospitals is much larger than just implementing efficiencies.

POLICY RECOMMENDATION: Need post acute care study group on length of stay (LOS) issue.

POLICY RECOMMENDATION: Need to examine hospitals' relationships with Federally Qualified Health Centers (FQHCs) to ensure that the FQHCs have proper incentives to enroll people into FamilyCare.

POLICY RECOMMENDATION: Need to pursue ways for hospitals to be able to better communicate with each other, the government and payers through new information system technology.

POLICY RECOMMENDATION: Need to examine if partnerships with local hospitals make sense for the delivery of healthcare in particular communities.

RATIONALIZING HEALTHCARE DELIVERY & REDUCING DEBT

One of the major detriments to pursuing mergers and consolidations is the existing debt that a hospital may carry which would provide a hardship to the surviving entity. Currently on the books in New Jersey is a law that established the Hospital Asset Transformation Fund, which would provide direct subsidies to surviving entities to assist in paying debt service on facilities that closed their acute care programs.

We believe that addressing the outstanding debt of current safety net hospitals will not only encourage competing facilities in a service area to see if the opportunity to consolidate or merge makes sense, but also to allow essential safety net hospitals to become more competitive by having greater access to capital funds. It would make sense for NJ to pursue a bond indebtedness relief program via a State Bond Issue.

POLICY RECOMMENDATION: State HCFFA should assume debt service payments or refinance or pay off or pay down debt of institutions whose planned or recent merger resulted in a closure of a redundant hospital.

POLICY RECOMMENDATION: State HCFFA should apply judicious relief upon application in cases where debt reduction will result in long-term survival of a hospital or enhancement of needed services to urban residents.

New Jersey's safety net hospitals' commitment to their communities is unwavering. These hospitals go above and beyond traditional care to fill the gaps that exist in their communities. But hospitals must remain solvent to be able to continue to fulfill their missions and cannot afford to be squeezed any further.

As stated earlier, a major determinant of an "essential" hospital, one upon which the community critically depends, is the amount of free care the hospital provides in charity care and bad debt. Currently, many urban hospitals are experiencing high volumes but are seeing "red" because you cannot lose money on every patient and survive. In short, you need a margin to fulfill your mission.

See the financial indicators below for an analysis of the current challenges facing our "essential" safety net hospitals:

PROFIT MARGIN

Insufficient charity care reimbursement, inadequate Medicaid rates and tough negotiations by payers, along with inappropriate managed care delays and denials, have had a severe effect on all hospitals but have hit Safety Net hospitals harder.

	<u>2004</u>	<u>2005</u>
Safety Net Hospitals	0.61%	1.41%
Others	2.29%	3.01%

Hospitals need a positive margin of 3-5% to invest in new technology, modernize physical plants, lower costs and improve quality healthcare. As non-profits, hospitals return any excess revenues back into improved and expanded services.

PROFIT MARGINS WITHOUT CHARITY CARE & HOSPITAL RELIEF FUNDS

This indicator demonstrates the importance of properly targeting limited subsidies to those hospitals with the largest burden of uninsured care. Without properly targeted subsidies, Safety Net hospitals' viability would be seriously threatened.

	<u>2004</u>	<u>2005</u>
Safety Net Hospitals	-8.51%	-7.99%
Others	0.82%	1.18%

BAD DEBT

Safety Net hospitals incur bad debt at a greater rate than others.

Bad debt as a percent of total expenses:

	<u>2004</u>	<u>2005</u>
Safety Net Hospitals	9.40%	8.32%
Others	6.69%	6.03%

A significant portion of emergency departments' bad debt is charity care where patients do not comply in providing the documentation necessary to meet the State's criteria.

CONCLUSION

To get back to our original question: What should New Jersey do when safety net hospitals are failing financially but want to remain open to continue a mission to their communities? Doing nothing is not the appropriate answer because if the market is left to just run its course, hospitals that are essential to our state's citizens will close. We must not underestimate the important role that our "essential" safety net hospitals play in the lives of New Jersey's most vulnerable citizens.

We have an opportunity with the impending formation of a commission to examine hospitals to provide for real healthcare policy change. By making sound healthcare policy decisions that will help our safety net hospitals become healthier entities, this commission has a vital role in ensuring healthcare access for our neediest citizens.

In summation, we ask that our Governor and Legislature focus on the following: update the base year for charity care or reimburse hospitals on an actual claims basis; increase Medicaid rates to recognize the priority of safety net care and examine CN to attract a better payer mix toward urban hospitals. To encourage mergers and affiliations among hospitals, our state leaders should amend the New Jersey Asset Transformation Act to allow HCFFA to assist hospitals where mergers have resulted in closure of a redundant institution and enact a "safety net" bond issue to help with long term survival of hospitals that provide needed services to urban residents.

In closing, while this was not expounded upon in this report, the commission should focus on initiatives that will maximize federal funds for our state.

We look forward to working with our state leaders to implement the recommendations set forth in this paper with the guiding principle of ensuring healthcare access for New Jersey's most vulnerable citizens.