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HOSPITAL ALLIANCE'S TESTIMONY BEFORE THE COMMISSION ON RATIONALIZING HEALTH CARE RESOURCES
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Good afternoon, my name is Suzanne Ianni, President and CEO of the Hospital Alliance of New Jersey that represents many urban hospitals that form our state's vital safety net for the poor and uninsured and who provide health access to populations that otherwise would go without. I am accompanied by Hospital Alliance's Board Chair Gary Horan, who is the President and CEO of Trinitas Hospital in Elizabeth, Steve Kirby, Acting President and CEO of LibertyHealth System and Jerry Jablonowski, President and CEO of St. Francis Medical Center in Trenton.

It is a privilege to talk with you, the members of the Commission on Rationalizing Health Care Resources, at such a critical time in healthcare. It is our hope that we can be helpful to you as you thoughtfully deliberate about some very serious healthcare policy decisions facing our state.

You have posed some very difficult and thought-provoking questions to us and we'd like to highlight our observations on excess capacity, mergers and consolidations, increasing efficiencies, lack of appropriate reimbursement from government payers, sources of funding, targeted distribution of subsidies, the resurgence of state health planning and Certificate of Need, federally qualified health centers (FQHCs), ambulatory surgery centers (ASCs), issues with managed care companies and last but not least, your efforts to define which hospitals are "essential" in this state.

Hospital Alliance, comprised of essential safety net hospitals, was created in 1993 in response to a deregulated healthcare market in New Jersey when urban hospital CEOs felt that the market would not compete for healthcare to the poor and uninsured and therefore a voice needed to be created to speak out for the unique needs of New Jersey's safety net. And since that time, NJ has for the most part unleashed the free, competitive market on our healthcare system.

In our opinion, this has resulted in a marketplace that has already squeezed out most of the excess capacity in NJ – with over twenty acute care hospitals that have either closed or transitioned to other services since that time. Yes, the market has been very effective in closing hospitals – but the problem is that the free market is not equipped or competent to decide which hospitals should close or stay open. And since no one is competing for the care to the poor and uninsured, market competition in healthcare is eroding NJ's safety net by contributing to the demise of essential hospitals.

As addressed in Executive Order No. 39 that established this Commission, 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.

Excess Capacity

You have asked us to address the issue of excess capacity. As we said earlier, we believe that most of the excess capacity in NJ has already been squeezed out of the system. In fact, some health economists like Ken Thorpe believe that nationally "hospitals may have to reverse course and add hundreds of thousands of beds in the next decade."[1] Also, healthcare journals surmise that with hospital in-patient days slated to rise over three and a half percent a year, there will be a need for increased inpatient bed capacity.[2]

In fact, cases like that of Jersey City Medical Center indicate that many urban hospitals are experiencing financial vulnerability even though occupancy rates are up, indicating this is not an "empty bed" problem, but lack of appropriate reimbursement for charity care and Medicaid which is driving the problem.

A clear example that indicates that reducing excess capacity in an urban area is not the panacea it is made out to be is demonstrated by the closure of two neighboring facilities in Passaic. The idea that consolidation of the market share of three facilities into one can provide all that is necessary to the surviving entity is naive – because that would assume that market share is tied to a population with proper reimbursement. You don't have to be an economist to understand that a negative plus a negative does not make a positive. With the additional stress of a larger charity care and Medicaid population coming through its doors, the surviving hospital, St. Mary's in Passaic, requires special attention to ensure its survival.

Consolidations and Mergers

That being said, we fully support voluntary efforts to consolidate services where appropriate and ask that this Commission put its power behind helping to facilitate voluntary mergers and consolidations, as Trinitas Hospital did when it consolidated Elizabeth General and St. Elizabeth's in 2000. Hospital executives in this state have an obligation to examine the needs of their communities and meet with neighboring hospitals in an effort to right size the care available.

As your esteemed Chair, Professor Uwe Reinhardt, once said, "The most elegant downsizing is not to let Hospital A die and Hospital B thrive, but rather for A and B to merge so that they prune pieces of themselves."[3] One of the major detriments to pursuing mergers and consolidations is the existing debt that a hospital may carry which would provide hardship to the surviving entity. Currently on the books in NJ 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 – but this law is not funded. In order to best "rationalize" healthcare delivery in an area, the state Health Care Facilities Financing Authority (HCFFA) should assume debt service payments or refinance or pay off/down debt of institutions whose planned or recent merger resulted in a closure of an acute care hospital. The state HCFFA should also 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.

For the source of funds, the State could assess private health plans to create a capital restructuring fund that would be used for these purposes. In this regard, I note that Maryland, which has the last non-Medicare rate-setting system in the country, adds an extra component to the rates of non-Medicare payers to address the costs of closing hospitals. Private payers have accepted and approved this system because a more efficient hospital is in the interests of all parties. New Jersey no longer has the ability to set private payers' rates but it could create a pool funded by private and State resources to address annual debt service obligations of closing hospitals where appropriate.

Also it is worth exploring the possibility with our state Medicaid program to see if a facility or system that absorbs another facility in a consolidation/closure could be eligible for a special adjusted Medicaid rate that represents Medicaid's share of the closing costs. This would also help New Jersey draw down federal dollars to facilitate closures and consolidations.

In addition, it should be under the purview of the Commission to recommend regulatory changes to allow for greater flexibility in transitioning beds so that hospitals can restructure capacity to respond to their community's changing needs.

Increasing Efficiencies

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 the rate of revenues. There are several strategies for increasing efficiencies including cutting staff, working to reduce length of stays, reducing resources per case (by examining if local consolidations or partnerships make 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 – especially urban hospitals, which make 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 and can be attributed to a pervasive and ongoing deficiency in reimbursement for treatment of Medicaid and charity care patients.

Low Reimbursement Rates

In fact, NJ is ranked last among states when comparing reimbursement to providers in a study just released by a watchdog group called Public Citizen. The report states that because of NJ's low payments to physicians participating in Medicaid, it is less likely that patients will get covered services. Additionally, Medicaid payments to hospitals on average cover only 70% of what it costs the hospitals to deliver the care. And because charity care reimbursement is based on Medicaid rates, there is a compounded effect. These abysmal payments should be the focus of serious policy discussions on access to care for the Medicaid and charity care populations.

Why Urban Hospitals Are Unique – A Case for Certificate of Need
Hospital Alliance would like to highlight that our state policy makers need to recognize the inherent differences between urban and other hospitals. While suburban hospitals are aggressively competing for market share of the insured populations and are able to participate in a medical arms race to get the latest and greatest technologies (which leads to unnecessary proliferation of services), urban hospitals bear the burden of considerable financial constraints to even upgrade their facilities.

Another clear indication that urban hospitals require different considerations than suburban lies in the fact that NJ's suburban hospitals are offering "boutique" services such as spa services, internet access and designer hospital gowns to compete for insured patients but urban hospitals are struggling to provide vital services to our poorest and most vulnerable citizens. Since one of the express purposes of the Certificate of Need program is to balance government regulation against market forces, in addition to increasing reimbursement for charity care and Medicaid services for our urban centers, it is the responsibility of our policymakers to review our Certificate of Need program to ensure that urban centers can attract some insured, paying patients to the cities to offset the care provided to those without insurance.

Targeting Healthcare Dollars
Hospital Alliance believes strongly that this Commission should weigh in on the State's ability to target funds to hospitals in urban areas that are treating patients for which the market is not competing. Hospitals with high charity care and Medicaid levels by nature have poor payer mixes so they have less ability to shift costs for this care than other hospitals. These hospitals also experience high bad debt volumes. Hospitals with high charity care and Medicaid volumes often must pay physicians to treat these patients who are frequently sicker and more in need of treatment. By providing a funding add-on to the rates of safety-net hospitals, New Jersey will help to maintain access to care for those citizens most in need of medical care and by doing so, help to address health disparities in this State. Hospital Alliance is advocating for a safety net add-on to the Medicaid rates to recognize the additional burden on hospitals that treat a sizeable portion of Medicaid and charity care patients in relation to all of their other patients. This initiative would "bump up" each Medicaid claim payment to more appropriately reimburse hospitals with high charity care and Medicaid as a percentage of their total business.

Hospital Alliance is working with state Medicaid officials and has suggested that the hospitals receiving the augmented rates would be those with the highest charity care and Medicaid days in relation to their total patient days. In order to target the distribution to about one-third of the hospitals statewide, one suggestion is to apply the add-on to those hospitals that reached the "median minus ten hospitals" – which would permit the top 27 hospitals delivering the most care proportionately to New Jersey's poor and uninsured to receive the add-on.

The Advisory Commission on Hospitals in 1999 recommended a safety net add-on to the Medicaid rates for urban hospitals and its implementation is long overdue.

Source of Additional Funding

But where does NJ obtain additional funds for increased reimbursement for charity care and Medicaid? Hospital Alliance believes that the answer can be found by seeking to rebalance the economic relationship between highly profitable insurers and the hospitals caring for those patients. After all, these insurers were and continue to be the beneficiaries of a huge profit windfall after the hospital industry was deregulated in 1992. By increasing the current assessments that insurers and HMOs pay, NJ can increase charity care payments to the hospitals in this state while also adjusting reimbursement for hospitals for Graduate Medical Education.

Since providers, especially urban hospitals, do not have the leveraging power to negotiate rates, which would allow for the cost-shifting necessary to pay for care to the uninsured, it follows logically that our state policymakers should mandate these contributions from insurers to help pay for the delivery of healthcare to the uninsured in our state.

Distributing Charity Care Subsidies

Once the question of where to obtain additional funds is answered, our next question becomes how charity care funds should be distributed. A recent report by the State Commission of Investigation made it clear that budget language inserted on behalf of those hospitals with the most political clout has resulted in a situation where "those with increased charity care face a reduction – exactly the reverse of how the program is supposed to function."

Hospital Alliance wants to make this very clear: if the charity care formula does not utilize the most recent year's data then simply put, the funding does not follow the patients and hospitals that are experiencing huge increases in charity care, which now amount to over a billion dollars annually, are placed in a very tenuous position.

We also feel very strongly that an additional amendment should be placed in the charity care statute to protect those hospitals in medically underserved areas from losing any charity care revenue. And we also feel strongly that it is not the place of this Commission to take any punitive action by denying any hospital their charity care reimbursement based on their financial vulnerability.

Hospitals Efforts to Insure More New Jerseyans

Hospital executives and many legislators know that the ultimate solution to the problem of the uninsured will come though the universal healthcare package being crafted by Senator Joseph Vitale and the committee of experts he has assembled. And we stand at the ready to help with any enrollment initiatives necessary for the success of his plan. Many hospitals have already devised creative ways to increase FamilyCare enrollment by distributing marketing materials in a variety of languages, working with community based groups to identify potential families, distributing gifts with promotional literature and dedicating staff for enrollment.

Unfortunately, due to decreases in the funding level of the FamilyCare program, many hospitals experienced problems because they aggressively outreached new enrollees. When the program got cut back and parents were no longer eligible for FamilyCare, hospitals could not get reimbursed under charity care for those patients who were no

longer eligible for FamilyCare due to budget cutbacks. It is our hope that as Senator Vitale's legislation from last year is rolled out and will expand coverage to parents in the coming months, that the State continues to fund the FamilyCare program at a supportable level so that payment for the services that hospitals provide to these enrollees does not fall through the cracks.

New Jersey should also support efforts by high Medicaid hospitals to out-station Medicaid eligibility on the hospital site. In this model, state workers would actually process and enroll qualified uninsured patients who seek care at hospitals. Out-stationing results in a much higher application completion and enrollment rate.

Federally Qualified Health Centers (FQHCs)
Recently New Jersey has helped to promote the expansion of FQHCs to help address and expand primary care capacity by dedicating all of the funding raised by a .53 assessment on hospital revenues to these centers. Hospital Alliance encourages all of its members to develop relationships with the FQHCs in its area and in fact, we have invited the Executive Director of the Primary Care Association to meet with our Board to discuss how we can best facilitate stronger relationships between hospitals and FQHCs. The State should support these efforts by enabling hospitals to reconfigure outpatient services where appropriate to partner with FQHCs.

We'd also like to state that FQHCs can help in establishing a medical home for currently uninsured patients; but they do not provide a cure-all since unlike hospitals that are open 24 hours a day, seven days a week, FQHCs do not provide that kind of access to treatment.

Ambulatory Surgery Centers
As stated earlier, because of their requirement to treat all comers regardless of ability to pay, hospitals unlike other providers like ambulatory surgery centers (ASC) are not able to operate only profitable lines of business.

Somehow the playing field must be leveled since the emergence of freestanding ambulatory care centers has created a situation where the ASCs are "cherry-picking" the profitable patients and leaving the hospitals to care for the sickest and poorest. Many of these physician-owned ventures have further strained the relationships between hospitals and physicians. This problem is clearly demonstrated by the popping up of freestanding dialysis centers across the street from urban hospitals. These centers skim all of the profitable, insured patients leaving the hospitals' dialysis unit left to treat only Medicaid and charity care for which their reimbursement is less than cost.

It is critical for hospitals to make profits where they can in order to subsidize the money-losing portions of their missions, including maintenance of stand-by costs needed to sustain emergency departments and trauma centers, funding emergency preparedness costs, treating the uninsured and serving Medicaid patients at below cost reimbursement. On this latter point, freestanding ASCs are marketing themselves to private payers as lower cost alternatives to hospitals, but this is an illusory set of savings. While an ASC might charge less for the same procedure in any given case, they actually add costs to the system by investing in new capital costs without lessening existing capital investments that

must be paid, and also by increasing hospital losses through the "cherry-picking" of profitable patients. This economic circumstance was eloquently described in a Health Affairs article by your distinguished Chairman, "Spending More Through "Cost Control:" Our Obsessive Quest to Gut The Hospital" where he states,

> "Yet some cost control techniques that are now wildly popular in the United States are not worth imitating. Techniques that may look efficient from the worm's eye view of a particular insurer paying for the management of a particular episode of illness actually may be quite inefficient from the more systemic bird's eye view of society as whole."[4]

Reinhardt explains that while hospitals are described as expensive places, the proper characterization would be that "hospitals tend to cater to very sick patients, that very sick patients tend to receive very elaborate treatments, and that such treatments tend to be very expensive. If the same sick patients received the same expensive treatment in any other setting (for example, in a bus or in an army tent) would we call buses or tents "expensive places?"[5]

The idea is that while insurers are shopping for best price for a service and often seek that outside the hospital, the capital costs and overhead that the hospital had hoped to recover from those inpatient days must now be prorated over the remaining days it sells. Reinhardt explains, "Bit by bit, the cost (and price) of those remaining days will rise over time."[6] And we see this in New Jersey as hospitals lose business to freestanding ASCs; hospitals are increasing their demands for higher payments from the State and private payers and/or experiencing such financial distress that prompts a State bail out. As Chairman Reinhardt expressed in the above-mentioned article, "Strategies that look efficient to insurance carriers may turn out to be inefficient for society as a whole."[7]

We believe there should be a moratorium on new non-hospital ASC approvals until a thorough analysis can be done as to the optimal – and most efficient – way to provide high quality ambulatory surgery services to New Jersey's residents. It is possible that the conclusion of such an analysis would be that existing capital investments have been made in hospitals and that before capital is sunk into non-hospital free-standing ASCs, there must be a demonstration that the hospital is at capacity and that existing capital investments are being fully utilized.

We also are concerned about the unregulated physician office based care that is emerging – further removing paying patients from the hospitals and increasing the strained relationships between doctors and hospitals. Because there are issues of quality care and non-regulation involved in these doctors' offices, we suggest that the Commission support the implementation of a regulation that states that ASCs that are unregulated by the Department of Health must include that disclaimer in their advertisements to the public.

We also suggest to level the playing field between existing ASCs and hospitals that ASCs be required to perform a certain amount of charity care each year. As this will reduce the profits of freestanding ASCs' operations, a requirement that they take all comers will limit the extreme proliferation of ASCs that is now occurring. It is imperative that some roadblocks are put in place so that some profitable services remain within hospitals.

Health Maintenance Organizations (HMOs)
You have asked what are the principal issues hospitals have with insurance carriers, including contract negotiation and payment problems. As we are sure you are aware, hospitals continue to have problems with inappropriate denials, delays and contract loading with HMOs. Hospital Alliance participated in a series of Hospital/HMO workgroups that represented over a year of meetings of industry representatives facilitated by NJ's Division of Medical Assistance on appeals and denials, contracting issues, claims process and payment practices and the emergency department.

Each workgroup prepared a white paper with lists of recommendations. We ask that this Commission follow-up with the Medicaid Director on the status of these recommendations, some of which are as follows:

- A task force should begin an enrollee education pilot project for managed care enrollees.
- A task force should develop Primary Care Physician Initiatives to decrease ED utilization – possibly through providing for more evening hours from doctors.
- DMAHS will conduct an analysis of data of enrollees that utilize ED services to determine why enrollees are utilizing the ED. Are there language barriers, non-compliance?
- Managed care organizations will provide clear mapping between ED codes and reimbursement to contracted hospitals upon request.
- Defined time frames must be established for contract loading so that the HMO adheres to new contractual payment arrangements.
- A mechanism needs to be developed to monitor compliance with prompt pay regulations.

Hospital Alliance is also extremely concerned that when the State uses its dollars to pay the Medicaid HMOs capitation rates per enrollee and then hospitals are delayed and denied payments, the HMOs are making interest income on these dollars. We would like the Commission to look into this with the appropriate authority within Medicaid and the Department of Banking and Insurance.

Definition of Essential Hospital
Last but not certainly not least, you have asked us to define what is an essential hospital. We believe the simple answer to that question is one that provides large amounts of charity care, Medicaid and self pay, where underpayment of Medicaid and charity care are the driving factors to poor financial health and whose closure would result in material barriers to care. However, many of our urban hospitals serve a unique role in protecting the public health of our cities. Questions need to be asked and answered as to whether if the hospital closed, could a neighboring hospital not only absorb increased admissions, but also what happens to the community outreach done by the closed hospital and what happens to the emergency room access – is there an increased risk of ambulance diversions and increased waiting and travel time for the local patients. Also in urban areas, policy makers have to consider the unique needs of the community – for example, is there an industrial facility that may need a nearby hospital to handle emergencies? Are there higher incidences of certain illnesses or environmental health hazards that increase the medical needs of residents in that community?
But even when the access exercise is complete, it does not answer the complete question of whether or not that hospital is "needed" in its community. As most likely the number one employer in its area, the closure of a hospital affects much more than just closing beds.

Hospital closures hit certain populations especially hard – the elderly, chronically ill and uninsured who rely on hospitals for emergency care and specialized medical services such as dialysis. And losing a hospital can disrupt relationships with caregivers. Closing hospitals can destroy community relationships and hamper patients' ability to seek medical care. Many hospitals perform invaluable outreach, for example, St. Francis Medical Center operates Saint Clare's Mobile Health Van in Trenton that provides healthcare to those unable to access it themselves.

We have received your framework outlining criteria to determine if a hospital is essential and we will provide comments in full on this issue to you by May 11.

Commission's Preliminary May Report

Hospital Alliance is very concerned about the preparation of the Commission's interim report slated for completion by the end of May. While we believe that it is a noble exercise to develop parameters to determine if a hospital should be bailed out through additional subsidies when facing bankruptcy, naming hospitals to stay open or those that may close is a very dangerous proposition. We are pleased to hear that your report will not name specific hospitals and we urge the Commission to keep individual, hospital proprietary financial information in a confidential report to the Governor. Exposing specific hospitals' precarious financial situations can wreak havoc with vendors and can become self-fulfilling prophecies as bondholders lose confidence in hospitals with weak bottom lines.
We ask that in your role as advisors to the Governor, the Commission is very careful in the content of its report and does not specifically name any hospital but instead carefully crafts standards on how to help manage failing hospitals and recommend policy changes to support healthcare in NJ's urban centers.

Our final comment is that the examination of healthcare in New Jersey is not a textbook exercise and that whatever algorithms or metrics are used to study hospitals, we must consider real world problems. We must identify that the root cause of hospitals' financial distress lies in the lack of appropriate reimbursement from government payers, that institutions are the victims of location with poor payer mixes, that urban hospitals are forced to pay doctors to be on-call because urban hospitals' payer mixes do not include enough insured patients and that increasing malpractice insurance costs are also added to hospitals' heavy burden.

We respectfully ask that whatever metrics are considered in your evaluation, 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.

Thank you for allowing us to comment on your important work. We are open to questions.

Notes

[1] "Prologue, Supply and Demand: The Big Picture," Health Affairs Nov/Dec 2003.

[2] Gloria J. Bazzoli, Linda R. Brewster, Gigi Liu & Sylvia Kuo, "Does U.S. Hospital Capacity Need To Be Expanded?" Health Affairs Nov/Dec 2003: 40-54.

[3] Michele Robinson, "Health Care Becomes Big Business" Business Health Annual 1996.

[4] Uwe. E. Reinhardt, "Perspective: Spending More Through "Cost Controls:" Our Obsessive Quest to Gut the Hospital" Health Affairs Summer 1996: 145-154.

[5] Ibid., 148.

[6] Ibid., 150.

[7] Ibid., 150.