PUBLIC HEARING

before

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

"The need for the planning, development and financing of a comprehensive State health plan and a review of the Certificate of Need Process"

November 28, 1990
Room 418
State House Annex
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman James E. McGreevey, Chairman
Assemblyman Nicholas R. Felice

ALSO PRESENT:

Eleanor Miller
Office of Legislative Services
Aide, Assembly Health Care Policy Study Commission

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New Jersey State Legislature
ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
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NOTICE OF A PUBLIC HEARING

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

Wednesday, November 28, 1990 10:00 A.M.
State House Annex
Room 418
Trenton, NJ

The Assembly Health Care Policy Study Commission will hold a public hearing on Wednesday, November 28, 1990 at 10:00 A.M. in Room 418 of the State House Annex, Trenton, New Jersey. The commission will receive testimony regarding State health planning including the need for the planning, development and financing of a comprehensive State health plan and a review of the certificate of need process.

Address any questions or requests to testify to Robbie Miller, Aide to the Commission (609-292-1646), State House Annex, Trenton, New Jersey 08625. Those wishing to testify are asked to submit 15 typed copies of their testimony on the day of the hearing. The chairman may find it necessary to limit the number of witnesses and the time available to each witness at the hearing.

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ASSEMBLYMAN JAMES E. McGREEVEY (Chairman): Good morning, everyone. My name is Assemblyman Jim McGreevey. I'm with the Assembly Health Care Policy Study Commission, and I'm pleased to have you join us today.

The focus today is on health care planning. Obviously -- as we all recognize health care planning -- its specific roles are to promote and protect the health of the population of the residents of the State of New Jersey.

It is also supposed to prospectively identify the unique health needs of New Jersey residents, and to advance in an orderly, reasonable fashion, the health care facilities and services which ought to be responsive to these unique needs, and to discourage those capital investments and human investments which lead to excess capacity, thereby introducing unwarranted new fiscal costs to the system which only provide incremental improvements at best in human health and comfort.

Most importantly, it is supposed to ensure that all of New Jersey's residents have access to critically needed health care services, and to ensure that those services are delivered in the most cost-effective, responsible, and compassionate manner, with respect both to the quality and to the cost implications.

Our first witness today will be Commissioner Raymond L. Bramucci from the Department of Labor.

We ask all witnesses today to join us in focusing on this frequently debated subject; that is, uniquely, the need for State health planning, and the role of the Certificate of Need as an integral part of that process.

At this time I'd like to call upon Commissioner Ray Bramucci.

C O M M I S S I O N E R R A Y M O N D L. B R A M U C C I: Thank you, Chairman McGreevey and Assemblyman Felice, for giving me the opportunity to come before you today. I applaud your determination in addressing one of the most crucial issues facing our State today.

We, in New Jersey, can be proud of our commitment to create a decent and humane health care policy; a policy that gives every resident access to health care and hospitalization, regardless of the ability to pay. But problems with the way that policy has been implemented have brought us to a financial crisis of monumental proportions.

When the Uncompensated Trust Fund expires at the end of this year, New Jersey will be left without a mechanism to pay for those who can ill afford health care. But continuation of the Fund -- as it is presently constituted -- is unacceptable; particularly in these tough economic times. With the costs of care skyrocketing, payouts will increase. The hospital surcharge will follow suit.

Insurers will then raise premiums, forcing employers and those who pay for their own health insurance to shoulder an even greater burden of the costs of our State's health care obligations.

The system is simply inequitable, and threatens to seriously imbalance our economy.

As your Commissioner of Labor, I am keenly aware of the impact this inequity is having in the workplace. Consider this startling statistic: In 1989, 78% of all labor disputes nationwide occurred over the provision of medical insurance. You may recall the NYNEX strike that disrupted in our area last year. The dispute centered on issues of health care.

In 1990, we in New Jersey can anticipate more of the same. Twenty of the State's largest labor contracts are due to be negotiated in New Jersey. I can predict with confidence that matters of health care will threaten the successful resolution of many of these negotiations. Negotiators will be hard-pressed to come to agreement, and the issue, inevitably, will be the high cost of medical insurance.

The turmoil in labor negotiations sends us a clear and strong signal: The current imbalances in the system are

unacceptable. We can no longer expect a limited segment of society to bear the unlimited cost of this important social and economic responsibility.

The question, then, is: How do we build a system that more equitably spreads the financial responsibility for uncompensated care? There are those who feel that the burden should fall on the shoulders of employers -- that the cost of care is a social responsibility of business. Others argue that government should somehow pay for uncompensated care out of general revenues -- that only public funds should be used to weave society's safety net. These solutions are popular, but they are not solutions that will work.

We favor an approach that distributes the burden of uncompensated care more equitably between government and the private sector. Such an approach recognizes a fundamental reality: That shared social obligations require shared social responsibility. And if we are to fashion a system rooted in partnership, then it is incumbent upon us to ensure that the system's creation is an act of partnership as well.

Let me speak plainly: The time for political finger pointing is over. A shared, bipartisan political dialogue must accompany any effort to overhaul our system of uncompensated care. Anything else does a disservice to all the citizens of our State. The crisis is too grave, the consequences too severe, and the time too short.

There are several recommendations favored by the Governor's Health Care Cost Study Commission that together must be considered if we are to relieve the burden of those footing the bill for their fellow citizens who are uninsured.

The Commission has recommended a broad-based tax model along the lines of our current unemployment tax. That kind of an approach is economical, efficient, and fair.

The Commission has also proposed an additional assessment on employers who refuse to provide medical insurance

to their employees -- a reasonable levy that will go a long way toward reducing the current economic stress on the system. The answers to these and other questions about the Fund would provide a factual backdrop for our negotiations. Like it or not, the recession has forced us into a partnership. We are all faced with reserve shortfalls. We are all faced with budget deficits. We are all faced with an escalating uncompensated medical care fund.

It is imperative that alternatives to that Fund be discussed now, fully, in the spirit of cooperation rather than conflict, for there is little time to lose. As the recession deepens, more and more workers will lose their jobs and, as a result, their health care coverage, also. The number of uninsured individuals serviced by the Fund is sure to increase, further straining an already strained system.

We are faced, then, with a choice. We can say, "It's their problem," and turn our backs on our State in its hour of greatest need. Or, we can say, "It's our problem," and solve it together.

Thank you.

ASSEMBLYMAN McGREEVEY: Thank you, Commissioner. It worsens daily. Assemblyman Felice?

ASSEMBLYMAN FELICE: Commissioner, I have a question and a problem with certain things. One: Before we throw out the baby with the bath water, I think we should have something else in place. Now, we're coming to a deadline again -- as we have in the past -- and I, for one, would like to see the Uncompensated Care Trust Fund continued until something can be put into place that is better.

With all its faults, New Jersey is one of the few states in the United States where at least people can go to a hospital and get health care, which is very rare in this country; having met with the other states just a month ago.

So I think, yes, we do have a problem with the million people who do not have any health care. The sad part of it, of course, is that two-thirds of them are working people -- working for small businesses. I think we have to be very careful how we penalize, first of all, the companies that are providing health care, so they're not hit with an additional tax.

And, of course, second of all, we have to make sure that we try to encourage small businesses to be a part of providing minimum health care -- to take those working people out of the Uncompensated Care Trust Fund debit and have them be a part of the health care system. So, I think we have to be very careful which way we go to assist those small businesses to help those people, especially those people who have jobs who work for small businesses. This is the only thing that I have a deep concern for. My first priority is to make sure that the Uncompensated Care Trust Fund is continued until a better system or something else can be put in its place. Otherwise, there would be a disaster in this State, such as we are seeing in other states, where they're rationing health care and so forth.

So I think this is one of the important things that government, labor, and business, working together, have to ensure; that we can do something that is fair to everybody concerned, and end up with a situation where we have more people having some kind of minimum health care.

I just wanted you to know that that is my feeling. And from all the hearings and testimony that we've had with this Committee, and with other Committees, and meeting with other states, this is the kind of situation that-- Here in New Jersey, we have to find some kind of equitable and fair type of situation for both the people that need health care, and the businesses that should be supplying it.

COMMISSIONER BRAMUCCI: I think I share all your concerns. I think it was a thoughtful statement you just made, and I certainly don't come here with some agenda of truths that God gave me to give you a solution to this problem. I came here because I'm really concerned about the economy, and I came here because I sense that we're locked into a partisan distance; that we're not talking about this in a way that will lend itself to solution.

I, earlier, talked about how in the State of New Jersey, where we faced a crisis in the unemployment insurance system, we were indebted to the Federal government to the tune of $750 million after the recession in the '70s. People came together, and worked out an equitable solution that they recommended to the Legislature, because the State of New Jersey was at peril. The alternative was to pass along large increases to employers. So we changed the rules. We tightened up the rules. We did all kinds of things that made an equitable solution possible. That kind of a discussion is not happening now.

It's my impression, Assemblymen, that this is sort of sitting there as an administration problem. It is not an administration problem. It's the State of New Jersey's problem. And I don't think anybody is trying to jam anything down anybody's throat, except to be eager to discuss alternatives: If the recommendations are wrong, how else can we find the way to spread the cost? Because right now, as you would acknowledge I'm sure, to expect a smaller and smaller segment of good citizens to pay an onerous charge and to have that continue indefinitely, is not an appropriate solution. For instance, at our collective bargaining sessions, that will be the issue. Employers will come to workers and say, "We cannot any longer afford to pay your medical costs. You've got to do this or you've got to do that," and the workers will say,

"No," because they take their medical plans for granted, since they've had them for years and years. We will have strife. So, if we drift on this, and if we don't try to come together in some kind of forum of respectful dialogue to really get at the issue which is-- No matter what your position is, the seriousness of it is not contended. We don't contend about that. We just say, "How is it that we solve it?"

We've got people over here, and people over there, and people over here, but they're not talking together to come to some rational solution which will guarantee that the safety net will be maintained. I share with you the need to maintain access to medical care for everybody. It's a sign of our decency and I'm proud of it; that New Jersey has such a system. But, we're not going to have a system last that increasingly tears the economy apart.

ASSEMBLYMAN FELICE: Commissioner, I have to agree with you. Excuse me, I didn't mean to interrupt you. Of all the things in the nine years that I've served in the Legislature -- the Committee that I served on was Health and Human Resources; something that I have found of all the Committees and of all the things that affect us in the State. I have to say to you, there is one thing that health care has never been -- a partisan issue. I think of all things that have ever come through in this State, and through the Legislature, as far as bills and so forth-- I think you'll find that even today this is not an issue.

That's why I'm pleased that at least, as one of the ranking members of the Health Committee, I was able to serve on this Committee, because we had no input on the Governor's Committee. And what I'm saying here is, we have the opportunity, the Chairman has given us this opportunity to--

ASSEMBLYMAN McGREEVEY: Ray and I felt the same way.

ASSEMBLYMAN FELICE: Okay. You know, we feel this is our way of saying to the Governor's Committee some of the

things that we would like to say, and we're putting on record here. I wanted to make it clear, and I have to tell you, Mr. Otlowski and myself, as the oldest members of the Health Committee, not in age-- But we've had a terrific rapport when it comes to nonpartisan health care legislation. I just wanted to make that clear. This is the opportunity that we have today, to at least agree without being disagreeable, and we'd like to get those points across. I thank you for your input on this subject.

ASSEMBLYMAN McGREEVEY: And, Ray, tomorrow we'll be releasing -- Nick, myself, and the other members -- the interim report of the Commission specifically focusing on the question of Uncompensated Health Care and recognizing the exigent circumstances and the need to deal with the question of the Fund on an interim basis, as well as to develop long-term solutions that will hopefully put an end to the need to permanently establish the Fund.

COMMISSIONER BRAMUCCI: One last-- I know that you're a serious public servant and I recognize that your attendance is as guaranteed at these sessions as anybody in the Legislature, and that does not go unnoticed, Assemblyman.

From my perspective, I have a sense of urgency that may be special because I also have responsibility for mediation. I know we're going to have large scale problems, so there's this immediacy to it that may not be so evident to others. I have no lock on truth or a way out of this except to say, if we can get people like you, and others in the Republican Party and other segments of our society who are resisting really coming to grips with a comprehensive attempt to deal with this -- not an answer necessarily, but a comprehensive attempt to deal with this -- we can deal with it. Not with magic or not with something that will be happy, but something that will work and give us some time and keep strife to a minimum. I appreciate the opportunity, and I appreciate your deliberations, and I hope we can work together.

ASSEMBLYMAN McGREEVEY: Thanks, Ray. And also, Ray, this is a note of thanks. You're one of the Commissioners in this administration who consistently spoke on the need to grapple with this problem. Sometimes that urgency to call for action is just as important. So, thank you.

COMMISSIONER BRAMUCCI: Thank you.

ASSEMBLYMAN McGREEVEY: Commissioner Dunston has previously notified us-- Dr. Dunston notified us she would be running late. We expect her around 11:00. So at this time we'd like to continue with the list and call upon Murray Bevin, Vice President Government Relations and Regulatory Affairs, New Jersey Hospital Association, and Harvey Holzberg, who's Chairman of the Council on Planning. Most importantly, Harvey's affiliated with the distinguished Robert Wood Johnson University Hospital.

M U R R A Y E. B E V I N: Thanks.

H A R V E Y A. H O L Z B E R G: Thank you, Assemblyman, and members of the Committee. Good morning. As Assemblyman McGreevey has indicated, I'm Harvey Holzberg, and I'm Chief Executive Officer of Robert Wood Johnson University Hospital in New Brunswick, and Chair of the Council on Planning of the New Jersey Hospital Association, and we do appreciate the opportunity to present testimony today.

As Chairman of the Council on Planning, I'm here on behalf of the Hospital Association regarding the health planning recommendations of the Governor's Commission on Health Care Costs. Let me begin by congratulating the Commission for its comprehensive review of the current health planning system, and its efforts to provide for the health care needs of New Jersey citizens. Several of the Commission's recommendations will serve to fine-tune our health care delivery system and will address the needs of both consumers and providers. I hope that through continued collaboration and cooperation, these recommendations will be further developed to foster an improved and effective health care delivery system.

My remarks today will address three primary areas of the Commission's health planning recommendations: The first is the proposed reform of the health planning system in terms of structure and process; the second, the changes to the Certificate of Need application process; and third, the increased level of authority and involvement of the Department of Health in managing hospital operations.

The proposal to reform the health planning system calls for a centralized planning system in which Certificate of Need applications could only be submitted when the State Health Plan identifies a need. The New Jersey Hospital Association objects to this centralization of the planning process. Although there will be provisions to allow for local input, the ultimate determination of all health needs will rest with the State. Local participation in the health planning process is essential as it ensures that local health needs and issues are taken into account. Similarly, hospitals submit Certificate of Need applications based on the needs of the communities they serve. A centralized planning system eliminates much of that local input and could overlook important community health needs in many areas of the State. We urge that health care providers be allowed to continue to initiate Certificate of Need applications in response to the health care needs of their local communities.

In addition, in order to be comprehensive, the State Health Plan would have to encompass all of the regionalized health care services. Gathering information, analyzing it, and creating this broad plan will be a substantial undertaking. The Department of Health is already short-staffed as a result of the State's hiring freeze. The New Jersey Hospital Association is concerned that the State simply does not have the staff to develop and update this comprehensive plan. It is important that the State's planning process not become a morass of red tape that will delay the implementation of needed health care services.

The State health planning system would also experience some structural changes. The Governor's Commission proposes to establish a State Health Planning Board to replace the current Statewide Health Coordinating Council. The New Jersey Hospital Association is concerned that the proposed membership of the SHPB includes many representatives of the State government and a minimum number of health care providers. Obviously, New Jersey hospitals would like to be participants in the development of rules that will ultimately affect them.

In addition, the Commission proposes that the health systems agencies be replaced by Local Advisory Boards which would receive State funding. We support the continuation of local health planning bodies and would like to see them given a major role in developing the State Health Plan and reviewing Certificates of Need. The Hospital Association concurs with the Commission's recommendation that these LABs -- we have to learn a whole new alphabet soup now, obviously -- receive State funding, but we would like assurances that these boards will function autonomously from the Department of Health.

Regarding the proposed changes to the Certificate of Need application process: First, we commend the Commission for including all providers in the Certificate of Need process. We strongly support "leveling the playing field" and are pleased to see that there is an effort to accomplish this long-awaited development. We would recommend that enforcement of this proposal will be difficult unless payers are required to pay only those facilities that have received a Certificate of Need. This would create an obvious incentive for all providers to participate in the Certificate of Need process, and give the State control over all regionalized health care services and major health expenditure.

The New Jersey Hospital Association also supports the proposed increase in the Certificate of Need thresholds. The Commission recommends an increase from $400,000 to $1 million

as the threshold for major movable equipment, and an increase from $600,000 to $1 million for modernization, renovation, and construction projects. These increases are noteworthy but we would suggest these thresholds be further increased. The Hospital Association has long supported a $1.5 million threshold for major movable equipment and a threshold of $5 million or 10% of a modernization, renovation, and construction project, whichever is less. I'm sorry, or 10% of the facility's operating budget -- whichever is less -- for projects that involve modernization, renovation, and construction. These higher thresholds represent a more cost-effective approach to reviewing substantial hospital projects. The Certificate of Need process is only further burdened both in terms of staff time and dollars when it must conduct reviews of minor projects.

The Commission also proposes an annual capital "cap" on major hospital construction projects. The intent of this recommendation is to reduce the number and total cost of hospital capital expenditures. We object to this proposal. First, it is unclear as to who will establish the cap and how it will be decided how much the State's hospitals can truly afford to spend on capital projects. Second, the Hospital Association cannot support the recommendation that hospitals should compete for permission to improve their capital facilities. Like all buildings, hospitals require routine renovation and modernization. Failure to meet these capital requirements can result in overcrowding, inefficiencies from operating obsolete facilities, and even closure when conditions become unsafe. Even now, absent a capital cap, New Jersey's hospitals have the fourth largest occupancy level in the country and are routinely forced to divert patients due to overcrowding. In the short run, the State may save money by delaying major capital projects; in the long run, it will end

up costing far more as a result of inefficiencies and maintenance costs. Like the ad said, "It's pay now or pay later."

Finally, throughout the Commission's Report, the State is given increased authority and control over the operations and management of hospitals. We are concerned about this recommendation particularly as it relates to planning. New Jersey's hospitals are already heavily regulated, and need to maintain some flexibility in order to respond to the changing needs of the communities they serve.

As proposed, the Commissioner of Health would be given the authority to remove beds from a hospital's license, based upon the underutilization of those beds over time. The Department of Health already has the power to close beds and should only use it when there is true underutilization. Hospitals that have closed beds because of manpower shortages, lack of usable space, construction, or manpower strikes, should not have their beds de-licensed.

Under the Commission's proposal the Department of Health would also have the power to become involved in the governance of a hospital if the Department feels there are excessive utilization, financial, or licensure problems. The New Jersey Hospital Association finds that such interference in hospital operations is unjustified. The State is no more capable of running hospitals than existing community boards and should not attempt to replace the outstanding business and industry leaders that comprise these boards.

In conclusion, we commend the Commission for its recommendations to institute a mechanism for local input through the designation of Local Advisory Boards, to include all providers in the Certificate of Need application process, and to increase the Certificate of Need thresholds. The New Jersey Hospital Association looks forward to the implementation of these needed changes. However, we are very concerned about

the proposed shift towards a centralized health planning system with inadequate local health input, the cap on capital projects, and the increased authority of the Department of Health to manage hospital operations. The Hospital Association stands ready and willing to work with the Governor's Office, the Department of Health, and the State Legislature to develop mutually acceptable solutions to these concerns.

Thank you for the opportunity to speak to you today.

ASSEMBLYMAN McGREEVEY: Thank you, Harvey. Murray? Hospitals for everyone.

MR. BEVIN: I have little to add except, obviously, hearing me for the fifth or sixth time-- I think it would be if I testify today. I think Harvey and--

ASSEMBLYMAN McGREEVEY: Do you want to go through the testimony, then?

MR. BEVIN: Sure.

ASSEMBLYMAN McGREEVEY: What is it in terms of, Harvey, -- I'm sure, in terms I guess you're specifically concerned about -- when you talk about the centralization of health care, of the planning process? You said local participation is essential -- hospitals submit Certificates of Need. Yet you're concerned that the centralized planning system eliminates much of local input and overlooks important community health needs in many areas of the State.

But at the same time, we're addressing some of the questions and concerns that you had. Namely, in fact, that the plan would include areas that have historically been concerns to the Hospital Association. I mean, not only would you include trauma centers, cardiac surgery, comprehensive rehabilitation, but in many cases you would address what even the Hospital Association has found to be sometimes, health care facilities in the same geographic area serving identical needs, whereas other areas aren't being addressed. In addition to that, I think you would recognize that a comprehensive State

Health Care Plan is perhaps the best way to ensure access to quality care and also develop the balanced approach to not only Certificate of Need applications, but to service delivery.

MR. HOLZBERG: Certainly the Hospital Association does not support duplication, and supports any efforts to eliminate expensive duplication of services. And we do support regionalization, and have supported regionalization of many expensive services.

I think our objection really is, one, the sort of top down approach that is taken, and even though there is local input, it's only going to be once a year. Given the short staffing that currently exists in the health care--

ASSEMBLYMAN McGREEVEY: And the staffing question aside -- which is very legitimate, and Dr. Dunston raises it and legitimately so -- ought not there be a State Health Plan?

MR. HOLZBERG: I think there could be a State Health Plan that is really developed in a way that doesn't become law, where it's totally inflexible.

ASSEMBLYMAN McGREEVEY: But then what is it worth if it doesn't-- If the State Health Plan doesn't have the full force--

MR. HOLZBERG: Whether it's called the SHCC or the State Health Planning Board, that agency can look at a State Health Plan and might want -- in their judgment and wisdom -- to divert from that plan for very legitimate reasons, as has happened in the past. I don't think we object to having a State Health Plan so much as the fact that it then becomes locked in cement, and I think we would like to see the continued flexibility in the system.

ASSEMBLYMAN McGREEVEY: The problem is now that's all we have is flexibility; that's all we have is diversity. The question is, if we are going to intelligently plan, isn't there an obligation to adhere to that plan or else the plan becomes meaningless?

MR. HOLZBERG: I don't know that I would agree, frankly, that now all we have is flexibility. I really don't. I think if you look at the current health planning process where they have developed methodology for the number of beds that will be allowed in a given area -- and for that they don't allow unnecessary duplication, replication -- I think the current system really is a planning process and is one that makes sense. New Jersey has far from overbuilt -- certainly isn't overcapitalized in any way.

ASSEMBLYMAN McGREEVEY: Some would disagree.

MR. HOLZBERG: Some might disagree, but if you allow the physical plants to deteriorate--

ASSEMBLYMAN McGREEVEY: No, and that's another issue. But I guess the threshold question is one where we have a question of the financing of the health system agencies and beleaguered--

MR. HOLZBERG: HSAs.

ASSEMBLYMAN McGREEVEY: --HSAs and their inability to receive adequate funding which has been a significant problem -- and the ability to intelligently plan. But I think the question before us is: How do we move to develop a cogent plan? And, once that plan is in effect, do we adhere to it? And even to the point where the Commissioner has to abide by the plan-- My concern with the testimony of the Hospital Association is with just this one specific point, if I may: Once we adhere to a plan, gathering local input from local applicants, I think it's important that the Commissioner and the entire Department-- And I think that would also auger well for the Hospital Association, such that you don't have a Commissioner or a Department which capriciously exercises administrative oversight of programs, or of a plan that is legitimately designed.

MR. HOLZBERG: I certainly would agree with that. I'm sure we all would agree with that, but-- You know, we also

have to look at the history. You say, let's put aside the short staffing and the problems that we're going to have and let's assume that everything is going to be done in a timely way. Should that happen, that would be a first. But, if you were sitting where we're sitting--

ASSEMBLYMAN McGREEVEY: Yeah. What you've gone through.

MR. HOLZBERG: --and you had gone through years of not seeing things happen in an orderly, timely fashion--

ASSEMBLYMAN McGREEVEY: Okay. In drafting the legislation then, Harvey, what would you change? I mean, I'm sure you're familiar with the Governor's Commission's recommendations which, you know, I guess eight, nine, and ten rate a nine-- What would you specifically change in the planning development process to amend -- to make it more meaningful to your concerns?

MR. BEVIN: Jim, I think when you say the "full force and effect of law," you're writing something, as Harvey said, almost in concrete. The State has an energy master plan. That plan is a plan. It's a guidepost; it's outlines. It's not a rigid, inflexible document. I believe the exact language in the master plan for energy says, "Should be enforced to the maximum extent feasible." That's more realistic, I think. And I think that if you use language like "full force and effect," you're almost-- You're not defining what a plan is, because a plan is a plan. It's not the law. I think that we might begin there by looking at a more reasonable way to apply a plan -- a road map, not this sort of concrete notion.

ASSEMBLYMAN McGREEVEY: Well, I mean, there are appeal procedures that were built into it. I mean, it-- If the Commissioner acts contrary to the recommendations of the report, of the plan, you know that the petitioner has the right of appeal, you know, through the Administrative Law Judge.

MR. HOLZBERG: But that's--

ASSEMBLYMAN McGREEVEY: But this is a one-year--

MR. HOLZBERG: That's an onerous process. I mean, to go through the Administrative Law Judge becomes expensive and something that we have all tried, and, frankly, have become loathe to continue to try because it is so long-term and so expensive. And, I would also like to see holding the Health Department's feet to the fire, a little bit in this.

ASSEMBLYMAN McGREEVEY: Well, I think that's also-- I think there is a sense of balance here. I mean, that was one of the-- I mean, I think it is a concern that it not be inequitable, that as you hold the provider community, you ought to also hold the regulatory community--

MR. HOLZBERG: Not just for following the plan. I think, you know, making certain that there is local input to the development of the plan -- if there is going to be a plan -- in a timely way, and if they don't do it in a timely way, some alternative to that.

ASSEMBLYMAN McGREEVEY: Well, could you give us some language on what you think is, in terms of a timely appeal--

MR. HOLZBERG: Sure. We'd be glad to.

ASSEMBLYMAN McGREEVEY: --process, because we're looking to work on legislation. I just, in terms of-- I agree, and I'm sure Ed Peloquin agrees on your recommendation that the LABs receive State funding. And I think there is support that the boards function autonomously from the Department of Health, because they're also suspect to legal liability if they become part of the Department of Health. And you're going to also guarantee rights of appeal if the LAB rules against. So, for both the legal reasons and for-- It probably makes sense to keep them autonomous.

The only other question that I had is: You obviously had a concern about the cap on capital projects which is something, frankly, that I've had a concern with. It's

primarily directed at acute care settings. Would you remove any cap at all, or do you not believe in having a cap?

MR. HOLZBERG: It's difficult to have a cap. One inner-city hospital-- If one inner-city hospital needs replacement, that's $200 million. Are you then not going to have any other projects in the State over $10 million annually?

ASSEMBLYMAN McGREEVEY: So you don't think we're overcapitalized?

MR. HOLZBERG: I do not think this State is overcapitalized at all. I really don't. I mean, I think if you look at the aging of equipment, of facilities in this State, you'll find that it probably compares unfavorably to many states in the southwest, the west, and the midwest. I mean, if you compare it to New York as a whole, you'd probably find that we're about the same, and if you did it to New York City, we might come out a little ahead. And there are communities in this State where the facilities are really worn out.

ASSEMBLYMAN McGREEVEY: I guess that's a difficult judgment call.

MR. HOLZBERG: It's been a regulated State for so many years. It's not as though--

ASSEMBLYMAN McGREEVEY: Everyone tells me every hospital -- with the exception of some in my district -- has been rehabilitated, and there is a concern out there as to--

MR. HOLZBERG: I think we could probably give you lists of projects that have not been done and need to be done that would--

MR. BEVIN: Assemblyman, I looked down the list of other hospitals that are going to testify here today, too, and I suspect you'll hear, very graphically, their input on that.

ASSEMBLYMAN McGREEVEY: The other question, Harve, that I have, is the question in terms of the Certificate of Need having a discreet period of time for implementation. Do you have any thoughts on that?

MR. HOLZBERG: I think probably there is some sense to having a discreet period of time, but I think there, too, you need flexibility.

ASSEMBLYMAN McGREEVEY: Now would you tie it to threshold levels of dollars in terms of--

MR. HOLZBERG: Probably.

ASSEMBLYMAN McGREEVEY: Okay. And if the Hospital Association also could provide, Murray, on the question of Certificate of Need and what time frames they deem appropriate on the period of implementation--

MR. BEVIN: We'll be glad to do that.

ASSEMBLYMAN McGREEVEY: Okay.

MR. HOLZBERG: Could I also ask you to look again at the composition of the State Health Planning Board?

ASSEMBLYMAN McGREEVEY: Yes. Yes, and I concur with you wholeheartedly--

MR. HOLZBERG: Thank you.

ASSEMBLYMAN McGREEVEY: --that there needs to be hospital representation and that the regulators ought not skewer the process such that--

MR. HOLZBERG: It has been our experience that Commissioners tend to vote in blocks.

ASSEMBLYMAN McGREEVEY: Blocks? There's been no recent demonstration of that, but I appreciate that historical pattern.

Assemblyman Felice?

ASSEMBLYMAN FELICE: I'm laughing because that is true, but I agree with you that the State Health Plan can't be set in cement because geographically and otherwise it varies. I think there has to be a more realistic approach to State health planning. But I think having some of the hospital people on that Committee would certainly give that kind of input, to equalize some of the unrealistic sections of that State Health Plan.

ASSEMBLYMAN McGREEVEY: Thank you.

MR. BEVIN: Thank you.

MR. HOLZBERG: Thank you very much.

ASSEMBLYMAN McGREEVEY: I'm very pleased to have join with us today, Dr. Frances Dunston, our Commissioner of the Department of Health. Dr. Dunston.

C O M M I S S I O N E R F R A N C E S J. D U N S T O N: Thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you for joining us.

COMMISSIONER DUNSTON: Pleased to be here.

ASSEMBLYMAN McGREEVEY: Your hectic schedule--

COMMISSIONER DUNSTON: Yes. Good morning, Assemblyman McGreevey, and members of the Committee. I'm Dr. Frances Dunston, Commissioner of Health, and I'm pleased to have this opportunity this morning to discuss State health planning with you.

Health planning is a frequently debated subject, one that often leads to heated discussion over how we allocate precious health resources. Still, we have to bear in mind that health planning has some simple but important goals.

Health planning is designed to protect and to promote the health of the population of this State. It is supposed to identify the health needs of New Jersey residents, and to advance the orderly development of health care facilities and services which are responsive to those needs.

It is to discourage those investments in human and financial capital which would lead to the development of excess capacity, thereby introducing unwarranted new costs to the system, or which provide only marginal improvements in human health and comfort. And it is supposed to ensure that all residents have access to needed health services, and to ensure that those services are delivered in a responsible manner with respect to both quality and cost implications.

When it comes to the health needs of New Jerseyans, the planning process has not been the guardian it is supposed to be. Instead, it has allowed providers to play the principal role in determining what health services they wish to provide. Essentially passive, we have chosen to briefly pass judgment on others' proposals without a real up-front say as to what is actually needed.

Consumed by the bureaucratic paperwork demands of the Certificate of Need program, we have lost track of what planning is supposed to be. As the Governor's Commission noted, this has to change. We now must develop a comprehensive State Health Plan designed to determine the adequacy of existing services -- and the need for future services -- and thus guide the development of the health care infrastructure.

In other words, we need to focus on identifying unmet health care needs by service and location, and we need to evaluate the impacts of the specific interventions on the promotion of health and well-being. This represents a shift in emphasis: providers must respond to needs identified through the State planning process. Thus we will use the regulatory mechanism to execute planning, rather than viewing regulation and review as ends unto themselves.

This will require a shift in orientation of the entire planning and Certificates of Need processes. As recommended by the Governor's Commission, the State Health Plan would be the basis upon which the Certificates of Need are reviewed. The Plan, created with local input, will assess where there is need in the State for specific, effective services. Currently we have no such guide, no such road map. With this new focus, providers would only file Certificates of Need for specific services in given areas earmarked in the Plan. Certificate of Need applications would not be entertained for services or areas not specifically identified in the State Health Plan. And thus, the regulatory mechanisms would be used to advance

health goals, rather than to spend an inordinate amount of time, staff resources, and so forth, reviewing applications for projects for which there is no need or for which there is excess capacity in the system.

We expect, and we certainly hope, that this will also result in a shift in emphasis in the types of services that are developed. High tech, high cost tertiary care services have typically received the most attention in our planning process. Now we do need to retain our commitment to the appropriate regionalization of expensive tertiary services, which are very expensive to deliver and which are needed by only a portion of the population. For instance, we need to regulate cardiac services because of the known association between cardiac surgical volumes and outcomes, and because we know that the proliferation of excess capacity of such a service will erode the quality of care at each center while draining our health care budgets.

But the need to develop community-based, primary services is typically overlooked in our current process and these are, in many instances, the most needed of the services in our State offering the best opportunity to promote human health in a cost-responsible way. These community-based, primary care services will be emphasized in the State Health Plan, and in a broadened conception of the planning process, because planning is more than just a Certificate of need; rather, it should be a guided vision of the best way to provide effective services for those who need them.

Along these lines, the need for preventive services will be emphasized because as noted in the recent report of the U.S. Department of Health and Human Services, "Healthy People 2000," which sets goals for the nation, prevention is now the single most important factor in achieving and maintaining good health. We've almost extended the benefits of our high-tech

provision of care, and we really need to exercise the capacity and benefits of prevention at this point.

One example where prevention and the expanded role of health planning overlap, is in the HealthStart Plus Program recently proposed by the Governor's Commission on Health Care Costs. We know the need exists. In fact, that our infant mortality rate is so high -- especially among vulnerable populations -- is a clear indication of this need. And HealthStart Plus is an initiative designed around the concept of community-based, primary services to achieve better birth outcomes. The role of planning and making this happen will be extremely important, because we will need to encourage and create services and provider sites across the State to meet this identified need. This is an example of proactive planning.

The planning and Certificate of Need processes were originally designed, at least in part, to help control the costs associated with the construction and the purchase of health facilities and equipment. As mentioned earlier, traditionally the focus has been on controlling the growth of expensive tertiary care services through the evaluation of the financial feasibility of proposed projects, and the regionalization of these services.

We now have to go beyond that and reassess the unchallenged primacy of hospital care as an unwritten tenet of the planning process. There are other ways to deliver health care and to deliver it in a high-quality and cost-effective fashion. The one important example will be the promotion and the encouragement of community-based health services such as those offered in community health centers. Our hope is to see that these efforts receive just as much attention, and certainly a greater emphasis, as we said about developing the State Health Plan.

Health care should be much more than the hospital, and our health planning process must recognize that. Hospital

emergency rooms are not good primary care sites, and reliance on them for care is bad for people, and bad for the financial health of our health care system. The health planning system has to take the lead in encouraging more appropriate levels of care. Additionally, costs can only be controlled if we regulate the entire health care system in an equitable fashion, instead of putting all of our efforts on only one segment.

The situation with Magnetic Resonance Imagers, or MRIs, is a case in point. We regulated only those in hospitals, so we wound up with dozens of these fabulously expensive machines outside of hospitals. In the interest of equity, we need to develop a level playing field, and that means that all health care providers must fall under the health planning regulation.

If we intend to look at this system as a whole and not in pieces, we also need to set some sort of capital expenditure cap. We cannot just go on approving and denying capital projects with no idea as to their effect on the statewide health care costs. We are now facing a future with an incredible amount of new hospital debt which will eventually be translated into higher insurance bills. This debt, you must be aware, is not unlike the savings and loan situation and other places in our economy where we have gone into deficit situations. Are patient outcomes going to be proportionately related to this amount of debt? We think not; that patient outcomes cannot be related to the almost $5 billion worth of debt that we're holding now in this State on capital projects. We need to decide how much additional costs we can actually afford in capital areas, and we need to use that as a ceiling.

I look forward to working with you and implementing the recommendations of the Governor's Commission's Report in this area, and also in other areas as well. Putting this plan into action will require hard work from all of us, but there is no other way. If we do nothing, we have failed many. Thank you very much for this opportunity to share my thoughts.

ASSEMBLYMAN McGREEVEY: Thank you, Doctor. I just want to share that tomorrow we'll be releasing our report, and one of the things that Assemblyman Felice and I are also concerned with, is that we focus on community health centers to encourage that promotion of primary and preventive care.

Just two points: One, an earlier concern is the creation -- and I think to a certain degree, a legitimate concern about the creation of the State Health Plan, and the role of the Department in establishing and coordinating that planning process, and the Hospital Association's prior testimony -- and I raised the question of the adequacy of staffing to bring about an efficient and regulated planning process. This planning process, not only in terms of funding LABs will be more costly, but if this final plan is to be embodied as a -- perhaps even stronger than a road map-- Does the Department presently have the ability, both in terms of staffing requirements and financial need, to develop this plan?

COMMISSIONER DUNSTON: I think that's a very fair question. One of the things that we are doing to increase our capacity in that area is, through the recently completed review of the Department, we are undergoing a reorganization that will establish an Office of Policy and Research that will be primarily responsible for the development of a comprehensive State Health Plan that not only looks at the facilities needs, and develops that portion of the plan, but also looks at human health needs, so we're looking at both in a comprehensive fashion. This Office is going to add new capacity to the planning functions that we have not had in the past.

The other thing that I think is important to recognize, is that with the new efforts that we're going to make toward planning, the process will actually be streamlined, and so some of the manpower resources needed to actually execute it will not be as tense as we have had in the past. We really want to reduce the bureaucratic paperwork to make it

less of an onerous process, and the actual State Plan process will allow us to have a more streamlined effort.

ASSEMBLYMAN McGREEVEY: Doctor, what do you say to the philosophical point that the Hospital Association makes that there is inadequate local health input in the creation of the plan?

COMMISSIONER DUNSTON: We agree that we need to have more local input, and, as you know, in the Commission's Report there is reference to strengthening that local input, and I also referred to it in my remarks. We recognize that we cannot have effective planning without good local input. Our actual planning process will embody a way to assure that local input.

ASSEMBLYMAN McGREEVEY: The Hospital Association obviously still has concerns with the adequacy, but I defer to-- The last question that I have is: You mentioned the $5 billion of the outstanding hospital debt, and we discussed in the Governor's Commission, and we discussed here, the question of capital debt-- What would you deem an appropriate cap? And, could you explain to us why you see that as being so necessary vis-a-vis this outstanding burden?

COMMISSIONER DUNSTON: What we are looking for as a bottom line is an affordability factor, where decisions as to where to place that cap will be based on how much we can afford. We've been spending, obviously, much more than we can afford. We don't exactly know where that might fall, but the Report references approximately $200 million a year. Our projects run the gamut from a few million to $20 million, to $40 million, to $50 million, in that order. It means that all of the projects in a given year, of course, will not be able to gain approval because we can't afford it. And I guess that is the bottom line. Can we move to an emphasis of doing what we can afford, is the question.

ASSEMBLYMAN McGREEVEY: So that the Department, in reviewing a specific project is, again-- The State Health Plan

will determine whether or not capital expenditure would be appropriate. And once you've reached this $200 million ceiling that-- Now, was that $200 million ceiling, in the Department's perspective-- Should that be adjusted on an annualized basis?

COMMISSIONER DUNSTON: Yes. Each year as we review the State Health Plan, which will be done on an annual basis, a capital ceiling will be set for that given year so that everyone will be well aware of what that ceiling would be. And then competition for various projects will be set forth based on those items in the State Plan of identified need, and specific to the localities where those needs exist.

ASSEMBLYMAN McGREEVEY: There have been some in the Legislature that would like to legislatively institutionalize that ceiling. And my concern is, obviously, that we not become so autocratic or rigid.

COMMISSIONER DUNSTON: Right.

ASSEMBLYMAN McGREEVEY: Could the Department develop for us, perhaps, a fiscal mechanism, a formula against the base -- whether it's $200 million or whether it's $500 million or whether it's $1 billion -- but a formula against which you could rationally measure the need to alter that formula?

COMMISSIONER DUNSTON: Certainly we will make an effort to do that.

ASSEMBLYMAN McGREEVEY: And then, Doctor, the other thing that I guess we're concerned about, and wrestling with, is the question of: Why $200 million? If you could provide that for us, it would be helpful.

COMMISSIONER DUNSTON: Yes. I think the $200 million figure is more figurative than it is concrete. In other words, we're saying that there should be a cap, and that it should be based on some assessment of affordability. We use the $200 million figure; it could be more in one given year, or less in one given year. And, I think you're correct in saying that

there needs to be a periodic assessment of what that need should be, and that's what we're intending to do on an annual basis.

ASSEMBLYMAN McGREEVEY: Thank you.

Assemblyman Felice?

ASSEMBLYMAN FELICE: Commissioner, just varied off that a little bit, something's been on my mind. The State of New Jersey, every year, loses millions and millions of dollars, and part of that money is coming out of the Uncompensated Care Trust Fund for the simple reason of the high technicality of applying for Medicaid applications. I think in the State of New Jersey -- correct me if I'm wrong -- 22 pages is an application?

COMMISSIONER DUNSTON: Yes.

ASSEMBLYMAN FELICE: Well, recently I was fortunate to meet with other states, and some of the states have come out with a one-page application for Medicaid. That certainly would expedite getting more moneys, and the hospitals then would be able to apply for those people that were eligible. If not what happens is that that money comes out of the Uncompensated Care Trust Fund. I wonder if you're looking into getting the eligibility, the approval of a shorter application for Medicaid, so that the State of New Jersey could acquire some of those millions of dollars that are available to us from the Federal government?

COMMISSIONER DUNSTON: I think you've touched on an important subject. We've been very concerned about the onerousness of the Medicaid eligibility process and how difficult it is for people to have the benefits to which they are entitled. Unfortunately, the Department of Health does not have direct responsibility for that area, but I'm well aware that many states have instituted a short form, and with actually massive retraining of the people who actually execute that instrument, have been able to open the gates for those who are actually eligible for Medicaid.

The other thing that has been done in other states that is referenced in the Report, is the out stationing of Medicaid eligibility workers in sites where there are large numbers of people who are coming in for care at hospital-based and community health centers. This is another way to facilitate the process of enrolling people in Medicaid. We feel that it's not good to have a program that has potential benefits that is suffering from misuse or disuse, and I think you've touched on a very important topic.

ASSEMBLYMAN FELICE: Plus, there's a new Federal regulation that we have to increase the percentage of the poverty level which would additionally help us, too.

COMMISSIONER DUNSTON: That's that HealthStart Program that I referred to -- HealthStart Plus.

ASSEMBLYMAN McGREEVEY: The only concern, Nick, is on the training. You would have to educate Human Service bureaucrats in English before they are able to apply the new Medicaid application.

ASSEMBLYMAN FELICE: We could put it in multi languages, that's all right.

ASSEMBLYMAN McGREEVEY: Exactly.

ASSEMBLYMAN FELICE: We do it for drivers' licenses. We could do it for Medicaid.

ASSEMBLYMAN McGREEVEY: Exactly.

Thank you very much, Doctor.

COMMISSIONER DUNSTON: Thank you.

ASSEMBLYMAN McGREEVEY: Appreciate your time.

At this time we'd like to call upon Rebecca Wolff. Rebecca is President of the Healthcare Planning and Marketing Society of New Jersey. Thanks, Rebecca.

R E B E C C A B. W O L F F: Assemblyman McGreevey, Assemblyman Felice, and those present, my name is Rebecca Wolff. I'm pleased to be here to provide testimony regarding

the recommendations of the Governor's Commission on Health Care on behalf of the Healthcare Planning and Marketing Society of New Jersey.

HPMSNJ is a professional organization comprising planners and marketers from health care organizations throughout New Jersey. Overall, the Society believes that change in the current health care regulatory system is warranted, and we support the diligent work of the Commission members in formulating these recommendations. We view the Commission's Report as addressing "macro" level issues which are long overdue to be addressed; however, as professionals who have daily interaction with the State health planning system and Certificate of Need process, we have substantial concerns regarding the potential "micro" level impact legislative and regulatory changes could have on health care providers. We hope our comments will caution the Assembly Commission as to areas where further technical consideration is needed prior to change.

The testimony of HPMSNJ is limited to the Commission Report section titled, "Regulatory Reform," according to the interest and professional expertise of the members of the Society.

My comments will be brief and correspond to the recommendations.

ASSEMBLYMAN McGREEVEY: Rebecca, why is it everybody admires our intent, they just have problems with the substance. (laughter)

MS. WOLFF: CR-3 is the first recommendation in the section addressing regulatory reform under a subsection called Planning Reform. It deals with the State Health Plan.

The intent of this recommendation appears to be the development of a State Health Plan as a driving force for centralizing health planning and submission of Certificate of

Need applications. As such, it is essential that health care provider input be incorporated into the development and ongoing modification of the State Health Plan.

We believe it is unrealistic to have a State Health Plan which identifies all health care needs of New Jersey residents. Health care is changing rapidly and the State is geographically and demographically diverse. Therefore it is very unlikely that one set of statewide criteria can apply equally well to all areas of the State. There must be a prov sion to respond to area-specific needs which are not identified in the Plan.

To meet the needs of New Jersey residents, the State Health Plan must remain flexible and should include waiver criteria under which a Certificate of Need could be submitted. The waiver criteria should be service specific and consider such factors as utilization, access, and other pertinent issues. With a well developed State Health Plan, relatively few Certificates of Need will need to be granted under a waiver provision.

We are concerned that the State Plan reflect fully the complex and dynamic nature of the delivery of health services. This concern is expressed in light of severe limitations of the State Health Department budgets at a time when demands on it are being increased.

Recommendation four addresses Local Advisory Boards:

We believe there must be a provision for local input which includes the opportunity for affected parties to make public comment regarding Certificates of Need, designations, and other issues.

Historically, local health planning models have not provided sufficient local input into the identification of local needs, and development of programs and policies to meet those needs and into the development of the State plan.

If constituted, we believe that these bodies should be separately constituted 501 (C)(3) corporations which are allowed to seek sources of funds in addition to State allocated funding.

As autonomous entities, the local bodies should be free to determine the composition of their boards so long as these boards are: 1) representative of the geographic area they serve, and 2) have a consumer majority.

We note that the Commission's Report provides for only limited local input into the Certificate of Need review. For example, how can the Local Advisory Boards review and make independent assessments of Certificates of Need if the analysis of need is conducted by the State staff and no exceptions are allowed?

CR-5 addresses the State Health Planning Board:

In order to allow for sufficient provider and consumer representation, there needs to be a further consideration of the number of seats allocated to government officials. There is concern that the proposed structure would limit provider input significantly.

CR-6 addresses the role of the Health Care Administration Board:

The State Health Plan, as other issues reviewed by HCAB, must be subject to a public comment period.

The Board should be required to respond to all comments it receives in a public meeting.

The next section addresses the Certificate of Need Reform and again references the State health planning CR-7:

As I stated previously, waivers to the State Health Plan should be permitted. Providers must be allowed to submit Certificates of Need for services that are not identified as "needed services" without the requirement that the State Health Plan be revised prior to their review. There should be a mechanism in place to concurrently grant a waiver to the State

Health Plan for the specific situation and review of these projects. These waivers and proposals must be handled on a case-by-case basis.

Local health planning, if it continues to be funded, should provide input into developing the State Health Plan.

CR-8 addresses the role of the Commissioner:

The roles of the Commissioner of Health and HCAB in the final decisions to grant or not grant Certificates of Need needs to be clarified.

CR-9 addresses appeal rights:

We support the affirmation of the applicant's appeal rights and believe it is essential that applicants who are denied a Certificate of Need have the opportunity to appeal the Commissioner's decision under the current process.

The next subsection addresses the Certificate of Need Application.

CR-10 specifically references the definition of a health care facility. In support of this recommendation we believe it is appropriate that Certificate of Need requirements be determined by the type of service, as opposed to by facility ownership.

CR-11 addresses Certificate of Need thresholds:

It is appropriate that Certificate of Need thresholds be raised; $1 million, we believe, is appropriate for major movable equipment. However, the construction threshold should be higher. One-and-a-half million was the figure which was recommended in an earlier draft of the Certificate of Need regulations.

CR-12 addresses the annual cap on capital projects:

Limiting capital dollars may be necessary. However, an annual cap may lead to inequitable considerations of competing projects.

It is critically important, if there are to be caps, that there be an equitable process for allocating capital among

competing projects. This process should specifically address both the need for some facilities to expand in response to population growth and others to expand in response to needed renovation and modernization of facilities, without necessary expansion in order to remain competitive.

We are greatly concerned that caps may unfairly postpone needed maintenance of the State's health system infrastructure, increase future costs because of deferred construction and renovation, and may result in New Jersey facilities being less competitive with New York and Pennsylvania facilities.

Provision should be made for hospitals to build equity as an alternative to debt financing.

CR-13 addresses the Department of Health review and categorization of providers by plant conditions:

We believe health care providers cannot be categorized based on facility age alone. Also to be considered in capital prioritization are the types of services provided, populations served, potential for growth in demand, and institutional mission.

Providers must have input into developing the criteria which will serve as the basis of how projects are to be prioritized.

Prioritization must be reviewed on a per-project basis.

CR-14 addresses the elimination of the 1991 capital batches, which has already been put into effect:

We feel that any moratorium could have serious negative consequences for the State's health care industry especially because the experience in New Jersey suggests that any moratorium is likely to last longer than one year.

CR-15 addresses the Department of Health being given authority to decertify paper beds:

We believe that adequate regulatory authority already exists for this purpose.

CR-16 addresses the Certificate of Need Period of Implementation:

We believe that varying the period of time for which a Certificate of Need is valid according to the type of project is a positive change.

Terminating Certificates of Need not implemented within the regulatory time frame should not be permitted without the applicant being given the opportunity to request an extension, as significant resources may already have been invested.

It is unclear from these recommendations also, as to what specifically constitutes "implementation."

Finally, CR-17 addresses physicians prohibited from referring to services in which they have an investment interest:

We see this as seriously counterproductive. It would inhibit, if not preclude, the development of joint ventures which would reduce demands for hospital borrowing, spread risk, and provide a means to cost-effectively and quickly respond to emerging needs. We believe that full disclosure of interests and providing information on alternative services should be sufficient.

This concludes the comments from the Health Care Planning and Marketing Society of New Jersey. Thank you for the opportunity to comment, and I'll be happy to answer any questions.

ASSEMBLYMAN McGREEVEY: Rebecca, what's left of the Reform section in the report? (laughter)

MS. WOLFF: I think I've covered about everything.

ASSEMBLYMAN McGREEVEY: Are there any recommendations that you support?

MS. WOLFF: Yes, there are.

ASSEMBLYMAN McGREEVEY: Okay. Just one technical question. You said in CR-15 that you believe that DOH has regulatory authority to decertify paper beds. Do you have a cite for that? I mean, DOH evidently doesn't believe that.

MS. WOLFF: Through the Certificate of Need process there are-- There's an opportunity for the Department of Health to look very closely at utilization levels vis-a-vis licensed bed capacity. There is also a--

ASSEMBLYMAN McGREEVEY: For existing Certificates of Need that have already been granted, what power does DOH have to certify paper beds now?

MS. WOLFF: I believe that it is limited to the Certificate of Need process.

ASSEMBLYMAN McGREEVEY: Okay. So I think what their concern is, is that if the hospital does not have a pending CN, how do they retroactively -- if they're not moving on a paper bed -- address that question?

So, thank you very much for your-- Assemblyman Felice?

ASSEMBLYMAN FELICE: Just briefly, one of the recommendations I think is very important, is that the Local Advisory Boards be a part of the State planning, because many times it ends up saying, "Well, let the State do it," and they have a particular need in that area, whatever it might be. And they had both the demand, and they have also the ability to work in that area to give advice to the State planning group. And the Local Advisory Boards are a very important part of health care in the community, and I think they have to be included in this. I agree with you there.

MS. WOLFF: I would have to agree. I think the Local Advisory Boards are most in tune to the needs of their particular communities. And also, the local advisory review forum provides an opportunity for input from area providers and affected parties. I think we'd need to see that addressed in some way, shape, or form without them, but we hope they would continue.

ASSEMBLYMAN FELICE: And they're more geared to give the support that they need, not only just for financial and zoning, but other things that are important to that community.

Where, if a State agency comes in, right away everybody's looking and saying, "Let's hold back a minute." But a Local Advisory Board is in tune to getting the type of support that they need to even put a State facility in there, and that's important.

Thank you.

ASSEMBLYMAN McGREEVEY: Thank you, Assemblyman. Thank you very much, Ms. Wolff. I appreciate your taking the time.

Dr. Thomas Terrill, Executive Vice President of the University Health System of New Jersey.

T H O M A S E. T E R R I L L, Ph.D: Assemblyman McGreevey and members of the Assembly Health Care Policy Study Commission, I appreciate your providing this opportunity to comment on the recommendations of the Governor's Commission on health planning.

I'm Dr. Tom Terrill, Executive Vice President of the University Health System of New Jersey. We are a consortium of eight of New Jersey's leading academic and teaching hospitals and the education network of the University of Medicine and Dentistry of New Jersey.

I intend to address the issues raised by the Commission in regard to regulatory reform. Specifically, the Commission identifies areas of particular concern:

* the lack of a level playing field among all providers through the Certificate of Need process;

* low Certificate of Need thresholds;

* limited attention to the affordability of capital investments;

* uncoordinated and limited participation of the citizenry in the health care planning process.

I would like to address those areas in that order. We support the recommendations of the Commission in regard to leveling the playing field and increasing the CN threshold. The lack of a level playing field among all providers through

the Certificate of Need process should be remedied. This is particularly true if the thresholds for Certificates of Need are raised to an appropriate level.

We believe that level should be $1.5 million, or 10% of the facility's operating budget. At this amount, construction would be included while most equipment -- such as CT Scanners -- would not require review. This would simplify and streamline the Certificate of Need process, while making it more equitable since all health care providers would be required to proceed through the same process.

With regard to affordability of capital and annual caps, the Commission proposed an annual cap be established for a period of five years and be incorporated into the State Health Plan. University Health System of New Jersey understands the Commission's concern about the costs that "bricks and mortar" add to health care.

Nevertheless, a restrictive annual cap could have a devastating effect upon the health care system. Before an annual cap is established, we recommend that the following matters be reviewed, and that these questions be answered:

* What expenditures will be included in the cap, i.e., will refinancing be included? If it is, that's foolish. Refinancing lowers costs.

* What priorities will be established, i.e., will plant conditions and age of buildings take priority over the development of regionalized services? Perhaps they should be considered separately, and separate caps established.

* Who will make the decisions regarding the size of the cap and the determination of priorities? What role will the New Jersey health care Facilities Financing Authority have in helping to establish that cap? What kinds of input will be provided by the health care industry vis-a-vis the Department of Health?

* Can an annual cap realistically be established for a five-year period of time? I think you know the answer. No.

* What impact will the annual cap have on the State Health Plan?

In order to properly plan for the future needs of our health care system, it may be preferable to establish several annual caps, one for refinancing, one for regionalized services, and one for construction. This would allow the planners and regulators more flexibility and provide some assurance that needed regionalized services and construction are not held hostage to refinancing and plan modernization.

Just as a sidebar, a recent friend of mine passed away of cancer at 55 years of age, in the middle of winter, in one of New Jersey's leading hospitals. And in the oncology unit that I was in, the snowflakes were coming through the window, because they had not had the money in their payment system to retuck and repoint the facility. New Jersey hospitals are deteriorating at a rapid rate by comparison to those in the midwest and the far west, and I think you heard from Mr. Holzberg about that this morning. Sorry for the personal observation.

Participation: Finally, the Commission is seeking to address increasing participation of the citizenry in the health care planning process. To accomplish this, the Commission recommends a State Health Plan be reviewed annually. Local input would be sought from Local Advisory Boards. The State Health Plan would be the basis upon which Certificate of Need applications are reviewed.

Our concern here is with the timeliness of a process that has the potential to be unduly cumbersome, unresponsive, and slow. For example, the State Health Plan may take two to three years to be developed if it is to be truly comprehensive, and to receive input from the Local Advisory Boards. Once completed, the data used to create the plan are already a few

years old. A provider seeking to offer a service or undergo construction may have been delayed two to three years while awaiting the completion of the State Health Plan.

As a sidebar, construction costs are going up at a rate of anywhere from 8% to 12%, depending on the region you're in in New Jersey. That adds 36% to the cost in a three-year period.

If the provider is eventually successful in receiving all approvals through the Certificate of Need process, what are his options if the annual cap has been reached? Will he be required to start back at step one of the CN process the following year?

In terms of providing greater participation of the citizenry, we at UHSNJ applaud the effort. However, unless the Local Advisory Boards have the right to appeal should the Commission act contrary to the recommendations, it is not clear to us how successfully the Commission has addressed the issue of greater participation.

CON issues: In reference to the Certificate of Need, I would like to comment on specific areas of concern. First, core teaching hospitals. The primary teaching hospitals of UMDNJ -- University Hospital, Robert Wood Johnson University Hospital, Cooper Hospital/University Medical Center, and Kennedy Memorial Hospitals-University Medical Center should be excluded from the Certificate of Need process. The core teaching hospitals of New Jersey's medical schools must have access to technologies and services in order to fulfill their missions of teaching clinical care, and clinical research. Exclusion from the Certificate of Need process will foster the development of a preeminent statewide health sciences University and position New Jersey to halt the exodus of patients to other states.

Decertification of paper beds and specification of the time frame for implementing a Certificate of Need should be

appealable. In both of these areas, circumstances beyond the control of the hospital may interfere with full bed usage or implementation of Certificates of Need. Appeals reduce the likelihood of arbitrary and unreasonable decisions.

In conclusion, I believe the Commission has done a remarkable job of sifting through very complex issues and developing recommendations to address the problems facing the health care system. However, before implementation of the recommendations, I respectfully suggest further study and clarification are needed on three issues:

* The Annual Capital Cap -- the scope and potential impact of the annual cap on the health care system.

* Scope and Time Frame -- of the scope and time frame development and implementation of the State Health Plan.

* Exceptions and Appeals -- exceptions and appeals to the Certificate of Need process.

University Health System of New Jersey stands ready to assist the State in developing a more equitable, efficient, and effective health care system. We would be pleased to serve as advisors or committee participants to assist the State of New Jersey in resolving the complex problems related to providing health care to all New Jerseyans.

Thank you.

ASSEMBLYMAN McGREEVEY: Thanks, Tom. Tom, if you have specific language that University Health Systems has regarding the annual cap, scope, and time frame, and how the execution of bill process would work, I just ask you to forward that to Robbie. (referring to Committee aide)

DR. TERRILL: I will do that.

ASSEMBLYMAN McGREEVEY: The only thing is, that's what I'd appreciate, especially on the point that you raised on the annual capital cap. The other thing is, realistically, I think we have to be mindful of the unique role of the University Health System. I don't see, necessarily, a removal of them

from the Certificate of Need process, but I think we have to look at how do we make them unique in the process such that we encourage them to continue to be premier institutions. Specific language and suggestions in that regard would be helpful.

DR. TERRILL: We will do that.

ASSEMBLYMAN McGREEVEY: I mean, how, keeping them within the CN process, do you--

DR. TERRILL: We have a suggestion with regards to keeping them in the CN process. If that has to be the ultimate decision for fairness, we would accept that. We also have a process and mechanism that could be used to guide the SHCC, or whatever group is in charge of that planning process, so that the new technologies that are being developed by our own pharmaceutical industries and biomaterials industries in this State can be readily and quickly applied without an onerous and bureaucratic delay. That's what we would speak to, and it would involve both activities on the part of the deans of the respective medical schools or health sciences schools involved, and the Local Advisory Boards and the hospitals involved -- if the hospitals were involved, and sometimes they won't be.

ASSEMBLYMAN McGREEVEY: Do you have a specific language, or whatever? You could forward that to Robbie.

DR. TERRILL: I will forward that.

ASSEMBLYMAN McGREEVEY: Assemblyman Felice?

ASSEMBLYMAN FELICE: I think one of the really important points you made is about the exemption to our teaching hospitals. Many of our best and brightest are going out-of-state. Consequently, they have a tendency to stay there, where we need them here in our urban and rural areas. And I think that's a very valid point. We just -- in the last five to eight years -- started to really build up our teaching hospitals where we have some of the finest technology being administered there. I think that's a very valid point because we never get them back when they go out-of-state, it seems.

DR. TERRILL: Assemblyman, you're absolutely right, and if you train them at home, they'll stay at home.

ASSEMBLYMAN FELICE: Except they all come back to you, after college and all, for a brief period.

DR. TERRILL: For a brief period. Other questions? (no response)

ASSEMBLYMAN McGREEVEY: Thank you, Tom. I appreciate it.

DR. TERRILL: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much, Dr. Terrill.

At this time I call upon Ed Peloquin. Mr. Peloquin is Executive Director of the Central Jersey Health Planning Council. Ed?

E D W A R D J. P E L O Q U I N: Good morning, and thank you for this opportunity to focus on, I think, the one part of the Commission Report that I understand was pretty well agreed to early on in the summary. The rest of the concentration of effort has been obviously on the uncompensated care issue and other issues. But it's this early agreement to the Commission Report that gave me a lot of encouragement and to reserve my remarks to this particular point in time.

There are two things in the presentation that is now before you. One you'll notice is not on the Central Jersey Planning Council letterhead. There's a specific reason for that. Our Board of Directors, except where I'm going to note, has not adopted these comments. These are my recommendations. It will be going to the Board of Directors at their December 19 meeting. So that's the first point you need to know.

There are two other things that are in the background before I start the presentation. One is that the presumption that I had coming here today is that there would be an orderly transition between the current system and the new proposals over a period of -- whatever time is appropriate -- one year or

two years. And the mechanics will be decided largely by the State Health Planning Board, in concert with the local and State officials. So in that regard, my comments are not to the mechanics, and I do agree with many of the predecessors in terms of mechanical issues that have to be dealt with, time frames, and who sets certain policies.

The following comments, though, are relative to the Regulatory Reform recommendations by the Governor's Commission on Health Care Costs and are based on the following goal of making health care affordable by the efficient allocation of facilities, equipment, and manpower, improved productivity in the delivery of treatment, diagnosis, and care, and promotion of prospective price competition. Now those three factors go into all of my recommendations, and the recommendations will be going to my Board.

The first Commission recommendation is: The State Health Plan should be developed. I'd like to point out that for selective services and facilities, the concept articulated in this recommendation is being partially implemented via categorical regulations now. The trauma center regulations, the cardiac surgery, and the inpatient comprehensive rehabilitation regulations are already in place and become sort of a mirror image of what a State Health Plan would be like. The recommendation expands the concept to all health care facilities and services covered under the current statues in the Health Care Facilities Planning Act. This has merit and should be pursued, in my opinion.

The second recommendation would be CR-4. The planning process should be governed by a new State Health Planning Board, Local Advisory Boards, and a State Office of Health Planning. I'd like to point out that for the fourth time since the demise of the Federally financed health systems agencies in 1986, it has been concluded the public's right to know and have some say in the orderly and acceptable development of health

services is best served through the existence of local health planning. And to that end, I put two attachments to the remarks. One of the attachments very clearly points out my belief that the existing new State law passed in 1987 should be utilized immediately to implement the Local Advisory Board Recommendations. We've had the statute reviewed in light of the Commissioner's recommendations, and it's pretty clear that all of the elements that provide autonomy, that provide the degree of independent action -- yet within the control of the overall development of the plan -- and that provide the ways in which to decide the areas, are embodied in the statute already, and there should be no need to create a new statute to have Local Advisory Boards put into place. This could be used and was designed that way a long time ago.

ASSEMBLYMAN McGREEVEY: So you're saying, Ed, this '71 Planning Act--

MR. PELOQUIN: That's correct.

ASSEMBLYMAN McGREEVEY: --addresses the need for LABs or the equivalent?

MR. PELOQUIN: It was LABs. It's called the Statewide Local Health Planning Program, which means you could title the local entities LABs or PDQs, but it specifies in there -- and this my Board did approve -- that the Commissioner establishes the program, that the areas are designated--

ASSEMBLYMAN McGREEVEY: And you were lost, basically, to fund it.

MR. PELOQUIN: Pardon me?

ASSEMBLYMAN McGREEVEY: And you were lost, basically, due to funding.

MR. PELOQUIN: This requirement of this Act said we should be funded at 12 cents per capita.

ASSEMBLYMAN McGREEVEY: Yeah.

MR. PELOQUIN: The prior administration, only at the continuing reassurance of the Legislature, provided funds at

about three cents per capita, and therefore the functions that were assigned were limited to what three cents could do, which was a very narrow Certificate of Need. The planning that was anticipated in this law, and the other aspects anticipated by the Governor's Commission, obviously cannot be implemented. But the concepts of a private, nonprofit corporation, the duties and functions being specified within the context of the State Health Plan -- and the provisions of legal protection which you talked about earlier from suit for their actions -- all this is embodied in the statute already. It's a matter of administratively implementing the statute, and I think the attorneys that represent the Legislature will conclude on that as well. We did some checking back again, to make sure.

Our point being, that this could be moved very quickly, and I think that, also related to that, we did attach another recommendation that goes directly to the issue that we saw in 1987 -- the Uncompensated Care Fund --that no one, and I mean no one, really monitors access to health care services through the Uncompensated Care Fund.

And we have proposed, in this legislation which was not funded by the Department or by the Legislature, a whole series of criteria on how the Local Advisory Boards would monitor that access, and at this time you would not be asking the questions we're hearing. We would have been able to have those answers: if it's really working, who's getting the care, how they're getting the care, and so forth. That should be a function of the Local Advisory Board, as well as the additional public information, the consumer information which, by the way, I supported, by handing you a sample of recent press clippings that show that health planning is in the news at the local level. And, we make impact. We are there every day, day to day, on these items here. Much is not maybe seen by the departments of government or even the Legislature with their other duties, but we're there every day, and this kind of education and information is what builds public confidence.

Let me continue on to CR-5: The State Health Planning Board should be established, etc. A comprehensive State Health Plan requires a comprehensive mechanism to assure that access, quality, and cost are balanced when developing the State Health Plan and deciding on Certificate of Need applications.

And obviously, we would expect the Governor's appointees there to represent members of the industry, as well as the consumers that are required to balance that Board in terms of the Commissioners.

It is strongly suggested that the rule-making functions, however, that are currently in the Health Care Administration Board, be included in the new State Health Planning Board. This would bring efficiency to the regulation development process which is now a very multiple step, complicated process. To illustrate, we get a draft of an idea, of a role that starts in a subcommittee, the State Health Coordinating Council. I've had input at the State Health Coordinating Council phone structure. It then goes to the Department of Health, goes back to the Health Care Administration Board, goes out to public comment, comes back in with public comment, goes to the promulgation of rules, and is finally adopted.

What happens is that all that time taken up, the amount of intensity of information and data provided, escalates along with the time frame. So when the rule is being developed we get concept, we don't get the full testimony, or the full force of the associations of the State or the individual hospitals. They're waiting to see what comes up. By the time it gets to the Health Care Administration Board, you've got a very controversial, complicated process, and the rule-making process then takes on a whole different meaning to where rules are even changed from the intent because the data and information that should have been there at the beginning of the process, is only there at the end of the process. And we're

talking about months and months and months of getting rules through. There's no reason for that with a good comprehensive State Health Planning Board process.

This will allow timely changes in reimbursement also. And, more importantly, merge the determination of need with reimbursement policy development. The reimbursement policy development would, in effect, result in a new system which I would call the Certificate of Affordability. I mean, that's what we're really talking about here. Certificate of Need and feasibility is what we've been dealing with in the past. They're needed, they're feasible, but they're at a price and no one is asking if they're affordable when they're really approved. I think we've got to bring the rate setting and the Certificate of Need function tighter together and ask that question as well. I think you could be doing this by bringing more of those Health Care Administration Board functions under the State Health Planning Board.

CR-6: The State Health Plan and each service regulation should be adopted by the Health Care Administration Board and have the force and effect of law.

This is a duplicative and inefficient way to establish the State Health Plan. The State Health Planning Board should be the final authority. The Commissioner of Health should manage the State Health Plan implementation. What we're talking about in that recommendation is exactly what I'm talking against in my comments on CR-5. The State Health Planning Board itself does not need to be overviewed by the Health Care Administration Board.

In general--

ASSEMBLYMAN McGREEVEY: Can you say that again, Ed?

MR. PELOQUIN: The State Health Planning Board does not have to have the overview of the Health Care Administration Board. What this does is, it says the State Health Plan and each service regulation should be adopted by the Health Care

Administration Board and have the force and effect of law. If you put the rule-making authority in the State Health Planning Board, you don't need to have another board going over it, after all the work, and we're talking about strengthening local input, so we have the Local Advisory Boards coming in, the provider process of that level-- Do you understand the point? And then you put it out to here-- It doesn't make any sense.

Item 7: The State Certificate of Need activities should be directed by the State planning process.

In general, this recommendation reinforces the importance of the State Health Plan and the necessity for all providers, especially physicians, to fully participate in its development. My one concern is with the Department of Health staff analysis as noted in the Commissioner's recommendations. To avoid predetermination on any one application prior to the completion of the review process, the staff analysis should be limited to findings of fact with regard to compliance with applicable regulations, licensing standards, and construction requirements. No conclusions should be issued as to need and affordability. These conclusions should only be reached by the Commissioner of Health after the review process is completed. And it's silent in there, in that it appeared that staff analysis would actually be directing the Board's decision when it should not.

CR-8: Reviewing applications and recommendations of the recommending bodies. The Health Care Administration Board should be the body that decides on appeals submitted by a denied applicant, the State Health Planning Board, or the Commissioner of Health application decisions and administrative rulings. I see that as a very viable road to appeals and they have the expertise to do that.

CR-9 deals with the regional recommending agents on matters related to Certificates of Need; the LABs should not have an appeal right; and should the Commissioner act contrary

to recommendations. Under the current statutes of Certificate of Need, the LABs, if formed early as planned, will still have appeal rights. However, if the process as designed by the Commission's Report actually works, I don't believe those appeal rights will be necessary down the road. Because, in effect, what I'm saying is that the amendment to the State Health Plan is where all the action should be.

We're doing this right now with trauma regulations. We're doing this right now with rehabilitation regulations. We're back to the State Health Planning process to free up the regulations so we can get another trauma center in the Mercer County area; for example, redistribute the rehabilitation beds fairly. That's an open and fair process, free of a lot of legal entanglements, a lot of dollars being spent, and a very, very productive process in the outcome. But, until that's in place, then the appeal rights should be made. But if that comes into place, the appeal rights would-- No, that should be necessary for the LABs.

However, in the recommendation of the Commission Report, I have a problem. The role of the Public Advocate is too broad. If they represent the State Health Planning Board it should be subject only to determination. The appeal is not allowable as a matter of legal procedure. The merit in public interest is a decision only the comprehensive judgment of the State Health Planning Board can be relied upon to decide. A better approach is to have a Deputy Attorney General assigned to the State Health Planning Board. The way this recommendation reads, it places the Public Advocate as almost the sole decision maker on merit, on the matter of public interest in terms of whether appeals should be handled or forwarded. And in my experience with the Public Advocate, that point of view does not necessarily represent the point of view of the general public in dealing with health care matters. And that would be an inappropriate use of the Public Advocate.

ASSEMBLYMAN McGREEVEY: Do you understand how it works, though, Ed? Basically, the Public Advocate is making a decision whether or not the State Health Planning Board has merit and then represents them.

MR. PELOQUIN: I understand that, and what I'm saying is merit, when you come to an appeal -- and I've served on many appeals, and I've won all but one when we appealed the State-- When you get into the issue of merit and legal process, there's a fine line of judgment here. And many, many times, what the State Health Planning Board may determine is merit for an appeal, is not a legal question. It has merit because it makes sense in changing the health system or because the State Health Plan didn't work and we need to have a facility.

ASSEMBLYMAN McGREEVEY: But I don't think there's a problem with the AG's Office. The AG's an assigned separate advocacy role; if anything, it would defend the institutional posture.

MR. PELOQUIN: Well again, I take this from many other states where attorney generals are assigned, and they can handle the management of an appeal very well if they are separately assigned and operated than a certain public advocate. And then they're only dealing with the legal questions, whereas the body makes the decision on the merit--

ASSEMBLYMAN McGREEVEY: Because the AG's Office also represents the Department, and I think there was a concern of a conflict of interest. On one hand they're representing the Department, and on the other hand they're representing the planning board and the appeal-- It just-- You'd have two AGs looking across to each other.

MR. PELOQUIN: I've heard that argument before and we get involved in those things from time to time as it is. My only concern really is that the Public Advocate cannot override the State Health Planning Board when it wants to appeal, except if there's a legal technicality that says it can appeal.

ASSEMBLYMAN McGREEVEY: Well, I agree with that.

MR. PELOQUIN: But the way it seems to read that merit and public issues--

ASSEMBLYMAN McGREEVEY: I see what you're saying. Okay, so that should be clarified.

MR. PELOQUIN: That's right.

CR-10, the definition of health care facilities, should be changed--

ASSEMBLYMAN McGREEVEY: Ed, I'm sorry. Could you send Robbie clarifying language on that CR-9 as to the appeal procedure?

MR. PELOQUIN: Sure, no problem.

ASSEMBLYMAN McGREEVEY: What you'd like to see? Keeping the Public Advocate as the representative, but concerning what constitutes legitimate meritorious appeal.

MR. PELOQUIN: We have a rough draft of that in my office.

ASSEMBLYMAN McGREEVEY: Good. I'm sorry for interrupting.

MR. PELOQUIN: No problem.

CR-10: The definition of health care facilities should be changed to include under Certificate of Need requirements, any service which is the subject of a State-adopted Health Planning regulation. My suggestion there is, "subject of a State Health Plan," as opposed to a regulation. I think the State Health Plan is where you bring it all together and not a separate independent regulation.

CR-11: The thresholds for major movable equipment should be left at $1 million. That appears to be reasonable provided items affecting safety and routine operations, like telephone systems and computer systems, that even are above that level, are processed only as administrative reviews.

The Certificate process can really get pretty sophisticated in that regard and the figure $1 million

represents to the public, a lot of money. It's a lot of money to me, anyway, $1.5 million, $2 million. I mean, those things-- I don't think the Certificates of Need are going to affect, as some people have claimed, the ability of hospitals to move ahead, because most of the items that they need to move ahead on are already exempted from that kind of process.

CR-12: There should be an annual cap on capital projects. It appears this recommendation is directed at the acute general hospital component of health care delivery. It is suggested this include psychiatric hospitals and related inpatient beds. The use of an annual cap for hospital bed additions, and/or modernization/renovation, appears to be the best way to prospectively address affordability and foster price competition, while assuring medical care quality and appropriate access. For instance, with a cap, judgments would have to be made among competing proposals. The proposals that provide the expected quality at least price, with greatest access, should receive the highest priority for the year. This would eliminate projects that are costly, but without direct measurable benefit in terms of access or quality of treatment, diagnosis, and nursing care.

ASSEMBLYMAN McGREEVEY: Hard question: How do you do that?

MR. PELOQUIN: I think, believe me, there has been a whole outline of a process and safeguards put together, back about seven or eight years ago, on how to do that, which I have in my files.

Obviously, there are two key questions: First, the $200 million is too low. The figure has to be substantially higher than that, and it has to include several of the other factors that we heard mentioned earlier today. However, the setting of that figure is going to be as important to the State Health Plan process, as we require the same kind of input. But it has, then, a reasonable approach to it. Because you're

going to hear the input of the needs of the inner city, the suburban areas, the growth factors, and you're going to decide reasonably with that process. Setting the cap cannot be done arbitrarily by a Commissioner setting the numbers; it should be up to the State Health Planning Board, essentially, where the process goes.

However, what you have to know of the current process is that the current review process does not allow a compared review of long-term need and benefit, nor the criteria detailed enough to distinguish between those items which improve productivity and those which primarily enhance the image of the facility.

For example, a few years ago they started a process of setting a certain amount of dollars per adjusted admission. It would be a cap or a limit on an individual application. There was no regionwide or statewide total aggregate cap, but per application. So there is, in effect, a cap of sorts already in place. When it was believed by the hospital industry that a cap would be fixed for two or three years -- and at that time it was something like $295 or maybe figure a little less than that -- projects that were submitted, and were above that cap, suddenly got reworked in the Certificate of Need process. And we've had a lot of deferrals and recommendations to bring the project underneath that cap.

However, subsequent to that process, the last administration then began to change the cap annually, or periodically, and we suddenly saw that second look at the hospital and the patient disappear, and we're seeing approvals way above the caps starting to come in on a hospital-to-hospital basis. The point being, if the cap is realistic, I'm convinced the hospitals will find a way to meet their responsibilities of access, to provide quality, but be more productive. We had nothing to force the institutions to be more productive. They all claim productivity and efficiency,

but I'm talking about really hard line productivity as recommended by the National Commission a few years ago, which we know the hospitals are not generally looking at, at this point in time, in a prospective sense.

Operationally they're trying to go through this cap and this cap is the issue we're having.

CR-13 concerns the review of statewide plan conditions and develops categories of priorities in order to establish the cap. This is essential and must be done prior to establishing the annual cap.

CR-14: In order to allow sufficient time to develop the above, and to eliminate a potentially counterproductive window, the capital batches scheduled for January and July should be eliminated. Agreed. This is necessary for an orderly process to determine the annual cap. Please note, elimination of this capital batch for 1991 would reduce the total annual number of CN applications by only 10% to 15%. Now it will reduce the amount of money by 40% to 50% in total dollars, but still we're talking over 200-and-some-odd applications going through the system starting in January and going through next year.

CR-15: The authority to decertify paper beds based upon the utilization of those beds over time. This must only be done if called for in the State Health Plan. It cannot be done ad hoc. Often, proposed bed reductions have been submitted with major modernization/conversion/renovation projects to meet the current utilization standards that, if not met, can lead to a disapproval. Consideration is not usually given to the longer term need and impact served on the area by two or more hospitals.

I won't spend the time, but I could give you case examples where the beds were reduced, but we know two years from now they're going to be opened up again. They have to be opened up again. There's no way to deal with that. So in the State Health Planning process, it can be dealt with.

CR-16: Each Certificate of Need issued should have a discreet period of time for implementation. The time periods I recommend are:

Hospital, $10 million or greater -- 3.5 years,
Hospital, less than $10 million -- 3.0 years,
Nursing Homes -- 2.5 years,
All other -- 2.0 years.

But now, here's a little twist: Should a project request an extension of time beyond these limits, the Certificate of Need should be submitted to the LAB for public review of the reasons for requesting the extension. The LAB recommendations would go directly to the Commissioner of Health, a very expedited quick process.

I want to emphasize that this process works. In the two or three times we had the opportunity to use this, there has not been one applicant that chose to appear in public to defend their project, and every one of those projects was implemented. The minute they could deal with the bureaucracy and behind the scenes and state a lot of good reasons, we had applications going five and six and seven years unbuilt but holding out the approval of needed applications of that money to bill. We can prove those things. That's the point.

Seventeen, we have no comment.

And I have one final point to make: I think it's the obvious point that, in all of the years of health planning in this State which I've been involved in, and particularly since 1986, we have been scrutinized and scrutinized by the Legislature, by the bureaucracy, by the public, and for four times in the last five years, local health planning is valuable and needed and necessary. I wonder if that kind of scrutiny put on the Uncompensated Care Fund would have helped alleviate those problems, but at the same time, the Uncompensated Care Fund goes out December 31. At the same time, what you say you need disappears December 31 also. The funding is zero.

And, gentlemen, wherever-- We know we have a promise from the Commissioner of Health to do something about that, but I have these decisions to make December 3. Somebody better do something about it pretty quick, or we lose about $75,000 for outstanding assets that are going to have to be sold off. We have no place to house them -- not just our agency, but the other agencies -- and you're going to end up spending between $75,000 and $125,0000 just in basic assets for the Local Advisory Boards to restart them, plus all the lost time. Transition is in order and that's the obvious point I would make--

ASSEMBLYMAN McGREEVEY: Has the Commissioner addressed that concern, Ed?

MR. PELOQUIN: We have the letter. The Commissioner says she agrees that transition is in order. We have made a grant application extension request; we do not have a decision yet from the extension funding. We are prepared--

ASSEMBLYMAN McGREEVEY: And you've submitted a request for extension funding?

MR. PELOQUIN: October 1, to the Commissioner of Health. We got a letter back in November saying that they agree that the transition is in order and will keep us informed as things develop. My point is, we're now going into December 1.

ASSEMBLYMAN McGREEVEY: Could you send a copy of the October letter and the November response to Robbie?

MR. PELOQUIN: I'll be glad to.

ASSEMBLYMAN McGREEVEY: Thanks. And in addition to that, could you also set forth your response to CR-12 as to-- You said you had something along the lines to discern what proposal produces the greatest response with the least price, greatest access, highest priority. If you have some sort of guidelines, it would be helpful if you could just send those to Robbie.

MR. PELOQUIN: We have those.

ASSEMBLYMAN McGREEVEY: Assemblyman Felice?

ASSEMBLYMAN FELICE: I think he made some very valid points which we talked about.

ASSEMBLYMAN McGREEVEY: Thank you, Assemblyman.

Thanks, Ed. I appreciate it.

Now at this time I'd like to call upon Stephen Fillebrown. Thanks, Stephen.

S T E P H E N M. F I L L E B R O W N: Thank you for the opportunity to testify. I do have a written report which I'll hand out at the end of my remarks, but what I want to do, in my oral remarks, is hit some highlights for you right now.

Very briefly, the financing authority is a quasi-public agency that was created by an act of the Legislature in 1972. Our mandate is to ensure that the State has modern, well-equipped facilities at reasonable cost to the citizens. Basically we do that through the issuance of tax-exempt bonds. The interest rate that hospitals pay on those bonds is typically 2% to 3% less than they would pay through other sources. That lower interest rate translates into lower health care costs to the consumer.

We have a seven-member board: Three ex officios, the Commissioner of Health, who serves as Chairperson, the Commissioner of Human Services, the Commissioner of Insurance, and four public members.

The basic role of the agency is to provide that the financing, as Commissioner Dunston noted-- There's about $5 billion in debt outstanding for health care in this State. Actually, it's probably closer to $4 billion, but whatever the amount is, it's in our name.

At our testimony in May before the Governor's Commission, we talked about how the investment community views the State and the system view that the investment community takes for New Jersey. We have a fairly detailed system of

planning regulations, rate-setting regulations, and oversight agencies. These regulations present a trade-off to investors.They see some good things. They see the Uncompensated Care Trust Fund. They see an all payer system, at least in name, and the protection from the Medicare cost reductions. They see a lot of oversight. They see the power of the Rate Setting Commission to address hospitals' specific and statewide problems. And they see a fairly detailed planning process.

On the negative side, they see very limited profitability. They see low cash reserves at the State's hospitals and they see a reliance on debt financing much higher than you would see in other states. They also see a complex system that creates timeliness problems. They also see a system that goes through frequent changes which create uncertainty; changes generally bad for the investors.

On the whole, though, the investment community has taken a fairly positive view of the State. Right now, New Jersey is regarded as a relatively safe State for investment, which means lower interest rates, which translates, again, into lower health care costs for the consumer.

The planning process is a very important factor in that system view that investors have come to accept. The close scrutiny by the local and State planning agencies means that the project is more likely to be needed, more likely to be utilized and, therefore, less likely to run into financial troubles down the line. It also reduces duplication. They're less likely to be underutilized facilities. You know, four facilities on the block, all competing for the same patient base. Perhaps the most clear example of this is in our occupancy rates. I think Harvey Holzberg earlier alluded to us being the fourth highest. We have about an 82% occupancy rate nationwide. It's about 68%, so you can see some of the impact that planning has had there.

The basic result of the planning process, though, is that the projects that the Financing Authority sees are likely to be stronger projects, needed projects, more fiscally stable projects.

We did note some areas of concern in the planning process in our testimony before the Governor's Commission. We talked about a lack of long-term capital planning. Basically, projects are approved on an individual basis, on a reactive basis by the SHCC. The batching process which they've adopted in recent years has improved that so much that now hospitals are often competing against each other for the same services. However, we really haven't gone beyond a six-month cycle.

The Authority participates in the SHCC Review Committee deliberations. We're a nonvoting member and there are times when a project will come before the SHCC that looks good, is efficient, makes sense, but the SHCC can't approve it, because a project was approved six months ago that fills that need.

Moving the planning process to a longer planning cycle would alleviate that problem. We also think it would provide more assurance that the needed projects are the ones that get through. And, obviously, in that regard we are supportive of the Commission's recommendations for a Statewide Health Plan. We think that that offers more comprehensive planning, longer term planning, a less reactive process, and should result in even more fiscally strong projects.

A couple of points, there: One is that the more macro focus of a comprehensive State Health Plan can help the State concentrate on what it does better, which are the broader issues, the bigger issues, and hopefully take it away from some of the more micro, very hospital-specific Certificate of Need type regulations that tend to tie the system down. Generally, we think they do a better job when they're looking at the bigger issues.

We would also be very concerned that local input was provided in that process, otherwise, there is no assurance that the projects approved are actually needed.

The second problem we noted in the Certificate of Need regulations, is that they're provider based right now, not service based. So you can have the situation where the hospital has to get a Certificate of Need for the particular piece of equipment that another outpatient type provider doesn't. We think that that circumvents much of the original intent of the Certificate of Need and planning regulations, and again, we support the Commission's efforts there to make Certificate of Need regulations service based as opposed to provider based.

Something I don't think we talked a whole lot about in the Commission testimony, was that in 1987 and 1989, the HCAB approved a number of rate-setting changes that were essentially designed to reward efficient and well-utilized hospitals at the expense of inefficient and underutilized hospitals. The clear goal of those changes was to create pressure to downsize the acute care hospital system, and that's a goal that we think has a lot of merit. Basically what you can end up with is the same dollar supporting fewer but stronger hospitals; a situation when the hospitals are better, but the State doesn't have to pay anymore.

At present, there is no process for managing that downsizing. We think that that could create some problems if we go into a sort of unmanaged period of hospital closures and just general lack of planning as to how we want the system to look in a few years. We're not saying that hospitals should be propped up. We don't think that unnecessary hospitals should be supported. But what we are saying, is that there should be a process to manage that. And, I think that CR-46 addresses that to some extent. It's not a specific proposal, but it does indicate a clear intent that hospitals that find themselves in

fiscal trouble should be working with the Rate Setting Commission and the various planning agencies to identify the appropriate solution, whether it be some cost containment measures or, perhaps, merger conversion or closure. We would support any efforts that develop in that regard.

The last point that we made at the Commission hearing was that there was, to date, very limited financial feasibility analysis in the current planning process. There's a very thorough evaluation of need, we feel, but the financial analysis is somewhat limited. The problem that this creates is that a project can be deemed needed and be six months to twelve months down the road, comes to the Authority, and then we finally do the feasibility study and find that it's not going to be able to-- The revenues won't support the project. That's a very difficult situation to find yourself in. There's been a lot of support for a project by that point. There's a lot of momentum and a lot of expense incurred, and it simply can't go forward until we have a feasibility study that says it can be done. We would be happy to work with the SHCC or any successor planning board to identify ways that that situation could be addressed, possibly.

ASSEMBLYMAN McGREEVEY: Stephen, do you support the annual cap on the capital budgets?

MR. FILLEBROWN: To tell you the truth, in our written remarks we didn't even address the annual cap. As we read it, it was a cap on Certificate of Need approvals, not on financings done by this agency. If we've read--

ASSEMBLYMAN McGREEVEY: But it would ultimately, perhaps -- may have an impact, perhaps, on financing.

MR. FILLEBROWN: That's true, it would.

ASSEMBLYMAN McGREEVEY: And obviously, if you only have so many approved, you only have so many applications.

MR. FILLEBROWN: Again, we're not clear whether that's something that we should have a position on; whether we should

be saying how much the State could afford. It's not clear that that's the role of this agency. We would be concerned if it did affect refinancings. Those are undertaken to reduce costs. Obviously--

ASSEMBLYMAN McGREEVEY: Sure. I would just find it helpful, and I think we all would, if the Financing Authority could review that recommendation and formally submit what would be their recommendation as to the question as to an annual cap on capital projects. And then if so, what would it include? After the question discerning what should it include, what should be the threshold amount, considering the amount of financing that presently exists, both privately and publicly, under the Authority's jurisdiction?

MR. FILLEBROWN: Okay. I think on some of the more technical aspects there will be no problem. We can suggest numbers of ways that you could derive a cap.

ASSEMBLYMAN McGREEVEY: Sure. But I'd just be interested in if you have a policy since--

MR. FILLEBROWN: Okay. My guess is that our Board would be reluctant to do that, but we can raise it at tomorrow's Board meeting,

ASSEMBLYMAN McGREEVEY: Thank you.

MR. FILLEBROWN: There was one other point that I wanted to make about the current planning -- two other points actually. One is that we would appreciate some sort of formal notification in whatever planning process is developed of applications, so that we can start to do some capital planning ourselves. We need to know approximately what yearly demands are going to be for capital. We'd like to plan where we're going into the market, and have some idea of what the volume will be.

And also we've been, through the SHCC Review Committee, providing our comments on the appropriateness of financing assumptions, and also some comments on the financial

conditions of hospitals. That hasn't always worked smoothly.Sometimes our comments get in fairly late and it's fairly disruptive, so if there was some way that we could be put into the process a little bit earlier, I think our comments might be more constructive at that point.

ASSEMBLYMAN McGREEVEY: Have you submitted a letter to that effect to Commissioner Dunston, or to--

MR. FILLEBROWN: No, we haven't. We could do that.

ASSEMBLYMAN McGREEVEY: That might be helpful, or even you could do it to Commissioner Dunston pursuant to this conversation. If you could just copy us through Robbie, it would be helpful.

MR. FILLEBROWN: Okay. We have had a number of discussions, but nothing formal has been developed.

Another point that has come up in SHCC review meetings is the issue that, once a Certificate of Need has been granted, it's essentially a franchise to that provider that says "We are giving you the right to provide that service in the area," and as part of that franchise, we're essentially limiting other providers from offering that same service in that area. That's done in the name of cost containment, and we think that generally the benefits of cost containment have supported that idea.

The problem is that after granting a Certificate of Need, perhaps five years or ten years down the line, there may be another provider that could offer that service more efficiently. That new provider will not be able to get approval because the planning process will say, "Well, we've already got that service in the area. We know you could probably do a good job, but you know, the regulations say this is how many we should have, and we have that many right now." Perhaps there should be some consideration to periodic evaluation of previously issued Certificates of Need or perhaps previously reviewed batches. For example, a particular service

might be reviewed every five years or ten years, in which case even those with existing Certificates of Need might have to reapply to demonstrate that they are, in fact, the most efficient provider.

That's generally our comments.

ASSEMBLYMAN McGREEVEY: Thank you very much, Stephen.

Assemblyman Felice?

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: Thank you very much.

I'd like to call the distinguished Chairman -- I admire his courage -- of the Statewide Health Coordinating Council, his eminence, Ralph Dean. (laughter)

R A L P H A. D E A N: I'm humbled by that introduction. On behalf of the Statewide Health Coordinating Council, I'd like to express my appreciation to the Health Care Study Commission for the opportunity to speak before you today.

I am Ralph Dean. I'm the current Chairman of the Statewide Health Coordinating Council -- from now on the SHCC, for our purposes. The present SHCC consists of 34 volunteer members from all over New Jersey. They are mostly consumers of health care services with a minority of providers from a broad array of areas directly or indirectly involved in the provision of health care services to the citizens of our State. All members are appointed by the Governor to serve three-year terms.

SHCC is a middle step, if you will, in the planning process which consists of four local health systems agencies responsible for local citizen input into the process. The SHCC is responsible for a statewide perspective; the Department of Health for direction, staffing, and decision making; and the Health Care Administration Board for the promulgation of regulation and final dissolution of denied Certificates of Need. The local HSAs and the SHCC are advisory only to the Commissioner of Health.

The SHCC has, essentially, no staff of it's own, nor has it ever had, with the local HSAs having a single person or two at this time to do their work. I won't dwell on the local HSAs. I think Ed Peloquin has done a very fine job of doing that, except to say that they're an extremely critical component in our present health planning process and the SHCC strongly supports their continued involvement in the future as recommended by Governor Florio's Commission on Health Care Costs.

Your Commission is concentrating on three areas that I will touch on in my presentation: 1) The need for planning; 2) the development of the financing of a Statewide health plan; and 3) a review of the Certificate of Need process.

Needless to say, the SHCC supports planning, the development of a strong statewide health plan, and a review of the Certificate of Need process. In fact, we welcome your review. But much more needs to be said in order to effectively control the rising costs of health care in the future, because, as we have seen, our present system of planning and CN, by itself, only gets at a piece of the problem and not at the entire pie. If we don't take a broader view at what is causing our problem today, I am confident that little will be done in the future and we'll find ourselves here again in five or ten more years. Some of you may remember similar debates and discussions that go back to the late '60s and early '70s, and again in the late '70s and early '80s.

Our rising costs problem really began with the passage, in 1966, of Medicare and Medicaid legislation at the Federal level. For the first time in history, a large and growing larger segment of our population had access to health care services not available before, and, most importantly, services paid for by someone other than themselves, for the most part. Within four years, the debate was on how best to control the rising costs of health care. The answer at that

time was regional medical programs and comprehensive health planning -- both very separate and distinct programs -- one program dealing with education, and the other with planning and Certificate of Need for hospitals and nursing homes, primarily. No measurable objectives were set to determine effectiveness, but clearly these two programs were not doing the job.

In the mid '70s, regional medical programs were not funded any longer, and health planning legislation was passed to further strengthen health planning and Certificate of Need by providing more involvement on the part of the states and the creation of HSAs and SHCCs on a national basis.

The program was heavily funded by the Federal government with little or no State funds involved. Health care costs, as a percentage of GMP, continued to rise from 9.4% in the early '70s towards 10%. Hospital rate setting was instituted in varying forms as another attempt to get at the rising costs. Nothing seemed successful, and the debates renewed in the early '80s. These debates gave rise to the DRG program in New Jersey as a means of paying for hospital care. We were continuing our focus on only facilities and their services as a means to control costs; we still had no realistic idea of what we were expected to accomplish.

We all know that the New Jersey DRG program, with modifications, was eventually adopted by the Federal government for the Medicare program. While this new reimbursement program was being implemented for Medicare patients only, it became very evident to observers that the Federal government was throwing in the towel, if you will, on its role in developing and implementing policy. They became merely a health insurance company for our senior citizens. Today, it's extremely difficult to tell the difference between Medicare, from what Medicare says, in the Hartford or Traveler's or Blue Cross or Prudential Insurance Company.

At the same time this was all going on, it was evident that health care was being caught up in a national effort towards deregulation, because Federal funding stopped for local health planning and health planning in total, in an effort to let competition control costs as it does almost everywhere else in American society.

The cost of health care has now skyrocketed to 11.4% of the gross national product and shows no indication of stopping there. New Jersey has chosen wisely, in our belief, to fill the void created by the Federal government's decision to concentrate on its own insured, and has proceeded to fund, in a limited way, our own planning effort for New Jersey.

The Federal government has demonstrated a lack of interest in, or an ability to deal with, the societal policy issues that must be dealt with if we are to effectively get a handle on health care costs.

So here we find ourselves in 1990 once again attempting to deal with the same problem. A different date for sure, and many different people and commissions involved, but not a different subject. As a matter of fact, these are probably the only differences between 1970, when I was doing my graduate work at Cornell, and now.

We now have an opportunity to once again make a real difference. In the SHCC's view, we could make that real difference by implementing the recommendations of the Governor's Commission on Health Care Costs, including the requirement that if a Certificate of Need is necessary, that it be necessary for all, regardless of whether its a hospital, a nursing home, a doctor's office, or HMOs. This, plus the other changes recommended, are major steps forward in our attempts to control costs. The SHCC seeks your support and offers itself to you in this regard.

It is absurd for us to believe that we will control costs if we don't control utilization and the number of

high-tech instruments available for use. There are, I believe, eight approved Magnetic Resonance Imaging machines in New Jersey for the 90 hospitals -- 90 acute care hospitals -- and there are over 80 of those machines in private doctors' offices. We're kidding ourselves and the general public if we don't recognize this is a major problem and a deterrent to effective cost control.

I believe everyone is in agreement that the area of greatest increasing cost is no longer the hospital, but the out-of-hospital setting. As a matter of fact, hospital costs in New Jersey appear very favorable when compared to the rest of the country, the northeast, and other highly industrialized states. In addition, our hospitals, as Steve just mentioned, are the fourth highest occupied hospitals in the country.

We've done something right in New Jersey, but we just haven't done enough. We need more planning in the future, not less, and we need to staff it, and fund it, and we need to make the changes recommended by the Governor's Commission. If we do these things, the health planning process will continue to be an important part of the solution to our problem. It will not, and it cannot, be the only or even the most important part of what needs to be done.

Health planning has been effective in New Jersey, although not nearly as effective as it could have, or should have been. We need a comprehensive State Health Plan that is developed in a public forum with input from all interested parties; something we haven't had for some time.

We need to be certain that we can approve CNs that meet the needs identified in that plan, and we need to be certain that our citizens receive the best care our society can afford to provide.

To this point I have limited my comments to issues involving health planning and, believe me, there's much more that I can say on the subject -- and, frankly, would look

forward to saying when there's more time available. But I would be remiss if I didn't take advantage of this opportunity to suggest areas outside of health planning that have an enormous impact on costs and seem not to be addressed by government, for one reason or another. There are three of them:

1) The debate continues over whether health care should be planned or part of the free market oriented system. We need to provide a clearer perspective on where we should be headed in this area.

2) An enormous amount of money is being wasted on issues surrounding malpractice and defensive medicine, not only in the hospital, but in the private doctor's office. The malpractice insurance company stated publicly before the Commission on Health Care Cost Containment that they encourage the practice of defensive medicine as a means of avoiding malpractice suits. The costs in this area are absolutely enormous. Private physicians will tell you that they are absolutely enormous and something has to be done about it.

3) We spend an enormous amount of money in the last few days and weeks of life. We need to understand the trade-offs involved in this in our society which more and more, every day, is concerned about our limited ability to support our current practices. Not that we have answers to any of these things, but it is government's responsibility to put the right people in place to deal with these and to come out with some sort of resolution.

Of a technical note in the Commission's Report, I'd like to suggest two areas that SHCC is concerned about:

1) That as it relates to the Attorney General for appeal purposes, we would like that not to be optional on his part. We would prefer that that just happens as a matter of course and not have it judgmental.

2) We believe that there is a big difference between the minds of the people it takes to run a Certificate of Need

process and the minds of the people it takes to run planning -- health planning. One is much more technical, and one is more visionary in nature. I'd like to see -- and the SHCC would like to see -- a separation of staff somehow within the Department of Health, although that's sort of their purview. But we think there could be some value in separating those staffs.

I'd like to thank you once again for the opportunity to appear before you on behalf of the SHCC, and I'd be happy to answer any questions.

ASSEMBLYMAN McGREEVEY: Thank you, Ralph. Ralph, on those last two points, could you just letter Assemblyman Felice and myself, attention of Robbie, regarding the separation of those two functions within DOH, as well as the AG appeal? I just-- And the other thing is, if I could have a copy of your testimony? I though it was exceptional.

MR. DEAN: You don't disagree with anything? (laughter)

ASSEMBLYMAN McGREEVEY: There's always a first time. Nick?

ASSEMBLYMAN FELICE: Yes. Mr. Dean, you know, it's gratifying to hear thrown in different testimonies some of the things-- Yes, New Jersey has some of the finest health care in the country, if not in the world. We are very high-tech oriented with our medical treatment, but as you mentioned -- which comes up every so often -- the fact of the high cost of malpractice insurance-- Many of the doctors and hospitals are practicing defensive medicine by doing a lot of tests that normally they wouldn't do with their analysis and judging a case. But the fact is, because of the need for defensive medicine, they do many high-tech testings that are not necessary, which is one of the big factors that brings the high cost of treatment in our hospitals. And I think you brought up a valid point: Beside the planning and everything else that

goes with it, part of it is looking to the overall picture of the insurance, liability, and the means to have some kind of control for the medical providers -- both doctors and hospitals and the groups that are involved -- because this is a very, very important factor for our high costs of health care in New Jersey. I think that's something that people are listening to now, and realize it is a big part of it.

Thank you.

ASSEMBLYMAN McGREEVEY: Thanks, Ralph. And, you'll follow up on just those three items?

MR. DEAN: I will.

ASSEMBLYMAN McGREEVEY: Thank you very much.

Mary Stevens. Thank you. Mary's here on behalf of the New Jersey Public Health Association. We would just ask you if you could keep your testimony and be mindful of the time requirements? Thank you.

M A R Y S T E V E N S: Yes, I'd be happy to.

ASSEMBLYMAN McGREEVEY: Thank you, Mary.

MS. STEVENS: Chairman McGreevey, Commission members Felice and Ms. Miller, and others: On behalf of the New Jersey Public Health Association, I thank you for the opportunity to share our perspective on health care planning in our State.

My name is Mary Stevens and I am on the Executive Board of the New Jersey Public Health Association. I have copies. If you'd like to follow along, that would be fine.

Our organization, an affiliate of the American Public Health Association, was founded more than a century ago to promote the cause of public health. More people are alive today because of advances in public health than because of advances in any other field of medicine.

Yet, as a society, we become complacent, more than that, negligent in our attention to the fundamentals of preventive and primary health care. Who would have believed 10 or even 30 years ago, that we would today be facing an

unchecked syphilis epidemic, or outbreaks of tuberculosis or measles? These are serious communicable diseases and they are eminently preventable. It was unquestioned 30 years ago that these things were things of the past. But, lo and behold, they are here again today. And why? We've neglected them. There's no profit in preventive health care. There's no constituency. Clinical medical intervention is part of the system of reimbursement and insurance; prevention is a public expense. I ask you, which one is hurting us more financially? A medical cure is dramatic; prevention is not. Today, only the failure to invest in the public health is dramatic.

Preventive health care is not only essential for the well-being and productivity of the community, it is cost-effective. Every dollar spent on WIC's prenatal care program saves $3 in averted medical care for low-birth-weight babies. Not every public health program can boast a 200% return on investment, I grant you, but it is the rare public health program which does not save far more than it costs. If you want to save acute care dollars, invest in public health.

Our State has a health plan, a well-thought-out plan running to some 1000 pages. Our State has competent, qualified health planners, well qualified to improve upon it, to revise it perhaps, and to monitor our progress. We do not lack a plan on paper so much as we lack a plan in action and in funding.

We have the infrastructure for an exemplary preventive health care system -- the system we used to have, remember? -- when TB was a thing of the past. We have trained personnel and we have more Master's in Public Health coming out of the graduate schools. That's the MBA of the '90s. We could again have mass health screening and routine vaccination in the schools. This was a system that served us well. Today, clinical intervention is, in part, no more than a mopping up operation. Much of what we treat today we could have prevented yesterday, and at less expense.

I turn now to the specific recommendations of the Governor's Committee on Health Care Costs and its CARE Report.

By and large, we support CARE wholeheartedly and we commend the Governor's Commission on Health Care Costs. Similarly, we have the greatest respect for our new Commissioner of Health who holds, among others, an earned degree in public health.

We applaud the emphasis on wellness, as against acute care.

We support an epidemiologically and demographically based plan. The planning process should include the local health officer and should draw upon the expertise and experience of local volunteer citizen and provider groups for local initiatives. We feel that a centralized plan is fine. I insert that because it's been the subject of so much discussion. We feel that the key factors are the epidemiological and demographic bases upon which the plan is built, and not whether the ultimate decision making is local or central. We think central is fine, but you need the input from people who are actually delivering services at the local level.

Not mentioned in the CARE Report but central to efficient health care, is the use of alternative providers of primary and secondary care. Again, they save money, including physical therapists, occupational therapists, pharmacists, chiropractors, clinical nurse practitioners, nutritionists, and physician assistants.

In one important respect we dissent from the CARE Report: We are astonished at the omission of any reference to local health officers, whose jurisdiction comprises the very items most likely to save the most dollars and most improve the state of our citizen's health.

We support the CARE recommendations regarding the Certificate of Need process. We have in New Jersey more Magnetic Resonance Imaging devices than there are in all of

Canada. As taxpayers and as consumers, we pay far more than we can afford for these medical Cadillacs. This is a shocking misallocation of financial resources when our women, our young children, our minorities, our elderly don't have, as it were, bus fare. The noninstitutional facility loophole should, of course, be closed and the process tightened up. And we have no quarrel with the plan as advanced by the Governor's Commission.

With regard to Blue Cross, it has been suggested that Blue Cross should behave more like the commercial insurance companies. We disagree. The solution to the Blue Cross problem is for the commercial insurers to behave more like the old Blue Cross. Specifically, experience and demographic rating should be prohibited as should preexisting illness exclusion clauses. Too many insurance companies profit by segmenting the market; picking off the good risks and dumping the poor risks or "demarketing" them. It is of no benefit to New Jersey that high cost procedures and high risk consumers be excluded. The uninsured reappear in the system later on; sicker, more expensive to treat, and with poorer health outcomes. Instead, all insurers should use a standard community rating based on health care costs for the population as a whole. Let the arena of competition be efficiency, not exclusion. We mention Blue Cross and we mention Uncompensated Care because finance is essential to the planning process. What you're really talking about is how we should spend our dollars to improve health care, and insurance is an integral part of that.

We see no alternative to the Uncompensated Care Trust Fund crisis but for the State to develop a broad-based revenue source to replace the current costly, inefficient, and inequitable system of public taxes and private premiums. In other words, when I do my family budget, quite honestly, I am unable to make a meaningful distinction between taxes and insurance premiums. They're both expensive and they're both

nondiscretionary. Either way, the money for the system that we have comes out of the pockets of all New Jerseyans.

In addition, under the current Uncompensated Care Trust Fund system, too much money goes to bad debt for people who fail to make their copayments and deductibles and on Medicaid eligibles who neglect to obtain coverage, or who cannot. While we must address the legitimate concerns of underinsurance and inaccessibility, we need not be taken advantage of by people who abuse the system. In this area, as in many other areas in the health care industry, there is too little enforcement and too little public accountability.

In conclusion, we emphasize our concern about the public health threat presented by people entering the health care system too late or not at all. Encouragement of good health practices, prevention of disease, and early intervention not only improves the health, well-being, and productivity of all of us, but it is cost-effective because it brings people into the system earlier when care is less intense and less expensive.

If there is any way in which we, in the Public Health Association, can assist you in your drafting, we would be most happy to do so.

And, finally, we urge you, our elected officials, to reverse this tragic and wasteful pattern of ignoring the public health; spend where it will do the most good, not where the wheel squeaks the loudest.

ASSEMBLYMAN McGREEVEY: Thank you very much. I think your statements as to the need to concentrate on primary and preventive care, focusing on public health as opposed to the durational acute care setting, are most appropriate.

Assemblyman Felice?

ASSEMBLYMAN FELICE: No, I think I have to agree, too. A lot of these comments have been echoed before, and I commend you for bringing them again to our attention.

ASSEMBLYMAN McGREEVEY: Thank you, Ms. Stevens.

MS. STEVENS: Thank you.

ASSEMBLYMAN McGREEVEY: Is Alan Kaufman here? (no response)

At this time I recognize it's out of order, but as a courtesy, I'd like to call upon Sister Margaret Straney. Sister is the President and CEO of Cathedral Healthcare System.

S I S T E R M A R G A R E T J. S T R A N E Y: Chairman McGreevey, members of the Committee, my name is Sister Margaret Straney. I'm the President and Chief Executive Officer of Cathedral Healthcare System, a multi-hospital system located in Newark. I welcome the opportunity to speak to the health issue of health planning and its importance to health care reform in New Jersey. And, I would like to say to you that I am not dealing with the particulars of implementation, but rather with the broader concepts.

Reform of the health planning process is the second recommendation in the report issued by the Governor's Commission on Health Care Costs, thus reflecting its significance to the overall effort to develop a more rational, realistic, and equitable approach to health policy and health care delivery.

There is little doubt that a significant shift in focus is required if health planning is to contribute to a reordering of priorities in the delivery of health services. As I stated before the Governor's Commission, our health care system has been focused more on dollars than on people, more on buildings than on services, more on providers than on consumers. Health care reform requires taking a bold position even though the industry may not be ready for it. However, to fail to be a leader in health care reform is a much greater risk.

We must, through any existing or proposed regulatory process, continue to encourage a fundamental shift in health

care from acute care to ambulatory care, from a sickness model to a wellness model, from a local to a regional perspective,and from a provider focus to a consumer focus. As the American Hospital Association section for health care systems recently noted, the needs of the population must drive health care reform. "Population is a broader term than patient." We should all commit to a healthy population as our fundamental objective; then organize ourselves to support that objective. The measure of our success should be health status, not full hospitals; manageable cost per capita, not profitability for thousands of separate provider units; value, not just control.

What is required in developing a comprehensive statewide health plan is a new vision of health care delivery in New Jersey. That vision must reflect what we, as a society, believe is realistic and attainable in pursuing a health care system that will result in producing a healthier New Jerseyan. It should articulate basic issues such as access, cost, need, and quality, and incorporate the role of payers, providers, consumers, labor, and government in any new health care structure.

This vision should also identify a regulatory philosophy that will, in part, govern subsequent actions and policies. For example, should there be a market-based focus or a pure regulatory-based focus? Most likely there should be a balance between the two. However, with a regulatory focus, special attention must be paid to implementation processes. Frequently, regulation has the potential to protect, but the administrative process negates the benefit through increased cost and complexity. Further, as the transition is made to a new delivery system, financial accommodation must be made to support that transition.

Clearly, this matter must be placed in proper context. It has been said that employers, government, labor, and individual consumers envision a less expensive package of

health care services delivered with greater efficiency and more caring. We know from current literature and from our own experiences that the consumer is now a key player in the health care debate, feeling the cost crunch, but also seeking quality of care. In constructing a State Health Plan it has been said that, like politics, health care is very much a personal dynamic, where hospital, doctor, patient, and employer/insurer meet face to face.

In developing a statewide health plan, we envision a tightly linked regional system with comprehensive, vertically integrated systems of services for defined populations, and that certainly includes our public health services.

Sometimes a hospital closure or conversion may be necessary to best fulfill the community's needs. As one who has experienced this firsthand, I recommend evaluating the concept of a hospital closure/conversion commission similar to the one established in Massachusetts. It's not the best. There are a lot of concerns, but we certainly could look at the model. This commission takes hospital conversions out of the established regulatory process, and has the authority to allot funds and grant approvals in a more expeditious manner than through the existing process. Need must be based on fact, not on emotion, and self-interest, regardless of its source, must be identified and challenged.

I strongly endorse the Commission's recommendation to establish a comprehensive State Health Plan, but for it to be successful and truly responsive to community needs, the health plan must reflect the basic shifts in focus that I alluded to earlier: from acute care to ambulatory care, from sickness to wellness, from local to a regional perspective, and from a provider focus to a consumer focus. The State Health Plan must reflect current trends in the nature and treatment of illness, rather than merely focus on forecasting the need for acute care beds.

It must also take into the consideration the very diverse health status of certain high risk groups, such as minorities, children, the elderly, the chronically ill, and the homeless.

Of crucial importance is ensuring access to primary care and chronic care. The planning process must build in incentives to health care providers to respond to these needs.

The State Health Plan should also encourage the development of a model of treatment that encompasses a continuum of care, which begins with prevention and education and responds to health care needs throughout a person's lifetime. A continuum of care also provides care in a variety of settings and at appropriate levels.

I would like to take a few moments to address some of the Commission's specific recommendations regarding health care planning:

* As the Commission recommends, the State Health Plan should be revised annually and should give careful consideration to the issues of consumer access and delivery of health care services. I am further suggesting that the plan should not only identify unmet health care needs, but prioritize these needs, and that should form the basis upon which Certificate of Need applications are reviewed.

* The Commission Report delineates a planning structure at the State and local levels which in essence replicates the current structure. The Local Advisory Boards, as outlined in the Report, would add an additional layer of bureaucracy without any apparent substantive benefits to the planning process. Now, I am not suggesting we ignore local input. We certainly have to have local input, but whether that's the most cost-effective way to obtain this local input we need to examine.

* As the Commission Report states, currently only a limited number of health care providers are covered by State

planning regulations. To create a level playing field and further encourage cost containment, the definition of a health care facility must be broadened and this would help to reduce duplication, protect quality, and conserve scarce resources.

* The Commission's recommendation for an annual cap on capital projects is certainly reasonable and necessary in light of spiraling health care costs. However, we would urge the Department of Health, in establishing the cap, to be sensitive to the age and condition of many of the facilities in the State, as well as to the mission of the institutions. For example, teaching hospitals have a broader mission than community hospitals, and there are concomitant costs in providing that service. The cap should be high enough to accommodate the very real needs of the populations served.

In the Commission Report, it is recommended that the Department of Health would have the authority to decertify paper beds based upon the utilization of those beds over time. I would caution against moving too quickly in this direction and with this focus. Beds should be decertified based on identified need within the region, and hospital CEOs and boards should be challenged to a more creative response to their population's needs.

As for the Certificate of Need process, it must be timely, responsive, relevant, and consistent with the overall goal or reordering priorities. The process should encourage an open and continuing dialogue between applicants, the State Health Planning Board, and other affected parties to ensure that projects are clearly understood and the interests of the community are best served. The Certificate of Need process should allow the applicant sufficient opportunity at all levels to express its views and needs.

I would encourage legislators, providers, and others to work together towards a new vision of what the New Jersey health care system should become. We must strive for real

reform rather than merely sustaining the system through the transition with an "ouchless Band-Aid." There must be a willingness to sacrifice by all parties if we are to achieve meaningful reform.

In conclusion, I would like to state my support for some initiatives that were proposed just last week by the Governing Council of the Section for Health Care Systems of the American Hospital Association:

* Shifting the emphasis of the health care system to initiatives targeted to promote the health status of the population, rather than acute illness and the associated technology which is the system's current focus.

* Emphasizing the elimination of waste in the system, not only waste by providers but by insurers, before new funding is added to the system to ensure access for the entire population. If we use our resources better and eliminate much of the waste that currently exists, we will have the resources to enable a far greater percentage of our citizens to have access to basic services through the reallocation of dollars that have been saved.

* Creating total delivery organizations to plan, to spread risk, to ensure that services are adapted to where people work and live, and that have the scope to deal with all levels of care needed by the community, through integrated programs, financing mechanisms, and public policy development.

* These organizations need to integrate the work of hospitals, physicians, and other providers, not continue the separation and competition that now exists and that no individual unit is able to overcome.

Integration of hospitals, physicians, and other providers is so desirable as to call for special programs to accomplish it.

* Organizing the flow of funds so that they can be allocated to their best use, through the integration of

hospital, physician, and other provider services; toward higher quality, appropriateness, and value of care; and toward the removal of obsolescent portions of the system, to generate innovation in delivery at a large scale in a relatively short time. The overriding and most fundamental structural problem of this country's health care system is the perverse incentive environment created by the current financing system.

* Requiring accountability for cost and quality on the part of all stakeholders -- business, government, payers, hospitals, physicians, educators, regulators, other providers, and, people. The industry's measures are generally inappropriate, as they center on utilization of services rather than on improvement in health.

A State Health Plan and a Certificate of Need process cannot be developed in a vacuum or outside of a clear philosophical base. It is important that the decision makers and the participants all come together regarding a vision for health care in New Jersey and the regulatory environment that will be established to actualize that vision.

Thank you.

ASSEMBLYMAN McGREEVEY: Thank you. Sister, I just made a note to myself. You talked about the decertification beds and the need to be cautious in this regard. And I think the specific language talks about hospital CEOs and boards should be challenged to a more creative response. What type of decertification process would you recommend?

SISTER MARGARET: Well, it seems to me that one of the problems that we are faced with is the absence of a reliable crystal ball. We have an incredible and very complex problem with AIDS, for instance. We are really looking at that very carefully because at St. Michael's Medical Center within our system, I believe we are the largest provider of AIDS care in the State. The problem with that -- and one of the things that we are seeing right now with the development of outpatient AIDS

services that we have provided -- is that we are finally beginning to get a stabilization of inpatient acute services.I don't know whether that trend is going to endure. We are now seeing AIDS development in a much older population.

I think it is unwise for us to develop a system that automatically eliminates licensed acute care beds. I think that has to be done with a very, very clear understanding of the population projections for any given region, and I think it has to be done on a regional basis. There are some areas of the State that I'm sure are probably never going to be involved in the AIDS issue. There are others that are going to continue to be absolutely inundated by it. That does not mean that those areas that don't have AIDS are not going to have a tremendous amount of chronic disease; possibly because of the industries that surround them, possibly because of the immigrations of populations. There's almost no area of the State that is not going to be impacted by the elderly.

Our hope is that if we develop a plan that, in fact, really addresses health care and not facilities that provide health care, that we will, in fact, be able to improve the general health status of the population along the continuum of life, and therefore reduce the ultimate need for long-term acute care at the end of life.

It's my assumption -- because this is the way we do it -- that when you look at planning, before you start to plan, you very carefully assess what you have. And, just as an example, in terms of the capital cap, if the Jersey City Medical Center is able to finally rebuild -- which it has a desperate need to do -- the proposed capital cap would be exhausted with that single project.

One of the problems that I find, and I've only been in the State now for four years -- and I've worked in four different States in health care-- One of the problems that I find is that numbeer one, our process is so complex, and it is so long--

ASSEMBLYMAN McGREEVEY: In the CN process?

SISTER MARGARET: Yes. The difficulty with procedures -- and I mentioned this in the beginning relative to regulation -- is you can be handed new regulations and you can review them from the perspective of what they are saying, and you'll find that the majority of health care providers will say to you, "I don't disagree with that." That's the way I feel about the Cost Commission's Report. I can't say that I can seriously disagree with what it is proposing. Where the rubber meets the road is how it's implemented.

We have a history of developing unclear administrative procedures, lengthy and very complex administrative procedures. We do not plan things through from the outset, so we get halfway through something and realize that that's not the way to go, and so we have to back up and start all over again. And that has caused tremendous difficulty among health care -- for health care providers in this State, regardless of whether they happen to be in a very affluent suburban area, or whether they're in the midst of an inner-city population that they serve. We have to be more clear about what it is that we want to achieve, and then develop the process by which we are to achieve it.

None of this -- and that's my concern about decertification of beds, just allowing to look at beds-- Someone said earlier this morning that, in fact, some beds are closed because of a person power shortage, and that's very, very true. That does not mean that those beds are not needed.

And so I think we have to be very, very clear about presenting the projections for the population in that area and identification of major needs, chronic illnesses, which will not -- should not -- require acute care beds. However, we've got to begin to find the delivery mechanism to address chronic illnesses. We also have to develop the mechanism to address the needs of the elderly, and that's when I said that you need

to challenge CEOs and boards because they're the people who are in the area. They know what's going on in their area. They should be very familiar with the demographics of their area, population projections. They should be very much in touch with their own public health agencies which can, in fact, give them guidance relative particularly to chronic illnesses.

And that integrated network that I spoke of has to include public health, has to include the existing agencies, most of which are underfunded or that live from grant to grant.

ASSEMBLYMAN FELICE: Sister Margaret, what you're really saying is -- if I may just jump in here -- the amount of beds that are there at this moment may not be needed today, but-- I think the last chart that I got this week-- We have over 9000 cases of AIDS in New Jersey as of October 1, and the percentage of women is increased, and of course children, and again, the elderly. Even though we find areas for them in residential nursing homes, they still return to the hospitals for medical care.

The greatest percentage of our nursing homes have limited health care facilities, so as our population increases, age increases. I think the fastest age group growing is 80 to 85 years of age, and those people will be cycled back and forth between nursing homes to hospitals and back to nursing homes. I think that is a true statement. Yes, we know about the lack of trained personnel to help take care of those beds, but the beds are still needed, and from the projections that we're getting, especially in New Jersey, that is increasing more than we even estimated. That's a concern that certainly all of us have. And paper beds or otherwise, those beds are going to be in short supply. And, unfortunately--

SISTER MARGARET: Might be.

ASSEMBLYMAN FELICE: Might be?

SISTER MARGARET: Might be.

ASSEMBLYMAN FELICE: Hopefully, through preventive care a lot of it can be eliminated or cut back, but I think there's some very valid points that you're making that have to be considered in the overall picture.

SISTER MARGARET: I am very concerned not just about the bed issue, because I think that that requires all the expertise that we have to evaluate everything that we know today, and to do some analysis that would give us some indication of our needs for the future, but I am very concerned about the transitional process. Someone else referenced that this morning and I referenced it here. We have a tendency to say, "Well, this is in fact, what we're going to do, and we're going to change the financing mechanism in order to do it. And it's going to be implemented on July 1," or whatever. I'm concerned that we will develop a State Health Plan which should be done well before anything else is done and should have massive participation from as many minds as we can muster, through whatever methodology.

But we ought, also, to be very concerned that in the meantime we have an existing system that needs to be supported. I look at, just as a simple example, the State Licensure Reform. State Licensure Reform went into effect on July 1. At the time there was concern, and legitimate concern, on the part of hospital administrators that, in fact, this was going to be a very costly change. And the response was that, "Well, in fact, we will have to do something, but we're not exactly sure what." This kind of lack of predictability in the system is one of the things that has created the problem that we have in the acute care facility, and I'm sure that it extends among other providers as well, especially those that are heavily regulated. It does not apply to those who don't have any regulation whatsoever. That's a major concern.

When we look at the cost -- and we're a very small system -- of those regulatory changes to Cathedral Healthcare

System alone, and take a look at magnifying that by the number of health care facilities that there are in the State, not to know beforehand how those changes were going to be financed is pretty scary. You can't run a household like that, and you certainly can't run a multimillion dollar business like that. And while I don't like to refer to us as a business, from the financial side we are, in fact, one. We have to behave responsibly and those kinds of things make it extremely difficult.

While I concur with the Commission's recommendations, and certainly would be as active as I could possibly be in terms of their implementation, I would be concerned that there will be precipitous action and that administrative procedures will not be well-thought-out before the deadline dates for implementation.

ASSEMBLYMAN McGREEVEY: Thank you, Sister. I think your concerns are well met. If you have any specific language, Sister, that you or corporate counsel of Cathedral would like to forward in terms of legislative implementation, we just encourage you to address it to Assemblyman Felice and myself, in care of Robbie.

SISTER MARGARET: Yes, I'd be glad to do that.

ASSEMBLYMAN McGREEVEY: Thank you very much for your time.

SISTER MARGARET: Thank you. I didn't expect you to do that. I must tell you that, while it has been a long day for me, I did appreciate hearing the other testimony.

ASSEMBLYMAN McGREEVEY: Thank you, Sister.

Maureen Lopes? Maureen Lopes is Vice President of Health Affairs, New Jersey Business and Industry Association.

M A U R E E N L O P E S: Thank you. I won't tell my Portuguese in-laws-- (laughter)

I thank you for this opportunity to testify today on the proposed changes to the State's health planning process.

My remarks will be brief because a review by NJBIA's Health Affairs Committee of the Governor's Commission Report in this area raised more questions for us than answers. Today's hearing presents the business community and other interested parties with an excellent opportunity to better understand the issues.

Before proceeding with a major overhaul of the State health planning process, it would be wise to clearly establish the criteria for evaluating the current process and any proposed changes: which system is more effective at controlling costs, providing access, and ensuring quality? I would like to raise a number of questions and concerns which I hope you will keep in mind as you hear testimony from individuals and groups which are more knowledgeable about health planning:

1) It will not surprise you that the business leaders of NJBIA philosophically support free market solutions to public issues wherever possible. On the other hand, we recognize that the health care system often does not respond to economic factors in a manner similar to other industries. Therefore, it is important that you question whether there is a need for a government-sponsored health planning process.

I think I echo here what Ralph Dean was saying. That the basic question is: "Do we need planning?" A lot of people have spoken to that this morning.

Does a centralized, controlled planning process better address cost, access, and quality concerns? Can it be expected to respond in a timely fashion to a rapidly changing environment?

Part of my impression this morning is that a lot of people feel strongly but planning has helped to control costs in New Jersey. I personally have not seen that demonstrated. I think that would be interesting -- trying to evaluate that.

2) As a related issue, we urge you to carefully consider how the health planning process interacts with the

proposed changes to New Jersey's hospital rate-setting process. These processes are not well-integrated today. Over the next several years, the Department of Health is proposing to increase the percentage of statewide average costs in each hospital's DRG rates. This rate-setting process will have the effect of increasing competition among hospitals. It is crucial that a health planning system move, to some d gree, in tandem with these changes.

3) The increased competition among hospitals, and between hospitals and other providers, raises a third concern: How can a State health planning process be protected from undue political influence? With hundreds of millions of dollars at stake each year, there would be a large number of parties interested in each Certificate of Need decision. The Commissioner of Health, under the proposal of the Governor's Commission, would have the authority to make final Certificate of Need decisions. This is a significant amount of power in the hands of one official. On the other hand, providing for an appeal process could severely hamper the system. We have not been pressed by the appeal process on the rate-setting side. Wouldn't like to see that replicated here.

4) Finally, we also ask you to consider whether a State-controlled health planning process would assist or hamper the continuing development of managed care plans. For example, what would be the financial and political repercussions of the following scenario? The State awards Hospital A the right to expand a surgical service. On the other hand, a preferred provider organization, having determined that a competing facility is already a center of excellence, is directing an increasing number of its patients to this surgicenter. Which service would, or should, survive? Should the State be the only entity which measures cost, access, and quality, and uses these criteria to award operating franchises?

As you proceed with your deliberations, we ask you to bear in mind these questions. Our previous testimony before this Commission supported encouraging managed care options, expanding Medicaid coverage, and revising underwriting practices for small business insurance. These recommendations for reforming other areas of the health care system met three basic goals: control costs, provide access, and ensure quality. The health planning process must meet the same standards.

ASSEMBLYMAN McGREEVEY: Maureen, do you oppose the concept of a State-devised health care plan?

MS. LOPES: I think we just really question it. If someone could more clearly demonstrate that it directly had an impact on cost control for the last decade, I'd feel stronger about it.

ASSEMBLYMAN McGREEVEY: But you don't take a position then?

MS. LOPES: No.

ASSEMBLYMAN McGREEVEY: Okay. And, just in terms of-- I agree with your concerns about the rate setting. When you say, "be protected from a large number of parties interested in each Certificate of Need decision," I mean, that's obvious. I mean, that exists now.

MS. LOPES: Right. And there's been some stories in the newspapers that cause concern.

ASSEMBLYMAN McGREEVEY: Sure. Well, I mean, the problem is how to eliminate those and make the system more legitimately adhere to the health care needs of the constituencies. What other method would you develop?

MS. LOPES: Well, I think we've heard some interesting things here today about to what extent we need other oversight of the system. Should the Health Care Administrative Board be involved? It seems pretty clear to me from hearing the testimony that an appeal process is needed; that that's the fallback position, an up-front public--

ASSEMBLYMAN McGREEVEY: Appeal from whom to whom?

MS. LOPES: I think that's the big question. Who could initiate those appeals?

ASSEMBLYMAN McGREEVEY: Because we do have an appeal process--

MS. LOPES: Yes, but whether it should just be the provider or whether the local community has standing in these issues-- I don't feel as strongly about that. They've been part of the plan originally and a Commission decision was within the plan that--

ASSEMBLYMAN McGREEVEY: You could also appeal something to death.

MS. LOPES: That's right, you could just appeal it to death. So a lot of it goes back to what Sister was saying, that if the implementation does involve parties, then I think we avoid a lot of the political problems.

ASSEMBLYMAN McGREEVEY: All right. I would just be interested if you have a specific mechanism on the appeal process that you would want us to consider. You could forward that to Robbie, because, I mean, that's perhaps one of the most well-discussed aspects of the-- After you get past the recognition of the State Health Plan, per se, how that plan and variations in the CN process -- how that is determined. So, if you have any specifics-- Thanks, Maureen.

MS. LOPES: Thank you.

ASSEMBLYMAN McGREEVEY: I appreciate that.

Joe Sherber. (negative response)

Michelle Palmer Lee.

M I C H E L L E P A L M E R L E E: Good afternoon, Chairman McGreevey and members of the Commission. My name is Michelle Palmer Lee. I'm the Executive Director of the Southern New Jersey Health Systems Agency and my testimonial statement this afternoon will be for the support of the

transitional and permanent funding of local planning agencies before this Commission today.

The Southern New Jersey Health Systems Agency is a private, nonprofit, voluntary organization of consumers and providers of health care working together to improve the health care delivery system in southern New Jersey. Created under the National Health Planning and Resources Development Act of 1974, the Agency has a mandate to study the health status and needs of the residents of southern New Jersey and to develop plans to improve the health care system and restrain rising health care costs.

On May 8, 1987, the Governor of New Jersey approved S-2372 and State Law P.L. 1987. Chapter 118 established a new statewide local health planning program. Effective July 1987, the existing health systems agencies were designated as the local health planning agencies to carry out the purposes of P.L. 1987, Chapter 118.

The new law required funding the local health agencies at 12 cents per capita, or $920,000 for the entire statewide program. The agencies have not received these dollars and presently are funded only to December 31, 1990.

On October 1, 1990, the Governor's Commission on Health Care Costs presented specific recommendations for the future local health planning system. In short, the health systems agencies would be reorganized into Local Advisory Boards, or LABs. These LABs would be responsible for Certificates of Need review and to participate in the development and implementation of the State health plan.

There are many issues which should be addressed in the creation and development of the new State Plan and process; and particularly with regard to Certificate of Need review at both the local and State levels: Issues such as sufficient capacity of services for specific service areas, underutilization of existing services -- not just "paper beds," but equipment and

programs such as MRIs and cardiac catheterization facilities -- a real working definition and formula for accessibility and availability of services to our diverse communities and populations, the steady migration of New Jersey residents to Pennsylvania and Delaware facilities due to lack of services in the immediate community, demonstration projects reflective of new technology and the new delivery systems for this new technology, a revamping of the completeness process for Certificate of Need review, and the Local Advisory Boards' right to formally present their positions regarding appealed projects before the State Planning Board in view of the proposal to eliminate their traditional appeal rights.

The existing health systems agencies with their historical participation and frontline experience in the health planning arena, should be actively involved in the evolution of their future. The LABs will be the new vehicle for the voice of the community. Presently, the Southern New Jersey Health Systems Agency has been structured and organized through the review mechanisms of our local county council and regional review board to provide the necessary systems to address the local and regional perspectives of our health care consumers and to scrutinize, develop, establish, and/or link crucial services that will meet the specific needs of the service population.

The geographical service area of the Southern New Jersey Health Systems Agency embraces the seven southern counties of the State of New Jersey, namely: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem Counties. According to the State of New Jersey, Department of Labor, Population Projections for New Jersey for 1990 to the year 2020 as of July 1985 data, our regional service population will equal 1,682,680 residents in our seven counties.

The focus of health planning and the review of the existing health resources for new and expanded services becomes

crucial, not just for the local communities, but for the entire region as a whole. Competitive plans from health care providers must be reviewed and studied to insure that the local and regional health care goals are fully served as various medical and health care institutions address their service and facility objectives. This review process becomes essential in light of current political, economic, and tax projections now being focused upon at all levels of government.

If the LABs are to replace the HSAs, then funding should be available during the transitional and development phase to ensure: 1) continuity and that the utilization of existing resources, experience, and knowledge are incorporated during this reorganization period; and 2) that the resulting system is effective in meeting the common goals of an efficient and tax-effective health planning system.

In times of budgetary constraints, the rising cost of health care insurance, and the swelling of the uncompensated care population, crucial and cost-effective resources should not be abandoned. Local health planning agencies since 1976 have served the taxpayers of the State of New Jersey well. The agencies have saved millions of dollars through the non-endorsement of health care projects that were ill-conceived, a duplication of service, or did not address the issues of cost, accessibility, responsibility, and efficiency.

The local health planning agencies need transitional dollars as the need for health planning continues during this period. Permanent funding of local health planning agencies as nonprofit entities is a must to ensure an independent, nonpartisan organization void of conflicts of interest. It is a must if the people of our communities, townships, cities, and boroughs are to have a free and separate role in establishing and expanding health care services.

In closing, the Agency recently endorsed a mobile cardiac catheterization project in our service area, because

residents in certain parts of southern New Jersey do not have proper access to this service. It did not receive unanimous recommendation from all the reviewing agents in the Certificate of Need process, but an endorsement was necessary. The Agency supported the project because services are desperately needed. We are the voice of our communities. We have served our communities well. Let the communities continue to be heard through the continued funding of local health planning agencies as independent voices for quality and accessible health care.

Thank you.

ASSEMBLYMAN McGREEVEY: Michelle, the only question that I have is you referenced, as did Ed Peloquin earlier, Chapter--

MS. LEE: S-2372

ASSEMBLYMAN McGREEVEY: S-2372. The only thing is, if you could provide us information for what you consider to be an appropriate level of funding for the local health care planning agencies-- You know, I appreciate you delineating the population projection, etc. But if you could just discuss, or perhaps on a practical level if you could forward to us your budgetary needs on an annual basis, as well as you talk about the need for transitional dollars-- If you could, recognizing that the budgetary constraints that the State is faced with -- and not saying we would endorse that budget, but I think it would be helpful as opposed to developing such budgets in abstraction-- If you could submit to us what you would consider to be an appropriate health care planning budget, as well as dollars necessary to conform with the transitional recommendation--

MS. LEE: Very good. I will present it to my Board and forward comments to you.

ASSEMBLYMAN McGREEVEY: Thanks, and you can forward that to Assemblyman Felice and myself through Robbie.

MS. LEE: Thank you very much.

ASSEMBLYMAN McGREEVEY: Thank you.

Okay. Jack De Cerce. Ira Rutkow says you are a vision from a--

J A C K D e C E R C E: From Hell. (laughter)

ASSEMBLYMAN McGREEVEY: No, no, no, from Freehold. He was on the phone for 20 minutes telling me wonderful things, and I appreciate--

MR. De CERCE: He was telling you that? I'm sorry about that.

ASSEMBLYMAN McGREEVEY: Besides, you all know he served on the Governor's Commission, and I appreciate your time.

MR. De CERCE: I appreciate the opportunity. I'm afraid I may present a bit of an alternative view. I sat here all morning and listened to this and it's very interesting, but I'm a consumer of the regulation you're discussing. I operated a hospital for a long time in New Jersey. I've been in three hospitals in the State. I've served in Perth Amboy, Middlesex County; served at Helene Fuld here in Mercer County; and I've been at Freehold for 20 years.

ASSEMBLYMAN McGREEVEY: When were you at Raritan, Jack?

MR. De CERCE: In the '60s.

ASSEMBLYMAN McGREEVEY: Okay.

MR. De CERCE: All the folks involved in planning are very sincere. My friend, Ed Peloquin, was a good example. Whether elected, appointed, or salaried or not, they are all very sincere, hardworking professionals. But I'm afraid that I would raise the same questions I heard earlier about what has been the value of this regulation. I think I'd like to give you my perspective from that, just as an alternative point of view. I think there are some handouts that were passed out.

ASSEMBLYMAN McGREEVEY: Sure.

MR. De CERCE: My name is Jack De Cerce, President of CentraState Medical Center since 1972, and that was one year after our hospital in Freehold opened. With the help of our

volunteers, trustees, and medical staff of over 300, we have continually developed strategic plans for more comprehensive services. Over the last 20 years, our hometown hospital has filed dozens of Certificate of Need applications and been in almost constant communication with a variety of health planning officials at the local and State levels.

Dr. Ira Rutkow, as you mentioned, is an attending physician on our Staff, and I have had a chance, even during the interim process to look at some of the proposals being discussed by the Governor's Commission. Substantial questions should be raised regarding the State Health Plan concepts to establish capital cost objectives based on specific areas of need. All New Jersey hospitals need to continually plan renovation of old facilities to maintain excellence and addition of new technology to provide appropriate access for all residents of their community.

A major worry of the centralized control concepts under discussion is that communities and hospitals such as mine will be shunted aside. Large bureaucracies are naturally more conservative and tend to focus on political or headline issues. The basic bread and butter concerns of access, renovation, and updates for new technology are in danger of being overlooked. Impacted areas affected by economic conditions, lack of medical service, or significant population growth need hometown advocates. The genius of American medicine lies in community hospitals governed by volunteer trustee fund-raisers, not central bureaucracy which tends to stifle innovation.

Based on my experience with the growing New Jersey bureaucracy, I would caution that a solution does not lie in more extensive regulation. The backlog in appeals faced by the Hospital Rate Setting Commission typifies the dilemma faced in using statewide policy objectives to govern all elements of hospital operation. Even the well-armed European Socialists

are abandoning central planning which could not provide even basic food and housing for their people.

I would like to plead for local initiative in providing hometown health care. Our Medical Center has a long record of innovation and I've attached some examples:

Short Stay Unit, and there was an article in "Hospitals" several years ago:

Our pioneering ambulatory care service for outpatient medical and surgical care had to overcome major regulatory obstacles. New Jersey Department of Health codes required a bath and window for each two beds and reimbursement would not approve any patient not listed on the midnight census.

Applewood Estates, and there's a brochure attached:

Our Life Care facility -- 240 apartments and 90 nursing beds -- is the first hospital-affiliated Continuing Care Retirement Center in New Jersey. We were scheduled for financing with the tax exempt authority until an Assistant Attorney General ruled us ineligible.

Health Awareness Center, there's a brochure:

We are working with school districts in surrounding counties to create a unique "hi-tech" health education program. Our nationally recognized Wellness Center provides support for thousands of local residents. Volunteer fund-raisers are working to raise nearly half-a-million dollars to equip this new center.

These innovations would not have been listed in a State Health Plan. How can you encourage creative approaches while working to control health care costs? One obvious solution is to liberalize existing statutes and eliminate Certificate of Need regulation for all but the largest projects. Our stringent hospital rate setting system inhibits all but the most feasible projects. Unless adequate patient volume exists, no new service can pay for itself. Based on the enclosed American Hospital Association panel survey -- and I

encourage you to look at that-- I've been getting this report from Chicago for about the last 10 years and it consistently shows that my hospital gets $1000 less a case than similar hospitals in the northeast and in the--

ASSEMBLYMAN McGREEVEY: Nation.

MR. De CERCE: --nation. That's interesting.

ASSEMBLYMAN McGREEVEY: I saw that.

MR. De CERCE: And I think that the fact that-- Let me get back to this.

Chapter 83 has forced New Jersey health care reimbursement down to a point where proposed programs are cut by hospitals unless a very strong economic feasibility can be demonstrated. CON requirements for new, less costly services only add expense to hospitals and government alike.

A good place for oversight to begin would be a review of the heavy regulatory load imposed on New Jersey hospitals. Despite best intentions, the regulatory mandate seems to expand each year. The cost to hospital patients and taxpayers must be examined versus the benefit. We have experimented with nationally unique health care regulations for several decades. It is time for legislative oversight to critically examine the definition and structure of our statutory intent and determine which regulation best serves the public interest.

In summary, local initiative and health planning should not be eliminated. History and logic would indicate that even the broad public interest would not be served best by centralizing all health care decisions in cumbersome bureaucracy. Like most other states, we should eliminate Certificate of Need for all but the largest projects. The severe cost controls under Chapter 83 will continue to inhibit all but the most needed services. Please let hospitals and their volunteer boards control community health care. New Jersey is a prosperous State with the ability to create excellence in health care on a community-by-community basis.

ASSEMBLYMAN McGREEVEY: Jack, how do you react to the dilemma that if it's done totally on the community level -- and I'm not sure that you're saying this -- there's an extreme danger, both politically and basically, that personalities within the local community would do nothing to restrain, say four local community-based hospitals -- all having similar technology -- afford dramatic renovations? I mean, how do you control -- if it's all reduced to the local level -- the almost institutional incentive not to plan?

MR. De CERCE: I think the institutions have to do the planning. When you read the report, you get the sense that things such as Ed is talking about, a rehab plan, would not be possible; that the State Health Plan would mandate only certain programs; and that I would be prohibited from filing a Certificate of Need application unless it was in keeping with the mandate. I could understand, for example, a RFP kind of concept that there are 30 or 60 or 200 psychiatry beds available and all hospitals apply in the batch system. But the notion of some kind of very strong doctrine -- doctrinaire kind of document -- that says that only these kinds of applications will be considered this year absolutely, precludes local planning.

ASSEMBLYMAN McGREEVEY: Well, look at the LABs that are going to be having input in the designing and planning--

MR. De CERCE: Well, Ed and I have had 20 years experience with that. It's a very difficult process and it's certainly wonderful to have consumers involved. This is my profession; this is what I do. I'm very good at it. I'm very creative at it, and I've got evidence of that. It's difficult sometimes to explain what you're doing to all those groups. But the feeling and the assumption that somehow a document is going to be produced each year that will address totally the needs, and include all opportunities for innovation across the State of so many million people, is hard for me to conjure. I

don't have a lot of confidence in the regulatory process. I'm about five years behind with the Hospital Rate Setting Commission.

ASSEMBLYMAN McGREEVEY: That's being rapidly addressed.

MR. De CERCE: Well, rapidly to some degree, sir, but I think that you have to assume that we're going to have to take a look at that.

ASSEMBLYMAN McGREEVEY: For better or for worse. Yes.

MR. De CERCE: We'll have to take a critical look at that and it's expeditious-- Whether it's beneficial in the long run I don't know, because some of those costs are legitimate: a good example, the nursing cost. The bureaucracy is fine and I have no opposition to it. I'm not an anarchist, but I think you have to come to grips with the fact that it's not always as effective as it might be; it is mired in changeover. I've been through several Governors, several commissioners, several layers of regulation, several changes of State plans and State regulations. I've lived here for 35 years and I'm listening and understanding all of it. What I'm saying is, it isn't always-- The philosophy of intent isn't always accomplished, and perhaps less often accomplished then it might be.

ASSEMBLYMAN McGREEVEY: How would you design, hypothetically, the planning process?

MR. De CERCE: Take priorities. Sister mentioned AIDS; I would add Lyme disease. Somehow we seem to focus on only the downtown issues. There are out of town issues as well. Lyme disease is terribly crippling. Clare Farragher, your friend, is terribly compromised by that disease.

I'd add, initiatives that relate to major issues would be given priority; an RFP that would say that these things deserve some priority and they will be the first considered, but not to preclude local hospitals from saying, "We would like to start a new program. We would like to try to address it in a different way."

The short stay business is taken for granted now, but 20 years ago when we established our unit they almost closed it. They almost had the Attorney General send me a letter, and I'm telling you there's an inhibition in the offices in this town that doesn't allow for innovation.

ASSEMBLYMAN McGREEVEY: Creation.

MR. De CERCE: It doesn't allow for that. I mean, that's not the issue there. The issue is much more conformance and there's a lot of creativity out there among physicians. Your friend, Ira, with his Hernia Center, is a very remarkable development. Those will continue. If you inhibit those, you will have pro forma, Stalinist approaches to, you know-- Block medicine is not the genius of American medicine or as I understand the volunteer system here. Physicians who have no involvement, only affiliation and trustees that don't get paid, spend long hours talking about things and trying to find new and creative ways, listen to folks like me all night long, and you're not allowing for that. You're saying that's precluded. There's been too much of it.

Govern the large projects; govern the $10 million projects. Allow the hospitals to operate within that. Allow some criteria or queue forming for renovations or whatever, but don't preclude local innovation. Don't say you can't file a Certificate of Need. I don't understand the purpose of that.

ASSEMBLYMAN FELICE: Jack, if I may-- I agree with you in that your renovation expansion program, since you have very heavy volunteer involvement and fund-raising, is done in your area, I think your goals are limited by your ability for the community that you serve, volunteers, and so forth. And I think that's an important aspect of local need for their own ability to expand. It's interesting when you brought up Lyme disease, that's the first thing that came to my mind. In fact, take areas like Jackson, where whole families have contracted the Lyme disease. That area would be specifically working to

incorporate special features in their hospitals, taking care to recognize and to be able to treat these people.

MR. De CERCE: Jackson's the next town to us and we have a day treatment center where we're taking care of them on an outpatient basis.

ASSEMBLYMAN McGREEVEY: That's exactly what--

ASSEMBLYMAN FELICE: That's a perfect example of--

MR. De CERCE: Well, what I'm hearing is, I'm not allowed to apply for that. That's what I hear. Unless it's in the State Plan, I can't even make an application. If that's true--

ASSEMBLYMAN McGREEVEY: I don't think that was the purpose.

MR. De CERCE: Well, that's what it says.

ASSEMBLYMAN McGREEVEY: No, but I mean the idea is to obviously have that within the plan to react specifically to those needs, to Lyme disease.

MR. De CERCE: That's presuming that's somebody's going to conjure up the idea that Lyme disease is becoming a monumental issue, and then you get into-- What I'm suggesting is, if you want to say that you would like to prioritize the dollars and focus among problems, then develop some sort of RFP approach that says these projects deserve priority. But, don't exclude me from filing an application. Don't say I'm not allowed to even apply. That's probably almost anti-American, my friend. It's something we ought to think through. I understand the genius of it, and Ira's tried to persuade me of the genius of it, but I think there's a need to take another look at the process here and not presume that a couple of folks in the eight-story building can conjure up a plan that will meet all the needs. It's just too big a job.

ASSEMBLYMAN McGREEVEY: Thank you, Jack.

MR. De CERCE: I appreciate your time.

ASSEMBLYMAN McGREEVEY: Thank you.

ASSEMBLYMAN FELICE: Thank you.

ASSEMBLYMAN McGREEVEY: Okay. Now at this time I'd like to call upon Rick Abrams and Richard Grosso. Mr. Abrams is with the New Jersey Association of Health Care Facilities, and Mr. Grosso is with the Lakeview Skilled Nursing and Rehabilitation Center.

W I L L I A M R. A B R A M S: Thank you, Assemblyman. It's been very instructive this morning and into the afternoon. Again, my name is Rick Abrams and I'm Vice President of New Jersey Association of Health Care Facilities. I have with me, Rich Grosso, Jr. Rich is the Administrator of Lakeview Skilled Nursing and Rehabilitation Center. What I'd like to do in the next few minutes is give a perspective of long-term health care in the areas of health care planning and Certificate of Need.

Our Association is an association that represents both nursing homes and residential health care facilities. Our membership numbers over 200.

I'd first like to discuss the health planning and the Certificate of Need recommendations set forth in the Governor's Commission Report. The Association supports the health planning and Certificate of Need recommendations in the Report. We support a health care planning system that is driven by the health planning process; not the Certificate of Need process. We support the retention of local health planning bodies that will finally have a stable, adequate funding source. We also support the placement of discreet periods of time on Certificates of Need, that will reflect the actual time that it takes to implement a particular Certificate of Need. However, we recommend that care be given to ensure that these periods of time reflect the realities of both a changing economy and governmental and legal interventions.

In Mr. Peloquin's testimony, earlier, he had recommended setting the discreet period for nursing home

Certificates of Need at 2.5 years. It's our position that that's too short a time. It's been our experience that a nursing home cannot complete the process in less than three years. We would therefore recommend that the discreet period be four years, the reason being that that would give the applicant a year leeway to address legitimate impediments that might come, you know, during the procedure.

In addition, I think an exception in a discreet period should be made for zoning litigation. This is very time-consuming. We believe, and again, our experience has shown, that the Certificate of Need applicant, if involved in zoning litigation, should receive automatic renewals until the point of the first court decision. Again, it's something that they have no control over. It would be regrettable if, indeed, their Certificate of Need was taken away from them.

ASSEMBLYMAN McGREEVEY: So you would have no time limit?

MR. ABRAMS: Oh, no, not at all. In fact, we're recommending a four-year time limit.

ASSEMBLYMAN McGREEVEY: I mean, you would have no time limit prior to-- I mean, it's a blank four years?

MR. ABRAMS: Yes. That's correct. Again, that's our experience, that the 2.5 years recommended by Mr. Peloquin is too short. Three years has been, our experience shows, pretty much in line. The reason for the extra year is to provide a little bit of leeway for legitimate impediments that come up in the process.

In addition to our comments on the Governor's Commission Report, we also have these suggestions that we believe will enhance the health planning process and the Certificate of Need process in this State:

First, we would recommend that in developing the State Health Plan, additional long-term care Certificates of Need should not be available in any region of the State having a bed

vacancy rate in excess of 10% and/or that utilizes temporary nursing agency labor in excess of 10%. If one or both of these components is present in a particular region, this signals that either there's no need for the additional long-term care beds in that region, or that there is an insufficient labor force in which to staff the additional facilities, and we believe this would cause, and in fact is shown to cause, deterioration in the quality of care.

Again, certainly we support access, cost containment, quality. I think those three bell words are very important not only in long-term care, but across the continuum in health care.

Secondly, if the State Health Plan is to be a multiyear plan, the number of beds projected to be needed over the life of the plan should be spread out over the life of that plan. Total projected bed need should not be awarded during the first year of a multiyear plan;

Third, in determining bed need, adjustments that reflect an assumption that a certain number of approved beds will never be built should not be used. If an adjustment for a region underestimates the number of beds that indeed actually are built, the result will be severe overbedding for that region. We would note that the Department of Health's current health planning methodology does not contain these adjustment factors. The Association would strongly recommend that it remain that way.

Fourth, in determining long-term care bed need for a region, the State Health Plan should take into consideration approved and funded slots in the Community Care Program for the Elderly and Disabled. By including CCPED slots, the State Health Plan will more accurately reflect the long-term health care services that are available in a particular region.

Fifth, we see no reason to disband the current Health Systems Agency and State Health Coordinating Council health care planning infrastructure. However, we do believe that

certain refinements are necessary and should be made. One refinement that the Association recommends would be to include at least one member with long-term health care expertise on the SHCC or its successor entity. However, again, we see no need to totally disband a health planning infrastructure that already exists.

And finally, to assist in streamlining the system and to save State government valuable revenue, we would recommend that the review of Certificates of Need transfer of ownership applications be transferred from the Certificate of Need program within the Department of Health to the licensure function within the Department. In such transfer of ownership applications, bed need is not the issue but, rather the reliability of the new ownership is the issue. This inquiry -- that being the reliability of proposed or new ownership -- is a routinely performed function of the licensure function within the Department of Health. In the past, inordinate delays have been experienced with this function residing in the Certificate of Need process within the Department. Current State policies--

ASSEMBLYMAN McGREEVEY: Excuse me. When you say inordinate delays--

MR. ABRAMS: In a mechanism that we were advised would take four to six weeks, in the past there have been delays of six and nine and twelve months.

ASSEMBLYMAN McGREEVEY: Okay.

MR. ABRAMS: And, again, it currently is within the licensure function of the Department. However, we have heard -- again as part of the reorganization within the Department -- that it may be transferred back. That's the way it was and we experienced severe problems there, and it's functioning very smoothly. And, again, given the focus of what the inquiry is on one of these transfer of ownership applications, it should rightfully belong within the licensure function or the Division of Health Facilities--

ASSEMBLYMAN McGREEVEY: Have you made known your intentions to the Commissioner of Health?

MR. ABRAMS: I believe Mr. Cunningham has.

ASSEMBLYMAN McGREEVEY: Okay. Could you just send a copy to Robbie for Assemblyman Felice and myself, just so that we're mindful of that concern?

MR. ABRAMS: Okay. I don't know if we've formally-- But, I'm sure informally--

ASSEMBLYMAN McGREEVEY: I mean if you have formally. Thanks.

MR. ABRAMS: In conclusion, the Association believes that the implementation of these recommendations in the area of long-term health care will foster efficiency and cost containment in the health care delivery system in New Jersey, and, most importantly, will ensure that the quality of care and the quality of life for persons currently residing in long-term care facilities in the State continue to be the best they can be.

With that I'll conclude, and I thank you very much for your time and your attention. Both Rich and I would be happy to answer any questions you may have.

ASSEMBLYMAN McGREEVEY: Just a copy of that request. That would be helpful.

Assemblyman Felice?

ASSEMBLYMAN FELICE: Thank you. You know, and I know, that one of the important factors is this long-term care and how it affects the overall program. It definitely has to be a major factor to be considered.

ASSEMBLYMAN McGREEVEY: And we'll be taking that up after-- The next hearing we'll be focusing on rate setting, per se, but then we'll be taking up the question of long-term care. So thanks.

MR. ABRAMS: That's great. That's good to hear, because again it's good to know that we're talking about the continuum of health care, rather than just blocks of things.

ASSEMBLYMAN McGREEVEY: Yes.

ASSEMBLYMAN FELICE: That's important because Assemblyman McGreevey's aging fast in this Committee. (laughter)

ASSEMBLYMAN McGREEVEY: Thank you.

MR. ABRAMS: Thanks very much.

ASSEMBLYMAN McGREEVEY: Thanks, Richard.

I'd like to call at this time, Reid Stroud, the Executive Director of Home Health Services and Staffing Association. Thank you, Mr. Stroud.

R E I D W. S T R O U D: Sorry I couldn't get in at an earlier hour, and I'm glad to follow my friends from nursing homes, because there are two kinds of long-term care: long-term care institutionalized, and long-term care in-home. And, at the same time, I'm glad to come at a time when I will bring -- it might almost be considered a breath of fresh air, because you've been thinking about hospitals, and big expenses, and technical equipment, and a different kind of technology, and now we face a different kind of problem.

As Executive Director of Home Health Services & Staffing Association of New Jersey, we represent more than 300 home care organizations. Those services are all registered by the Division of Consumer Affairs, and they provide home care services to over a quarter of a million taxpayers and clients in every town of the State.

Today I come not to talk to you about hospitals or even about nursing homes and building permits and zoning problems and things of that nature, but I come to recommend to you that the Certificate of Need process, as it applies to home health agencies, be repealed in New Jersey. The health planning process and Certificate of Need for structure and for equipment may be very valid. I'm not looking at that particularly, but I look at the Certificate of Need process and home care, and recommend that it be repealed in New Jersey in

order for professional, quality home health care services to reenter the free marketplace. Doing so would be an advantage to the potential clients of the system, since more sources of service would be available to them. It would also be a dollar advantage to State government, being able to eliminate job titles in the departments that are devoted to the administration of Certificate of Need for home care. It would be an additional advantage both to State government and also to potential clients, because there would be reduced costs for the services provided in home care.

If the Committee desires, at a later date to be scheduled at mutual convenience, we would be pleased to bring before you a national expert in the field who would come from out-of-state. Unfortunately, arrangements could not be made for that special testimony to be presented at this time. In the meantime, we direct your attention to a report prepared by the Bureau of Economics of the Federal Trade Commission: "Certificate of Need Regulation of Entry Into Home Health Care -- An Economic Policy Analysis." This document was published in January 1989, and the results are as valid today as they were when they were written.

ASSEMBLYMAN FELICE: Excuse me. Is that '89 or '86?

MR. STROUD: I'm sorry. I said '89, and you are correct. That's what you get when you have trifocals.

ASSEMBLYMAN FELICE: That's all right.

MR. STROUD: Eighty-six is the correct date, but the results are valid and have not been repudiated.

In releasing the document, the Acting Director of the FTC's Bureau of Economics said: "Certificate of Need regulations impose barriers to entry into the home health care field, resulting in reduced competition and increased costs and prices. In addition, there is no evidence that the regulations provide any benefits." What else would we want to be looking for than those results? The report continues: "Regulations

requiring that new home health care firms justify the need for their services before receiving state approval result in higher home health cost with no apparent benefits." The authors found that, "The regulations do not improve home health care firms' economic efficiency and they may decrease competition and increase costs."

The report states that, "The Certificate of Need regulations, by retarding or stopping entry of new firms, may deny consumers the benefits of innovative or cheaper services that could lower the cost or improve the quality of home health care."

Proponents of CON regulations argue that competition in this industry would result in too many firms, each providing too few units of each service at a higher cost than necessary. However, the authors of this report point out that, "Small firms in this industry can operate efficiently because the capital costs necessary to establish a home health care firm", are not prohibitive -- as, for instance, the construction costs of a hospital or its technological equipment. The study also concluded that home health care firms subject to Certificate of Need regulations do not achieve greater economies when the firm is larger than do firms in unregulated markets.

"On the average," the study found, "home health care firms' costs are 2% higher in markets with Certificates of Need regulations than in the unregulated markets. The additional costs are not accounted for by any other factors examined, such as difference in wage rates."

The final paragraph of this 107-page report -- and I'm not going to read the whole 107 pages to you -- but these are the highlights: The final paragraph of this 107-page report speaks for itself, it speaks for our Association, it speaks for the citizens of New Jersey, and I quote, as I have on several other occasions: "In conclusion, we find no evidence that Certificate of Need regulation contributes to lower costs for

the provision of home health care services. If anything, CON regulation appears to be associated with higher costs. Further, a Certificate of Need program for home health firms involves administrative costs" -- governmental administrative costs. "Perhaps more importantly, by retarding or stopping entry of new firms, CON regulation of home health markets may be denying consumers the benefits of innovative or low cost services that could lower the cost or improve the quality of health care. There is no reason for not allowing the market to function unencumbered by these regulations."

I appreciate being able to come in and share these comments with you. And after having been thinking about all the buildings and building permits, and all of that other kind of thing, this is a completely different breath of fresh air. We're dealing with a whole different kind of subject, but it is Certificate of Need and Certificate of Need process. And if you have any questions, or if we can talk about the possibility that you'd like to hear more Certificate of Need and home care, we'd be happy to arrange for outside testimony to come in.

ASSEMBLYMAN McGREEVEY: I think your point is well-taken, the need to encourage home health care. You make an interesting point. Obviously, at some point we have to be concerned about quality control and maintenance of standards, and those would be the issues. But I think for future discussion I'd like to delve into this question early, how to actually encourage and enhance opportunities for home health.

MR. STROUD: How to encourage and enhance?

ASSEMBLYMAN McGREEVEY: Well, not necessarily now, but at a later point in time.

MR. STROUD: Okay. All right. Sure. If you're talking about long-term care later on at another hearing, that would be another possibility. Excellent.

ASSEMBLYMAN FELICE: I think you have a valid point. Regulation always costs money; overregulation costs twice as

much. But the fact was made years ago -- in this very capitol we had hearings-- There was really no official count of how many homes in areas were converted into nursing homes in which there was no regulation. There was no control. They really didn't know. The only way they knew is eventually the police, ambulance, and whatnot, were keeping count of when they went to a building where there were people that were actually living in a residential nursing atmosphere.

And I think while the Certificate of Need is a process that, yes, could be a little expensive and time-consuming in some areas, certainly in New Jersey, especially in some of the early shore areas that were converted, there was a need to have some kind of a record of those and the need for those areas to be considered residential nursing homes. But your point is well-taken, and I agree with you that a certain amount of regulation can be overregulated and cost dollars.

MR. STROUD: Our perspective, Assemblyman, remember, is not for the nursing home or the homes that are converted to a nursing home kind of operation, but for a firm that is at one location and has employees that come to that location, perhaps, and then go to the individual homes of the individual clients so that the care is being provided not at a centralized location, as in all of the other kinds of situations that you're facing in your conversations today, but in the individual homes that will be scattered through the whole community. And that kind of care becomes cost-effective, because you're not paying for the overhead, because the overhead of their own homestead and their own family is already there.

ASSEMBLYMAN McGREEVEY: They're incurring the costs.

ASSEMBLYMAN FELICE: You're absolutely right. Throughout the country this is the direction that most states are looking into.

MR. STROUD: And that's the direction in which, certainly, quality must be controlled. And that's a problem because not everything that's happening with that potential client is happening within sight of the total supervision. You can't go two halls down and take an elevator and the president of the organization is available that quick under the same roof, or any of the other staff. But quality control can be maintained in the home of the individual client, therefore saving money and making it possible to save the big overhead of a lot of the other kinds of situations that you're going to face in your health care planning in this State.

And for this portion Certificate of Need becomes defeative, and if anything, the 2% variance is probably higher in the inflation factors from the years in which the statistics of this report were delved, then being published in '86 to the present -- probably 3%, 3.5%, 4% higher by now in markets where there are Certificates of Need for home care.

ASSEMBLYMAN McGREEVEY: Thank you.

At this time I'd like to call upon Edwina Cuddihy.

E D W I N A C U D D I H Y: Mr. Chairman and members of the Committee, my name is Edwina Cuddihy and I'd like to share with you some of our experiences over the past eight years.

Until 1982, my husband and I obtained our health insurance through employer group plans. In 1982, my husband's job was eliminated due to a takeover of his company -- I think the very famous M&As that have gone on -- and we could not afford the conversion rate available from Prudential at that time. I think it was in the area of $8000 a year.

In 1984, I was employed at a very small firm that offered no health benefits and I suffered a heart attack. I was hospitalized for two weeks. At that time, we did not have individual insurance because we couldn't afford the premiums and we had to take a home equity loan -- which we're still paying off -- to pay hospital and doctors' costs.

By early 1988, my husband's income as a self-employed consultant had improved to the point that we could afford health insurance. We called brokers; we called every insurance company in the yellow pages, and no one would insure us because I had had a heart attack in 1984.

In March of '88, Blue Cross/Blue Shield, the only insurer available to us, as the "insurer as the last resort," sold us the only policy they said they would give us, and that was Co-op Coverage with Major Medical. This policy has a $500 deductible per family member, $100,000 lifetime cap, which today is nothing, and they pay 80% of my doctor bills and prescriptions, if they pay them.

Our annual premiums in December 1988 were $2815 a year. Okay, that's $700 a quarter. In January of 1989, the premium was increased to $4415. In the same year, our son, who was born on September 27, 1970, was no longer eligible for coverage under our policy, although he is a full-time student and dependent on us for his support. In most group plans, full-time students are covered until graduation. We now buy his health insurance for about $600 from his college.

In June of 1990 -- this year -- Blue Cross/Blue Shield received another increase for a total of $6000 per year for two people, my husband and myself. We have received no increased coverage despite the huge premium increases. In fact, we have paid Blue Cross/Blue Shield $11,000 in two-and-a-half years in premiums.

We are now faced with another increase of possibly $4000 to $5000 a year on top of the $6000 we're currently paying. And we can't do it. We have reached the point where we simply cannot afford to pay the premiums.

Over and over again, in this State, individuals have borne the brunt of exorbitant health premiums and more and more of us are uninsured because we can't buy it. And if it is available, we can't afford it. We're middle-income people.

We're used to working hard for what we pay for; we don't want charity. But $11,000 or even $6000 a year, is not reasonable. In fact, my current health premiums -- without any increases -- as of today, already cost me more than the taxes on my house; it's more than all my utility bills combined; and, furthermore, it's more than the tuition for two students at Rutgers University. And that's for a year.

It's meaningless for Blue Cross/Blue Shield to be the "insurer of last resort," if the cost to the individual is beyond their pocketbook. In August of 1990, "Consumers Report" dealt with the 'Crisis in Health Insurance." In one of their stories, David Curnow, 47, has a health problem and he asks, "How many sick and disabled people do you know who can afford to pay $6000 a year for health insurance?" How many middle-class people without a health problem can afford to pay that kind of money?

I have a health problem. Since 1984 I've had a heart attack, I've developed asthma due to a medication reaction, and I've suffered a hearing loss. Okay? The very idea of not having insurance is terrifying.

A short hospital stay could run $50,000, and that would mean we'd have to give up our home. There's nothing I can do about this situation -- not a thing. But the Legislature, the Assembly, and the Senate, can help me. They can help other people like me. We want to pay for our health insurance. I'm not asking for charity, but we need a policy that's affordable -- like the policy the Commission recommends -- and that's going to meet health needs. We need your help.

Thank you for your time.

ASSEMBLYMAN McGREEVEY: Very moving. Very-

MS. CUDDIHY: Well, I hope it gets it across that we do need a health plan policy, not three years from now--

ASSEMBLYMAN McGREEVEY: Now.

MS. CUDDIHY: --now. I mean, there's something in there. I attached the MacNeil/Lehrer Newshour. The last thing I'm saying in it is probably something people in government may not like to hear--

ASSEMBLYMAN McGREEVEY: No.

MS. CUDDIHY: --but I say, I'd like somebody in government to stop talking about it and start doing something about it. They keep going around and around.

ASSEMBLYMAN McGREEVEY: I agree with you and tomorrow we're going to be issuing a report. I agree with you that the crisis is now and its worsening on a daily basis. It's tragic that the Federal government hasn't moved on national health care insurance and I think it's incumbent upon this State to move aggressively in that direction as soon as possible. Because the situation worsens. It's not going to alleviate itself.

MS. CUDDIHY: And it's not going to go away.

ASSEMBLYMAN McGREEVEY: No.

Thank you.

MS. CUDDIHY: You're welcome. Thank you.

ASSEMBLYMAN McGREEVEY: At this time I'd like to call upon Susan Perry with the New Jersey Junior League. (no response)

Is there anyone else who would like to share? (no response)

Thank you very much for the true survivors who listened to today's testimony, and especially Assemblyman Nick Felice, and staff. I appreciate your time.

Assemblyman Felice, any concluding comments?

ASSEMBLYMAN FELICE: Yes, just let the record show we had no expensive luncheon today. In fact, we didn't even have any lunch, or coffee. (laughter)

ASSEMBLYMAN McGREEVEY: Thank you. Thank you very much.

(HEARING CONCLUDED)

APPENDIX

TESTIMONY OF LABOR COMMISSIONER
RAYMOND BRAMUCCI
BEFORE THE ASSEMBLY HEALTH CARE POLICY
STUDY COMMISSION
NOVEMBER 28, 1990

THANK YOU, CHAIRMAN MC GREEVEY, AND COMMISSION MEMBERS (IMPREVEDUTO, MENENDEZ, MATTISON, COHEN, FELICE AND KELLY) FOR GIVING ME THE OPPORTUNITY TO COME BEFORE YOU TODAY. I APPLAUD YOUR DETERMINATION IN ADDRESSING ONE OF THE MOST CRUCIAL ISSUES FACING OUR STATE TODAY.

WE IN NEW JERSEY CAN BE PROUD OF OUR COMMITMENT TO CREATE A DECENT AND HUMANE

HEALTH CARE POLICY - A POLICY THAT GIVES EVERY RESIDENT ACCESS TO HEALTH CARE AND HOSPITALIZATION REGARDLESS OF ABILITY TO PAY.

BUT PROBLEMS WITH THE WAY THAT POLICY HAS BEEN IMPLEMENTED HAVE BROUGHT US TO A FINANCIAL CRISIS OF MONUMENTAL PROPORTIONS.

WHEN THE UNCOMPENSATED CARE TRUST FUND EXPIRES AT THE END OF THIS YEAR, NEW JERSEY WILL BE LEFT WITHOUT A MECHANISM TO PAY FOR THOSE WHO CAN ILL AFFORD HEALTH CARE.

BUT CONTINUATION OF THE FUND AS IT IS PRESENTLY CONSTITUTED IS UNACCEPTABLE, PARTICULARLY IN THESE TOUGH ECONOMIC TIMES.

WITH THE COST OF CARE SKYROCKETING, PAYOUTS WILL INCREASE. THE HOSPITAL SURCHARGE WILL FOLLOW SUIT.

INSURERS WILL THEN RAISE PREMIUMS, FORCING EMPLOYERS AND THOSE WHO PAY FOR THEIR OWN HEALTH INSURANCE TO SHOULDER AN EVEN GREATER BURDEN OF THE COST OF OUR STATE'S HEALTH CARE OBLIGATIONS.

THE SYSTEM IS SIMPLY INEQUITABLE, AND THREATENS TO SERIOUSLY IMBALANCE OUR ECONOMY.

AS YOUR COMMISSIONER OF LABOR, I AM KEENLY AWARE OF THE IMPACT THIS INEQUITY IS HAVING IN THE WORKPLACE. CONSIDER THIS

STARTLING STATISTIC; IN 1989, 78 PERCENT OF ALL LABOR DISPUTES NATIONWIDE OCCURRED OVER THE PROVISION OF MEDICAL INSURANCE.

YOU MAY RECALL THE LONG AND EXPENSIVE NYNEX STRIKE THAT DISRUPTED SERVICE IN OUR AREA IN 1988 AND CAUSED WORKERS TO SUFFER A STAGGERING LOSS OF INCOME. THAT DISPUTE CENTERED ON ISSUES OF HEALTH CARE.

IN 1990, WE IN NEW JERSEY CAN ANTICIPATE MORE OF THE SAME. TWENTY OF THE STATE'S LARGEST LABOR CONTRACTS ARE DUE TO BE NEGOTIATED IN NEW JERSEY. I CAN PREDICT WITH CONFIDENCE THAT MATTERS OF HEALTH CARE WILL THREATEN THE SUCCESSFUL RESOLUTION OF MANY OF THESE NEGOTIATIONS.

NEGOTIATORS WILL BE HARD PRESSED TO COME TO AGREEMENT, AND THE ISSUE INEVITABLY WILL BE THE HIGH COST OF MEDICAL INSURANCE.

THE TURMOIL IN LABOR NEGOTIATIONS SENDS US A CLEAR AND STRONG SIGNAL: THE CURRENT IMBALANCES IN THE SYSTEM ARE UNACCEPTABLE. WE CAN NO LONGER EXPECT A LIMITED SEGMENT OF SOCIETY TO BEAR THE UNLIMITED COST OF THIS IMPORTANT SOCIAL AND ECONOMIC RESPONSIBILITY.

THE QUESTION, THEN IS THIS: HOW DO WE BUILD A SYSTEM THAT MORE EQUITABLY SPREADS THE FINANCIAL RESPONSIBILITY FOR UNCOMPENSATED CARE?

o

THERE ARE THOSE WHO FEEL THAT THE BURDEN SHOULD FALL ON THE SHOULDERS OF EMPLOYERS -- THAT THE COST OF CARE IS A SOCIAL RESPONSIBILITY OF BUSINESS.

OTHERS ARGUE THAT GOVERNMENT SHOULD SOMEHOW PAY FOR UNCOMPENSATED CARE OUT OF GENERAL REVENUES -- THAT ONLY PUBLIC FUNDS SHOULD BE USED TO WEAVE SOCIETY'S SAFETY NET.

THESE SOLUTIONS ARE POPULAR WITH CERTAIN SEGMENTS OF OUR ECONOMY. BUT THEY ARE NOT SOLUTIONS THAT WILL WORK, ESPECIALLY IN THESE TIMES OF ECONOMIC DISTRESS.

I FAVOR AN APPROACH THAT DISTRIBUTES THE

BURDEN OF UNCOMPENSATED CARE MORE EQUITABLY BETWEEN GOVERNMENT AND THE PRIVATE SECTOR. SUCH AN APPROACH RECOGNIZES A FUNDAMENTAL REALITY: THAT SHARED SOCIAL OBLIGATIONS REQUIRE SHARED SOCIAL RESPONSIBILITY.

AND IF WE ARE TO FASHION A SYSTEM ROOTED IN PARTNERSHIP, THEN IT IS INCUMBENT UPON US TO ASSURE THAT THE SYSTEM'S CREATION IS AN ACT OF PARTNERSHIP AS WELL.

LET ME SPEAK PLAINLY.

THE TIME FOR POLITICAL FINGER-POINTING SHOULD BE OVER. A SHARED, BIPARTISAN POLITICAL DIALOGUE MUST ACCOMPANY ANY EFFORT TO OVERHAUL OUR SYSTEM OF UNCOMPENSATED

CARE.

ANYTHING ELSE DOES A DISSERVICE TO ALL THE CITIZENS OF OUR STATE. THE CRISIS IS TOO GRAVE, THE CONSEQUENCES TOO SEVERE, AND THE TIME TOO SHORT. THE CRISIS IN MEDICAL CARE COSTS IS NOT THE BURDEN OF A PARTICULAR POLITICAL PARTY. IT IS A BURDEN BORNE BY CITIZENS OF THE STATE AND OUR ECONOMY.

THERE ARE SEVERAL RECOMMENDATIONS FAVORED BY THE GOVERNOR'S HEALTH CARE COST STUDY COMMISSION THAT TOGETHER MUST BE CONSIDERED IF WE ARE TO RELIEVE THE BURDEN OF THOSE FOOTING THE BILL FOR THEIR FELLOW CITIZENS WHO ARE UNINSURED.

THE COMMISSION HAS RECOMMENDED A BROAD WAGE-BASE TAX MODELED ALONG THE LINES OF OUR CURRENT UNEMPLOYMENT TAX. THAT KIND OF APPROACH IS ECONOMIC, EFFICIENT, AND FAIR.

THE COMMISSION HAS ALSO PROPOSED AN ADDITIONAL ASSESSMENT ON EMPLOYERS WHO REFUSE TO PROVIDE MEDICAL INSURANCE TO THEIR EMPLOYEES - A LEVY THAT WILL GO A LONG WAY TO REDUCING THE CURRENT ECONOMIC STRESS ON THE SYSTEM.

OUR EFFORTS MIGHT BEGIN WITH AN AUDIT OF EXACTLY WHO IS USING THE TRUST FUND AND WHY. ARE THERE THOSE WHO ARE NOT PAYING WHO COULD? WHAT PERCENTAGE OF THOSE SERVED BY THE TRUST FUND ARE TRULY NEEDY?

THE ANSWERS TO THESE AND OTHER QUESTIONS ABOUT THE FUND WOULD PROVIDE A FACTUAL BACKDROP FOR OUR NEGOTIATIONS.

LIKE IT OR NOT, THE RECESSION HAS FORCED US INTO A PARTNERSHIP. WE ARE ALL FACED WITH RESERVE SHORTFALLS. WE ARE ALL FACED WITH BUDGET DEFICITS.

AND NOW WE ARE ALL FACED WITH AN ESCALATING UNCOMPENSATED MEDICAL CARE FUND.

IT IS IMPERATIVE THAT ALTERNATIVES TO THAT FUND BE DISCUSSED NOW, FULLY, IN THE SPIRIT OF COOPERATION RATHER THAN CONFLICT.

FOR THERE IS LITTLE TIME TO LOSE. AS

THE RECESSION DEEPENS, MORE AND MORE WORKERS WILL LOSE THEIR JOBS AND, AS A RESULT, THEIR HEALTH CARE COVERAGE. THE NUMBER OF UNINSURED INDIVIDUALS SERVICED BY THE FUND IS SURE TO INCREASE, FURTHER STRAINING AN ALREADY STRAINED SYSTEM.

WE ARE FACED, THEN, WITH A CHOICE. WE CAN SAY 'IT'S THEIR PROBLEM,' AND TURN OUR BACKS ON OUR STATE IN ITS HOUR OF GREATEST NEED.

OR WE CAN SAY, 'IT'S OUR PROBLEM,' AND SOLVE IT -- TOGETHER.

THANK YOU.

New Jersey Hospital Association
Statement Regarding the Planning Recommendations of the
Governor's Commission on Health Care Costs

Presented to the Assembly Health Care Policy Commission
November 28, 1990

New Jersey Hospital Association
Statement Regarding the Planning Recommendations of the
Governor's Commission on Health Care Costs
November 28, 1990

Good morning. I am Harvey Holzberg, Chief Executive Officer of Robert Wood Johnson University Hospital in New Brunswick and Chairman of the Council on Planning of the New Jersey Hospital Association (NJHA). I appreciate the opportunity to present testimony today.

As Chairman of the Council on Planning, I am here on behalf of the Hospital Association regarding the health planning recommendations of the Governor's Commission on Health Care Costs. Let me first begin by congratulating the Commission for its comprehensive review of the current health planning system and its efforts to provide for the health care needs of New Jersey's citizens. Several of the Commission's recommendations will serve to fine tune our health care delivery system and will address the needs of both consumers and providers. I hope that through continued collaboration and cooperation, these recommendations will be further developed to foster an improved and effective health care system.

My remarks today will address three primary areas of the Commission's health planning recommendations: 1) the proposed reform of the health planning system in terms of structure and process; 2) the changes to the Certificate of Need application process; and 3) the increased level of authority and involvement of the Department of Health in managing hospital operations.

13X

The proposal to reform the health planning system calls for a centralized planning system in which Certificate of Need applications could only be submitted when the state health plan identifies a need. The New Jersey Hospital Association objects to this centralization of the planning process. Although there will be provisions to allow for local input, the ultimate determination of all health needs will rest with the State. Local participation in the health planning process is essential as it ensures that local health needs and issues are taken into account. Similarly, hospitals submit Certificate of Need applications based on the needs of the communities they serve. A centralized planning system eliminates much of that local input and could overlook important community health needs in many areas of the state. We urge that health care providers be allowed to continue to initiate certificate of need applications in response to the health care needs of their local communities.

In addition, in order to be comprehensive, the State Health Plan would have to encompass all of the regionalized health care services. Gathering information, analyzing it, and creating this broad plan will be a substantial undertaking. The Department of Health is already short-staffed as a result of the state's hiring freeze. The New Jersey Hospital Association is concerned that the state simply does not have the staff to develop and update this comprehensive plan. It is important that the state's planning process not become a morass of red tape that will delay

the implementation of needed health care services.

The state health planning system would also experience some structural changes. The Governor's Commission proposes to establish a State Health Planning Board (SHPB) to replace the current Statewide Health Coordinating Council (SHCC). The New Jersey Hospital Association is concerned that the proposed membership of the SHPB includes many representatives of the state government and a minimum number of health care providers. Obviously, New Jersey's hospitals would like to be participants in the development of rules that will ultimately affect them.

In addition, the Commission proposes that the Health Systems Agencies (HSAs) be replaced by Local Advisory Boards (LABs) which are to receive State funding. We support the continuation of local health planning bodies and would like to see them given a major role in developing the State Health Plan and reviewing Certificates of Need. The Hospital Association concurs with the Commission's recommendation that these LABs receive state funding, but we would like assurances that these boards will function autonomously from the Department of Health.

Regarding the proposed changes to the certificate of need application process. First, we commend the Commission for including **all** providers in the certificate of need application process. We strongly support "leveling the playing field" and are pleased to see that there is an effort to accomplish this long-awaited development. We would recommend that enforcement of this proposal will be difficult unless payers are required to pay

only those facilities that have received a certificate of need. This would create an obvious incentive for all providers to participate in the certificate of need process and gives the state control over all regionalized health care services and major health expenditures.

The New Jersey Hospital Association also supports the proposed increase in the certificate of need thresholds. The Commission recommends an increase from $400,000 to $1 million as the threshold for major moveable equipment and an increase from $600,000 to $1 million for modernization, renovation, and construction projects. These increases are noteworthy but we suggest these thresholds be further increased. The Hospital Association has long supported a $1.5 million threshold for major moveable equipment and a threshold of $5 million or 10% of a facility's operating budget, whichever is less, for modernization, renovation, and construction projects. These higher thresholds represent a more cost-effective approach to reviewing substantial hospital projects. The certificate of need process is only further burdened both in terms of staff time and dollars when it must conduct reviews of minor projects.

The Commission also proposes an annual capital "cap" on major hospital construction projects. The intent of this recommendation is to reduce the number and total cost of hospital capital expenditures. We object to this proposal. First, it is unclear as to who will establish the cap and how it will be decided how much the state's hospitals can truly afford to spend

on capital projects. Second, the Hospital Association can not support the recommendation that hospitals should compete for permission to improve their capital facilities. Like all buildings, hospitals require routine renovation and modernization. Failure to meet these capital requirements can result in overcrowding, inefficiencies from operating obsolete facilities, and even closure when conditions become unsafe. Even now, absent a capital cap, New Jersey's hospitals have the fourth largest occupancy level in the country and are routinely forced to divert patients due to overcrowding. In the short run, the state may save money by delaying major capital projects; in the long run, it will end up costing far more as a result of inefficiencies and maintenance costs.

Finally, throughout the Commission's Report, the state is given increased authority and control over the operations and management of hospitals. We are concerned about this recommendation particularly as it relates to planning. New Jersey's hospitals are already heavily regulated and need to maintain some flexibility in order to respond to the changing needs of the communities they serve.

As proposed, the Commissioner of Health would be given the authority to remove beds from a hospital's license based upon the underutilization of those beds over time. The Department of Health already has the power to close beds and should only use it when there is true underutilization. Hospitals that have closed beds because of manpower shortages, lack of usable space,

construction, or manpower strikes, should not have their beds delicensed.

Under the Commission's proposal the Department of Health would also have the power to become involved in the governance of a hospital if the Department feels there are excessive utilization, financial, or licensure problems. The New Jersey Hospital Association finds that such interference in hospital operations is unjustified. The state is no more capable of running hospitals than existing community boards and should not attempt to replace the outstanding business and industry leaders that comprise these boards.

In conclusion, we commend the Commission for its recommendations to institute a mechanism for local input through the designation of Local Advisory Boards, to include all providers in the Certificate of Need application process, and to increase the Certificate of Need thresholds. The New Jersey Hospital Association looks forward to the implementation of these needed changes. However, we are very concerned about the proposed shift towards a centralized health planning system with inadequate local health input, the cap on capital projects, and the increased authority of the Department of Health to manage hospital operations. The Hospital Association stands ready and willing to work with the Governor's Office, the Department of Health, and the state legislature to develop mutually acceptable solutions to these concerns.

Thank you for the opportunity to speak to you today.

TESTIMONY

NEW JERSEY STATE DEPARTMENT OF HEALTH
FRANCES J. DUNSTON, M.D., M.P.H.
STATE COMMISSIONER OF HEALTH

ASSEMBLY HEALTH CARE POLICY COMMISSION

19X

Good morning Assemblyman McGreevey and members of the Committee. I am Dr. Frances Dunston, Commissioner of Health, and I am pleased to have this opportunity this morning to discuss state health planning with you.

Health planning is a frequently debated subject, one which often leads to heated discussion over how we allocate health resources. Still we have to bear in mind that health planning has some simple but important goals:

I. Goals of planning

A. Health Planning is designed to protect and to promote the health of the population of the State.

B. It is supposed to identify the health needs of NJ residents and to advance the orderly development of health care facilities and services which are responsive to those needs. It is to discourage those investments of human and financial capital which lead to the development of excess capacity, thereby introducing unwarranted new costs to the system, or which provide only marginal improvements in human health and comfort.

C. And it is supposed to ensure that all residents have access to needed health care services and to ensure that those services are delivered in a responsible manner, with [illegible] both quality and cost implications.

II. Meeting health needs

A. When it comes to the health needs of New Jerseyans, the planning process has not been the guardian it was supposed to be. Instead, we have allowed providers to play the principal role in determining what health services they wish to provide. Essentially passive, we have chosen to briefly pass judgement on others' proposals without having a real, up-front say in what was needed. Consumed by the bureaucratic paperwork demands of the Certificate of Need Program, we have lost track of what planning is supposed to be.

B. As the Governor's Commission noted, this has to change. We now must develop a comprehensive State Health Plan designed to determine the adequacy of existing services and need for future services -- and thus guide the development of the health care infrastructure.

1. In other words we need to focus on <u>identifying unmet health care needs</u>, by service and location, and we need to evaluate the impacts of specific interventions on the promotion of health and well-being.

   This represents a shift in emphasis: providers must <u>respond</u> to needs identified through the state planning process. Thus we will use regulatory mechanisms to execute planning, rather than viewing application and review as ends in themselves.

C. This will require a shift in orientation of the entire planning and certificate of need processes:

1. As recommended by the Governor's Commission, the State Health Plan would be the basis upon which CN applications are reviewed. The Plan, created with local input, will assess where there is need in the state for specific effective services. Currently we have no such guide, no roadmap.

2. With this <u>new</u> focus, providers could only file CNs for specific services in given areas earmarked in the Plan. CN applications would not be entertained for services or areas not specifically identified.

3. Thus, the regulatory mechanisms will be used to advance health goals, rather than to spend an inordinate amount of time, staff resources, etc. reviewing applications for projects for which there is no need or for which there is excess capacity in the system.

D. We expect and hope that this will also result in a shift in emphasis in the <u>types of services</u> that are developed.

1. High [illegible] cost/ tertiary care services have typically received the most attention in the planning process

Now we do need to retain our commitment to the appropriate regionalization of expensive tertiary services, which are very expensive to deliver and which are needed by only a portion of the population. For instance we need to regulate cardiac services because of the known association between cardiac surgical volumes and outcomes, because we know that the proliferation of excess capacity of such a service will erode the quality of care at each center while draining our health care budgets.

2. But the need to develop community-based, primary care services is typically overlooked in this process.

And these are in many instances the most needed services in the state offering the best opportunity to promote human health in a cost-responsible way..

These services will be emphasized in the State Health Plan and in the broadened conception of the planning process. Because planning is more than Certificate of Need.... rather it is a vision of the best way to provide effective services to those who need them.

- o Along these lines the need for preventive services will be emphasized-- because as noted in the recent report of the US Public Health Service (Health

people 2000") prevention is now the single most important factor in achieving and maintaining good health.

- o One example where prevention and the expanded role of Health Planning overlap is in the HealthStart-Plus program recently proposed by the Governor's Commission on Health Care Costs. We know a need exists- the fact that our infant mortality rate is so high especially among vulnerable populations is a clear indication of the need.

- o HealthStart-Plus is an initiative designed around the concept of community-based primary care services to achieve better birth outcomes. The role of planning in making this happen will be extremely important, because we will need to encourage and create services and provider sites across the state to meet an identifiable need. This is an example of proactive planning.

III. Controlling costs through the planning process

B. The Planning and CN processes were originally designed, at least in part, to help control the costs associated with the construction or purchase of health facilities and equipment.

1. As mentioned earlier, traditionally the focus has been on controlling the growth of expensive, tertiary care services through the evaluation of the financial feasibility of proposed projects and regionalization of services.

2. We now have to go beyond that, and reassess the unchallenged primacy of hospital care as an unwritten tenet of the planning process. There are other ways to deliver care, and to deliver it in a high-quality cost-effective fashion. One important example will be the promotion and encouragement of community based health services such as community health centers. Our hope is to see these efforts receive much greater emphasis as we set about developing a State Health Plan. Health care should be much more than the hospital, and our health planning process must recognize that. Hospital ER's are not good primary care sites, and reliance on them for this care is bad for people and bad for the financial health of our system. The health planning system has to take the lead in encouraging more appropriate levels of care

3. Additionally, costs can only be controlled if we regulate the entire health care system in an equitable fashion, instead of putting all our efforts on only one segment. The situation with Magnetic Resonance Imagers, or MRI's, is a case in point. We regulated only those in hospitals, so we wound up with dozens of these fabulously expensive machines

outside of hospitals. In the interest of equity we need a level playing field, and that means that all health care providers must fall under health planning regulation.

4. If we intend to look at the system as a whole, and not in pieces, we also need to set some sort of capital expenditure cap. We cannot just go on approving or denying capital projects with no idea as to their effect on statewide health care costs. We are now facing a future with an incredible amount of new hospital debt, which will be eventually translated into higher insurance bills. Are patient outcomes going to be proportionately that much better because of this debt? I doubt it. We need to decide how much additional cost we can afford in the capital area, and use that as a ceiling.

I look forward to working with you in implementing the recommendations of the Governor's Commission in this area as well as others. Putting this plan into action will require hard work from all of us, but there is no other way. If we do nothing we will have failed many. Thank you for this opportunity to share my thoughts.

HPMSNJ
HEALTHCARE PLANNING AND MARKETING SOCIETY OF NEW JERSEY
SEVEN HUNDRED SIXTY ALEXANDER ROAD • CN 1 • PRINCETON, N.J. 08540 (609) 275-4000

November 28, 1990

The Assembly Health Care Policy Study Commission
c/o Robbie Miller
Aid to the Commission
State House Annex
CN068
Trenton, New Jersey 08625

Re: Report of the Governor's
Commission on Health Care

Members of the Assembly Health Care Policy Study Commission:

I am pleased to submit the attached testimony regarding the recommendations of the Governor's Commission on Health Care on behalf of the Healthcare Planning & Marketing Society of New Jersey. HPMSNJ is a professional organization comprising planners and marketers from health care organizations throughout New Jersey. The enclosed position paper was endorsed by the HPMSNJ Board of Directors at its November 9, 1990 meeting.

Overall, the Society believes that change in the current health care regulatory system is warranted and we support the diligent work of the Commission members in formulating these recommendations. We view the Commission's Report as addressing "macro" level changes which are long overdue; however, as professionals who have daily interaction with the State health planning system and Certificate of Need process, we have substantial concerns regarding the "micro" level impact legislative and regulatory changes could have on health care providers. We hope our comments will caution the Assembly Commission as to areas where further technical consideration is needed prior to change.

The testimony of HPMSNJ is limited to the Commission Report Section titled, "Regulatory Reform" according to the interest and professional expertise of the members of the Society. These comments are numbered to correspond with the Commission recommendations, CR3-CR17. Should you require additional information, all inquiries should be addressed to me at the

following address:

Rebecca Wolff, Director of Planning
Morristown Memorial Hospital
100 Madison Avenue
P. O. Box 1956
Morristown, NJ 07962-1956

1-201-285-4385

Thank you for the opportunity to provide this testimony.

Sincerely,

Rebecca Wolff

Rebecca Wolff
President, HPMSNJ

enclosure

cc: Louis Scibetta, President, NJHA
Harvey Holzberg, Chairman, NJHA Council on Planning
Tom Foley, Chairman, Health Care Administration Board
Ralph Dean, Chairman, Statewide Health Coordinating Council
Brenda Bacon, Office of the Governor
Frances Dunstun, MD, Commissioner of Health

Healthcare Planning and Marketing Society of New Jersey
Testimony Pertaining to the Report of the Governor's Commission On Health Care
Section on Regulatory Reform
Endorsed by HPMSNJ Board: November 9, 1990

Planning Reform

CR3. State Health Plan

- We believe that it is unrealistic to have a State Health Plan which identifies all health care needs of New Jersey residents; health care is changing rapidly and the State is geographically and demographically diverse. Therefore it is very unlikely that one set of statewide criteria can apply equally well to all areas of the state. There must be a provision to respond to area-specific needs which are not identified in the Plan.

- To meet the needs of New Jersey residents, the State Health Plan must remain flexible and should include waiver criteria under which a Certificate of Need could be submitted. The waiver criteria should be service specific and consider such factors as utilization, access and other pertinent issues. With a well developed State Health Plan, relatively few Certificates of Need will need to be granted under a waiver provision.

- The intent of this recommendation appears to be the development of a State Health Plan as the driving force for centralized health planning and submission of Certificate of Need applications. As such, it is essential that health care provider input be incorporated into the development and ongoing modification of the State Health Plan.

- We are concerned that the State Plan reflect fully the complex and dynamic nature of the delivery of health services. This concern is expressed in light of the severe limitations of State Health Department budgets at a time when demands on it are being increased.

CR4. Local Advisory Boards

- There must be a provision for local input which includes the opportunity for affected parties to make public comment.

- Historically, local health planning models have not provided sufficient local input into the identification of local needs and development of

CR4. Local Advisory Boards (Continued)

programs and policies to meet those needs, and into the development of the State Plan.

- If constituted, these local bodies should be separately constituted 501 (C) (3) corporations who are allowed to seek sources of funds in addition to State allocated funding.

- As autonomous entities the local bodies should be free to determine the composition of their boards so long as these boards are 1) representative of the geographic area and 2) have a consumer majority.

- We note that the Commission's report provides for only limited local input into the Certificate of Need review. For example, how can the LAB's review and make independent assessments of Certificates of Need if the analysis of need is conducted by State staff and no exceptions are allowed.

CR5. State Health Planning Board

- In order to allow for sufficient provider and consumer representation, there needs to be a further consideration of the number of seats allocated to government officials. There is concern that the proposed structure would limit provider input significantly.

CR6. Role of Health Care Administration Board

- The State Health Plan, as other issues reviewed by HCAB, must be subject to a public comment period.

- The Board should be required to respond to all comments it receives in a public meeting.

<u>Certificate of Need Reform</u>

CR7. State Health Plan

- As stated above, waivers to the State Health Plan should be permitted. Providers should be allowed to submit Certificates of Need for services that are not identified in the State Health Plan as "needed services" without the requirement that the State Health Plan be revised prior to their review. There should be a mechanism in place to concurrently grant a waiver to the State Health Plan for the specific situation and review these projects. These waivers

and proposals must be handled on a case by case basis.

- Local health planning, if it continues to be funded, should provide input into developing the State Health Plan.

CR8. Role of the Commissioner

- The roles of the Commissioner and HCAB in the final decisions to grant or not grant CN's needs to be clarified.

CR9. Appeal Rights

- We support the affirmation of the applicant's appeal rights and believe it is essential that applicants who are denied a Certificate of Need have the opportunity to appeal the Commissioner's decision under the current process.

Certificate of Need Application

CR10. Definition of Health Care Facility

- In support of this recommendation, it is appropriate that Certificate of Need requirements be determined by the type of service as opposed to by facility ownership.

CR11. Certificate of Need Thresholds

- It is appropriate that Certificate of Need thresholds be raised; $1.0 million is probably appropriate for major moveable equipment, however, the construction threshold should be higher ($1.5 million as recommended in the draft CN regulations).

CR12. Annual Cap On Capital Projects

- Limiting capital dollars may be necessary, however, an annual cap may lead to inequitable considerations of competing projects.

- It is critically important, if there are to be caps, that there be an equitable process for allocating capital among competing projects. This process should specifically address both the need for some facilities to expand in response to population growth and others to renovate and modernize without expanding, in order to remain competitive.

- We are greatly concerned that caps may unfairly

postpone needed maintenance to the State's health system infrastructure, increase future costs because of deferred construction/renovation, and may result in New Jersey facilities being less than competitive with New York and Pennsylvania facilities.

- Provision should be made for hospitals to build equity as an alternative to debt financing.

CR13. DOH To Review and Categorize Providers by Plant Conditions

- Health care providers cannot be categorized based on facility age alone. Also to be considered in capital prioritization are types services provided, populations served, potential for growth in demand, and institutional mission.

- Providers must have input into developing the criteria which will serve as the basis of how projects are to be prioritized.

- Prioritization must be reviewed on a per project basis.

CR14. Elimination of 1991 Capital Batches

- We feel <u>any</u> moratorium could have serious negative consequences for the State's health care industry. The experience in New Jersey suggests that any moratorium is likely to last longer than one year.

CR15. DOH Given Authority to Decertify Paper Beds

- We believe adequate regulatory authority already exists for this purpose.

CR16. CN Period of Implementation

- Varying the period of time for which CN is valid according to the type of project is a positive change.

- Terminating CN's not implemented within the regulatory time frame should not be permitted without the applicant being given the opportunity to request an extension as significant resources may already have been invested.

- It is unclear from these recommendations, as to what constitutes "implementation" of CN.

CR17. Physicians Prohibited From Referring To Service In Which He/She Has An Interest

- We see this as seriously counterproductive. It would inhibit, if not preclude, the development of joint ventures which reduce demands for hospital borrowing, spread risk, and provide a means to cost effectively and quickly respond to emerging needs. We believe that full disclosure of interests and providing information on alternative services should be sufficient.

This concludes the comments from HPMSNJ relative to the Commission's Report, Section on Regulatory Reform.

A New Jersey Non-Profit Corporation

UHS University Health System of New Jersey

Plaza II
317 George Street
New Brunswick, New Jersey 08901
(201) 418-8000

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION
NOVEMBER 28, 1990
10:00 A.M.
ROOM 418, STATE HOUSE ANNEX, TRENTON

TESTIMONY REGARDING STATE HEALTH PLANNING

Assemblyman McGreevey and members of the Assembly's Health Care Policy Study Commission:

I appreciate your providing this opportunity to comment on the recommendations of the Governor's Commission of Health Planning. I am Thomas E. Terrill, Ph.D., Executive Vice President of the University Health System of New Jersey. We are a consortium of eight of New Jersey's leading academic and teaching hospitals and the education network of the University of Medicine and Dentistry of New Jersey.

I intend to address the issues raised by the Commission in regard to Regulatory Reform. Specifically, the Commission identifies areas of particular concern:

- the lack of a level playing field among all providers through the Certificate of Need process
- low Certificate of Need thresholds
- limited attention to the affordability of capital investments
- uncoordinated and limited participation of the citizenry in the health care planning process

I would like to address those areas in that order. We support the recommendations of the Commission in regard to leveling the playing field and increasing the CN threshold. The lack of a level playing field among all providers through the Certificate of Need process should be remedied. This is particularly true if the thresholds for Certificates of Need are raised to an appropriate level.

We believe that level should be $1.5 million. At this amount, construction would be included while most equipment (such as CT Scanners) would not require review. This would

Atlantic City Medical Center
Cooper Hospital/University Medical Center
Hackensack Medical Center
Helene Fuld Medical Center
Jersey Shore Medical Center
Kennedy Memorial Hospitals-University Medical Center
Robert Wood Johnson University Hospital
University of Medicine and Dentistry of New Jersey
UMDNJ-University Hospital

simplify and streamline the Certificate of Need process, while making it more equitable since all health care providers would be required to proceed through the same process.

With regard to greater attention to the affordability of capital investment, the Commission proposed an annual cap be established for a period of five years and be incorporated into the State Health Plan. University Health System of New Jersey understands the Commission's concern about the costs that "bricks and mortar" add to health care.

Nevertheless, a restrictive annual cap could have a devastating affect upon the health care system. Before an annual cap is established, we recommend that the following matters be reviewed, and that these questions be answered:

- What expenditures will be included in the cap? (i.e., Will refinancing be included?)
- What priorities will be established? (i.e., Will plant conditions, age of buildings take priority over the development of regionalized services?)
- Who will make the decisions regarding the size of the cap and the determination of priorities?
- Can an annual cap realistically be established for a five year period of time?
- What impact will the annual cap have on the State Health Plan?

In order to properly plan for the future needs of our health care system, it may be preferable to establish several annual caps - one for refinancing, one for regionalized services and one for construction. This would allow the planners and regulators more flexibility and provide some assurance that needed regionalized services and construction are not held hostage to refinancing and plant modernization.

Finally, the Commission is seeking to address increasing participation of the citizenry in the health care planning process. To accomplish this, the Commission recommends a State Health Plan be revised annually. Local input would be sought from Local Advisory Boards. The State Health Plan would be the basis upon which Certificate of Need applications are reviewed.

Our concern here is with the timeliness of a process that has the potential to be unduly cumbersome, unresponsive, and slow. For example, the State Health Plan may take 2-3 years to be developed - if it is to be truly comprehensive and to

receive input from the Local Advisory Boards. Once completed, the data used to create the Plan are already a few years old. A provider seeking to offer a service or undergo construction may have been delayed 2 - 3 years awaiting the completion of the State Health Plan. If the provider is eventually successful in receiving all approvals through the Certificate of Need process, what are his options if the annual cap has been reached? Will he be required to start back at step one of the CN process the following year?

In terms of providing greater participation of the citizenry, we at UHSNJ applaud the effort. However, unless the Local Advisory Boards have the right to appeal should the Commission act contrary to their recommendations, it is not clear to us how successfully the Commission has addressed the issue of greater participation.

In reference to Certificate of Need issues, I would like to comment on specific areas of concern.

1. The primary teaching hospitals of UMDNJ - University Hospital, Robert Wood Johnson University Hospital Cooper Hospital/University Medical Center and Kennedy Memorial Hospitals-University Medical Center should be excluded from the Certificate of Need process. The core teaching hospitals of New Jersey's medical schools must have access to technologies and services in order to fulfill their missions of teaching, clinical care, and research. Exclusion from the Certificate of Need process will foster the development of a preeminent statewide health sciences University and position New Jersey to halt the exodus of patients to other states.

2. Decertification of paper beds and specification of the time-frame for implementing a Certificate of Need should be appealable. In both of these areas, circumstances beyond the control of the hospital may interfere with full bed usage or implementation of Certificates of Need. Appeals reduce the likelihood of arbitrary and unreasonable decisions.

In conclusion, I believe the Commission has done a remarkable job of sifting through very complex issues and developing recommendations to address the problems facing the health care system. However, before implementation of the recommendations, I respectfully suggest further study and clarification are needed on three key issues:

The Annual Capital Cap - the scope and potential impact of the annual cap on the health care system.

The Scope and Time Frame - the scope and time frame of development and implementation of the State Health Plan.

Exceptions and Appeals - exceptions and appeals to the Certificate of Need process.

University Health System of New Jersey stands ready to assist the State in developing a more equitable, efficient and effective health care system. We would be pleased to serve as advisers or committee participants to assist the State of New Jersey in resolving the complex problem related to providing health care to all New Jerseans.

(11-28Testimony)

PRESENTATION TO

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

NOVEMBER 28, 1990

BY: EDWARD J. PELOQUIN

The following comments relative to the Regulatory Reform recommendations by the Governor's commission on Health Care Costs are based on the goal of making health care affordable by efficient allocation of facilities, equipment and manpower, improved productivity in the delivery of treatment, diagnosis, and care, and promotion of prospective price competition.

CR3 A State Health Plan should be developed and have the force and effect of State Law.

For selected services and facilities, the concept articulated in this recommendation is being partially implemented via categorical regulations (e.g., trauma centers, cardiac surgery, and inpatient comprehensive rehabilitation). The recommendation expands the concept to all health care facilities and services covered under the current statues P.L. 1971, c136 & 138, Health Care Facilities Planning Act. This has merit and should be pursued.

CR4 The planning process should be governed by a new State Health Planning Board, an unspecified number of Local Advisory Boards, and a State Office of Health Planning within the Health Department.

For the fourth time since the demise of federally financed Health Systems Agencies in 1986, it has been concluded the public's right to know and have some say in the orderly and acceptable development of health services is best served through the existence of local health planning (see Attachment 1). It is believed the existing State Law P.L. 1987 Chapter 118, Statewide Local Health Planning Program, should be utilized immediately to implement CR 4 (See Attachment 2).

CR5 A State Health Planning Board should be established, with responsibilities for the development of the State Health Plan in concert with the LABs and the State Department of Health.

A comprehensive State Health Plan requires a comprehensive mechanism to assure access, quality, and cost are balanced when developing the State Health Plan and deciding on Certificate of Need Applications.

It is strongly suggested the rule making functions of the Health Care Administration Board be included. This would bring efficiency to the regulation development process (e.g. eliminate the multiple step process) and, more importantly, merge the determination of need with reimbursement policy development. This would allow timely changes in reimbursement to bring about less costly, more productive health care services. In effect, the result could be embodied in a Certificate of Affordability, with rate setting considered prior to a final decision on expenditures for health care facilities and services.

CR6 Both the State Health Plan and each service regulation should be adopted by the health Care Administration Board and have the force and effect of law. The State Health Plan would be re-evaluated each year and appropriate revisions made.

This is a duplicative and inefficient way to establish the State Health Plan. The State Health Planning Board should be the final authority. The Commissioner of Health should manage State Health Plan implementation.

CR7 The State Certificate of Need activities should be directed by the State Planning process.

In general, this recommendation reinforces the importance of the State Health Plan and the necessity to for all providers, especially physicians, to fully participate in its development. My one concern is with the Department of Health staff analysis. To avoid predetermination on any one application prior to completion of the review

process, the staff analysis should be limited to findings of fact with regard to compliance with applicable regulation, licensing standards, and construction requirements. No conclusions should be issued as to need and affordability. These conclusions should only be reached by the Commissioner of Health after the review process is completed.

CR8 The Commissioner should review the applications and recommendations of the recommending bodies. The commissioner is empowered top make final decisions on Certificate of Need approvals and/or denials, if his/her decisions are consistent with the State Health Plan. An application which is denied has appeal rights to the HCAB.

The HCAB should be the body that decides on appeals submitted by a denied applicant, the State Health Planning Board, and the Commissioner of Health application decisions and administrative rulings.

CR9 As regional recommending agents on matters related to Certificates of Need, the LABs should not have an appeal right, should the Commissioner act contrary to their recommendations. Only the State Health Planning Board, the applicant and other parties of standing would retain the right to appeal the Commissioner's determinations. The State Health Planning Board, representing the public process, could appeal the Commissioner's decision through the Administrative Law procedures, thereby establishing a separate record to be presented to the HCAB or to the courts. In such case, the State Health Planning Board would be represented by the Public Advocate, subject to the determination by the Public Advocate that the appeal has merit and is in the public interest.

The role of the Public Advocate is too broad. If they represent the SHPB, it should be subject only to a determination the appeal is not allowable as a matter of legal procedure. The merit and public interest is a decision only the comprehensive judgement of the SHPB can be relied upon to decide. A better approach is to have a Deputy Attorney General assigned to the State Health Planning Board.

CR10 The definition of a health care facility should be changed to include, under Certificate of Need requirements, any service which is the subject of a State adopted Health Planning regulation or any service or acquisition with a total project cost exceeding $1 million.

This should be changed to read, "...subject of the State Health Plan."

CR11 The Certificate of Need thresholds for major movable equipment and for modernization, renovation, and new construction willbe raised to $1 million, with an annual adjustment for inflation.

This appears reasonable, provided items affecting safety and routine operations (e.g., telephone and computer systems) above that level are processed only as administrative reviews.

CR12 There should be an annual cap on capital projects.

It appears this recommendation is directed at the acute general hospital component of health care delivery. It is suggested this include psychiatric hospitals and related inpatient beds.

The use of an annual cap for hospital bed additions, and/or modernization/conversion/renovation appears to be the best way to prospectively address affordability and foster price competition, while assuring medical care quality and appropriate access. For instance, with a cap, judgements would have to be made among competing proposals. The proposals that provide the expected quality at least price, with greatest access should receive the highest priority for the year. This would eliminate projects that are costly, but without direct measurable benefit in terms of access or quality of treatment, diagnosis, and nursing care.

The current review process does not allow a comparative review of long term need and benefit, nor are the criteria detailed enough to distinguish between those items which improve productivity and those which primarily enhance the image of the facility.

CR13 The Department of Health should conduct a review of the statewide plan conditions and develop categories of priority against which capital expenditures will be judged. This analysis will be reviewed by the planning process and incorporated in the State Health Plan.

This is essential and must be done prior to establishing the annual cap.

CR14 In order to allow sufficient time to develop the above, and to eliminate a potentially counterproductive window, the capital batches scheduled for January 1, 1991, and July 1, 1991, should be eliminated.

Agree. This is necessary for an orderly process to determine the annual cap. Please note, elimination of this capital batch would reduce the total annual number of CN applications by only 10 to 15%.

CR15 The Department of Health would have the authority to decertify paper beds based upon the utilization of those beds over time.

This must only be done if called for in the State Health Plan. Often, proposed bed reductions have been submitted with major modernization/conversion/renovation projects to meet the current utilization standards that, if not met, can lead to a disapproval. Consideration is not usually given to the longer term need and impact on the area served by two or more hospitals.

CR16 Each Certificate of Need issued should have a discreet period of time for implementation.

The time periods I recommend are:

Hospital, $10 million or greater	3.5 years
Hospital, less than $10 million	3.0 years
Nursing Homes	2.5 years
All other	2.0 years

Should a project request an extension of time beyond these limits, the Certificate of Need should be submitted to the LAB for public review of the reasons for requesting the extension. The LAB recommendations would go directly to the Commissioner of Health.

CR17 A statute prohibiting any physician from referring to a service in which he, his partners, or his family have a fiduciary interest should be proposed

No Comment.

LOCAL HEALTH PLANNING AGENCIES
MAKE A DIFFERENCE

The 1971 New Jersey Health Facilities Planning Act established as public policy that no health care facility or service should be implemented unless it contributes to the orderly development of adequate and effective health care services. Since 1971, the public's right to know and have some say in the orderly and acceptable development of hospital, nursing home, and other health care services has been manifested in local area health planning agencies. As recently as May, 1987, this public right was reaffirmed by State Law P.L. 1987, Chapter 118. The new law established a New Jersey specific local health planning program with a requirement that each agency be governed by volunteers and funded at 12 cents per capita.

One only has to review the extensive examination of local health planning that took place prior to passage of P.L. 1987, Chapter 118 to comprehend its value.

On December 4, 1986, the Assembly Health and Human Resources Committee held a Public Hearing "To examine the Health Planning System in New Jersey". Sixteen agencies, organizations, provider associations, and individuals presented testimony. All of these diverse groups testified that health planning was needed.

On January 30, 1987, the Report of the State Blue Ribbon Task Force on Local Health Planning was issued. It concluded that the State of New Jersey needs to "...assure the residents of New Jersey that the local planning process would remain a viable and productive part of the overall system". The membership included representatives of private business (e.g. Atlantic Chemical, The Bergen Record, NJ Business Group on Health), hospital and nursing home providers, insurers, and the State Department of Health.

On March 12, 1987, after hearings by both the Assembly Appropriations Committee and Assembly Health and Human Services Committee, the full Assembly approved the local health planning agencies legislation by a 72-0 vote!

On March 26, 1987, the Senate concurred and voted approval by a vote of 32-1!

On May 7, 1987 the Governor signed P.L. 1987, Chapter 118 into law!

Local health planning agencies are an "integral component" of the Commissioner of Health's decision making process relative to Certificate of Need applications. Local health planning agencies provide assurance to the public that community concerns and priorities are advocated at the state level prior to a final decision being made. More importantly, the local health planning agency involvement in the Certificate of Need process makes a difference in the public trust for our state officials. No where did this become more evident than in early 1988 when the local health planning agency was by-passed by state officials and a new nursing home in northern New Jersey was approved without the required local review. The subsequent public outcry led to a court remand which stated, "...omitting the (local health planning) agency from the permitting process was particularly serious.". This reaffirmed the necessity of local health planning agency review for siting future facilities. A return to the orderly process in 1989 resulted in two new AIDS facilities approved in central New Jersey after extensive public input. Even though there was similar public objection to the proposals, the community as a whole felt they had a fair and full opportunity to express their views.

Attachment 1

Perhaps of more significance were the findings of a seven month investigation by the State Attorney General's Program Integrity Section into allegations involving favoritism in the awarding of Certificates of Need. The report, issued in December 1988, contained this conclusion:

> "This investigation has confirmed that the process for reviewing Certificates of Need, when followed, provides a system of checks and balances which would made it difficult for any applicant or any government actor within the system, to dominate the process. Specifically, the review procedures entail many different levels, and thus depend upon the recommendations of many different actors. In addition, each actor within the process is held accountable for his or her recommendation and is expected to justify the recommendation based on objective criteria."

As New Jersey entered the 1990's, local and state health planning was reviewed for the fourth time in the past five years. This time by the Governor's Commission on Health Care Costs. In their October 1, 1990 report, CARE for New Jersey, the Commission affirmed that local health planning should continue in the form of Local Advisory Boards, as successors to the health service area (HSA) agencies.

It is clear the public's right to know and have some say in the orderly development of health care facilities and services has once again been objectively determined as valuable and necessary. The next logical step is to transition, without disruption of local input, from the HSA's to the LAB's.

Prepared by:
E. J. Peloquin
Executive Director
Central Jersey Health Planning Council
November, 1990

CHAP. 118 P.L. 1987
APPROVED 5/7/87

[SECOND OFFICIAL COPY REPRINT]

SENATE, No. 2372

STATE OF NEW JERSEY

INTRODUCED JUNE 30, 1986

By Senator McMANIMON

Referred to Committee on Institutions, Health and Welfare

AN ACT establishing a Statewide local health planning program **[and]** ** supplementing Title 26 of the Revised Statutes**, *and making an appropriation therefor***.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. As used in this act:

a. "Commissioner" means the Commissioner of the Department of Health.

b. "Corporation" means an independent private, nonprofit corporation which is not a health care facility, or a subsidiary thereof, or an affiliated corporation of a health care facility.

c. "Health care facility" means a health care facility as defined in section 2 of P. L. 1971, c. 136 (C. 26:2H-2).

d. "Health care service" means a health care service as defined in section 2 of P. L. 1971, c. 136 (C. 26:2H-2).

e. "Health systems agency" means a health systems agency as defined in section 2 of P. L. 1971, c. 136 (C. 26:2H-2).

f. "Local health planning" means planning by a corporation *[of]* **pertaining to* health care *[facilites]* **facilities* and *[a health care]* services **which are* located in or serving a specific geographical area designated by the commissioner.

g. "Provider of health care" means a provider of health care as defined in section 2 of P. L. 1971, c. 136 (C. 26:2H-2).

2. The commissioner shall establish a program to provide local health planning on a Statewide basis in a minimum of three specific geographical areas to be designated by the commissioner, each of which *[should]* **shall, to the extent possible,* include sufficient

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.
Matter printed in italics *thus* is new matter.
Matter enclosed in asterisks or stars has been adopted as follows:
*—Senate committee amendments adopted November 17, 1986.
**—Assembly committee amendments adopted January 8, 1987.

Attachment 2

resources to provide a comprehensive range of health care facilities and services. The commissioner shall consider the compatibility of social, economic, transportation and geographic characteristics in determining the areas to be designated.

3. a. The commissioner shall establish requirements for the composition of the governing body of each corporation and shall specify, under the terms of an agreement with the corporation for the awarding of a grant pursuant to subsection c. of this section, those functions which the corporation at a minimum shall perform.

b. The commissioner shall approve a corporation within each of the geographical areas designated by the commissioner, pursuant to section 2 of this act, to provide local health planning in that geographical area.

c. The commissioner, on January 1, 1987, and annually thereafter, shall award to each corporation a grant of such monies as shall be determined by the commissioner, except that the grant shall be no less than *[20]* *12* cents per capita.

d. The membership of the governing body of each corporation approved by the commissioner pursuant to subsection b. of this section shall be composed of consumers and providers of health care who reside or have their principal place of business within the geographical area designated by the commissioner, except that no less than 51% but no more than 60% of the members shall be persons who are not providers of health care.

[4. The Department of Health, to effectuate the provisions and purposes of this act, may charge health care facilities which are licensed by the department pursuant to P. L. 1971, c. 136 *[(C. 25:2H-1]* *(C. 26:2H-1* et seq.) *[,]* reasonable fees *[which]* *. *These fees* are eligible for reimbursement by third party payers, the aggregate annual amount of which shall not exceed *[25]* *12* cents per capita during each fiscal year. The commissioner shall develop an equitable method of determining the fees to be assessed each health care facility. *A corporation may charge an additional fee, in an amount established by the commissioner, for review of a certificate of need application submitted to the corporation.*]

[5. If, during fiscal year 1987, there is a termination or reduction of federal funds for health systems agencies, funds shall be provided, in an amount to be determined by the commissioner, to operate the health systems agencies until the local health planning program established pursuant to this supplementary act begins operating.]

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[6.] **[*5.*]** **4.** a. Except as provided in subsection c. of this section, a corporation shall not, by reason of the performance of any duty, function or activity, required of, or authorized to be undertaken by the corporation pursuant to this act, be held civilly or criminally liable if the member of the governing body of the corporation or any employee of the corporation who acted on behalf of the corporation in the performance of that duty, function, or activity acted within the scope of his duty, function or activity as a member of the governing body, or as an employee of the corporation, exercised due care and acted without malice toward any person affected thereby.

b. Except as provided in subsection c. of this section, a member of the governing body of a corporation or an employee of the corporation shall not by reason of that person's performance on behalf of the corporation of any duty, function, or activity required of, or authorized to be undertaken by the corporation pursuant to this act, be held civilly or criminally liable if that person *[believed he was acting]* *acted* within the scope of his duty, function, or activity as a member of the governing body, or as an employee of the corporation, and with respect to the performance of that duty, function or activity, without gross negligence or malice toward any person affected thereby.

c. The provisions of subsections a. and b. of this section do not apply with respect to a civil action for bodily injury to an individual, or to physical damage to property brought against a corporation or a member of the governing body of the corporation or employee of the corporation.

[7.] **[*6.*]** **5.** The commissioner, pursuant to the "Administrative Procedure Act," P. L. 1968, c. 410 (C. 52:14B–1 et seq.), shall adopt such rules and regulations as are necessary to effectuate the purposes of this act.

6. There is appropriated $250,000.00 from the General Fund to the Department of Health to effectuate the purposes of this act.

[8.] *7.* This act shall take effect immediately **[*and shall expire two years thereafter*]**.

HEALTH PLANNING AND COST CONTAINMENT

Establishes local health planning program and appropriates $250,000.00.

46X

Central Jersey
Health Planning Council, Inc.
2 Well St. (Research Park), Princeton, NJ 08540 • (609) 921-0884

MEMO TO: Board of Directors

FROM: Ed Peloquin EP

SUBJECT: Suggestions for HSA Functions with Full Funding

DATE: July 26, 1989

In 1987, under the auspices of HSA Shared Services, Inc. (the predecessor to IHP, Inc.), a proposal was prepared to implement the new State local health planning law. I have reviewed the proposal and enclosed an updated modification for your consideration. In order to support full funding, we will have to agree upon the purpose and use of additional funds beyond the fact the program is not stable at $475,000 and clearly underfunded for Certificate of Need Review.

For the period July 1, 1988 through June 30, 1989, we have processed $578,811,163 in applications. The following summarizes the activity:

Total number of applications	97	
Number approved	64	$410,832,146
Number disapproved	9	91,337,944
Number withdrawn	9	26,367,883
Number deferred	4	6,917,045
Number no comment	11	43,356,145

The cost to the State for this local review activity was $84,457. This translates to $685.33 reviewed for each $1.00 expended. The average per application processed is $596,712.53.

Looking ahead to the 1990's, I have given a great deal of thought to the concept of Certificate of Need established in the early 1970's. Without going into details, it appears to me the concept, after twenty years, should be reexamined for the 90's. My personal opinion is that a new concept, based on affordability of health care, should be considered. For lack of a better term, I have selected the term Certificate of Affordability.

SUGGESTED HSA FUNCTIONS WITH FULL FUNDING

In addition to providing review and comment on Certificate of Need applications and facilitating implementation of the epidemiologically based health plan developed for 1989-90, it is suggested two additional functions be assigned to HSAs, with a concurrent funding increase to the mandated 12 cents per capita level.

1. Accessibility to health services continues to be a major public issue, but one which does not have sufficient and timely information always available to determine if Certificate of Need decisions, or new reimbursement policies, or remedies to the problem of uncompensated care, are working efficiently and effectively to improve access.

   It is necessary there be regular monitoring of the situation at the local level to track the extent to which low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups are actually obtaining health care. Such monitoring would lead to timely suggestions for new or revised public policy. To quantify accessibility HSA's would need to answer questions at the community level, such as:

   - how many people are still medically underserved;
   - are those underserved in easily defineable groups;
   - what are the prevailing attitudes and values regarding acceptability of public health services;
   - what is the extent to which Medicaid and medically indigent patients are served by providers;
   - are there eligibility criteria and admission practices which inhibit timely access;
   - how many persons do not have a source of regular medical care and why;
   - how many times did people not obtain services (e.g. primary care or home health, etc.) because they felt discouraged or it was not affordable;
   - did people use available public health services as an alternative;
   - what are the transportation or physical barriers experienced by people;
   - to what degree does out of pocket cost, waiting time to see a provider, and amount, or lack of, information influence satisfaction with health care delivery;
   - to what extent will manpower shortages affect the ability of providers to maintain accessible services and;
   - what is the performance of licensed health care facilities regarding access conditions incorporated with Certificate of Need approvals?

A variety of processes involving the County Health Planning Committees could be utilized to obtain the necessary information. At a minimum, there would be an annual survey of the County Health Planning Committee to obtain their observations concerning access problems and solution concepts. Using analysis of State public health data and DRG statistics, regional task forces or technical panels would be convened to develop recommendations to solve access problems.

2. The public's continuing desire to obtain reliable and factual information beyond that available in the media has been confirmed as a result of participation in Certificate of Need review meetings and the Epidemiologically based health planning process. Such information, to be most useful, should be available ahead of issue crises and not as a reaction to events or decisions after they have occurred. It is suggested HSA's produce consumer information and community education on the availability, affordability and accessibility of quality health services. This would help the consumer understand what choices are available and what to expect in the way of outcomes and cost. This may take the form of a monthly newsletter, public forums where public health professionals educate consumers on current issues, consumer guides, resource directories, public issue papers, fact sheets, and studies that delineate access and quality problems.

   Note: Producing a monthly newsletter which serves the purposes of providing consumer information on facilities, programs, new services, and available health education programs, would also be used for Certificate of Need purposes by providing a public notice to affected parties. It would include the NJDH need projections (i.e. beds, visits, etc.) and listing of date, time, and meeting location for applications to be reviewed.

These two additional HSA products are useful:

- To the New Jersey Department of Health in keeping all existing public and potential providers informed of need statistics, and the significance of emerging regulatory and policy changes;

- To the Statewide Health Coordinating Council in preparation of the State Health Plan, legislative activities, monitoring access to health services and assessing the appropriateness, acceptability and impact of proposed new health planning regulations;

- To area providers who must constantly assess their position in the market and self evaluate their responsiveness to the public needs;

- To the local citizens in their own community in making informed choices about selection of timely and appropriate services; and

- To assure routine and clear notice to affected parties, concerned groups and the general public in the Certificate of Need process.

Each Local Area Health Planning Corporation (HSA) would continue to organize its personnel to concentrate on the work program while making maximum use of centralized services (e.g. administrative support, etc.), from the Institute of Health Planning, Inc.; data from NJDH; and obtain expert information from the technical staff of the Department of Health. In addition to agency organization and management, the operation would have four general components:

1. Certificate of Need Review
2. Epidemiological Based Health Planning
3. Access research and status reports
4. Consumer information, preparation and dissemination

(It is assumed one of the most essential Department of Health services, the provision of data, will be done in a timely, up-to-date and complete manner so as to assure the work program will be implemented according to the expectations of the annual grant.)

The financing would be derived from full funding of PL 1987, Chapter 118 at the 12¢ per capita level. This equates to $920,640 using current State population data. The elements of cost include:

Certificate of Need Review	$475,000
Epidemiological Based Health Planning	225,000
Access Research	160,000
Consumer Information	60,000
	$920,000

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LOCAL HEALTH PLANNING

"IN THE NEWS"

Press Clippings Examples

August - November, 1990

submitted by
Edward Peloquin

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editorial

The Times

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E. J. Baumeister Jr./Managing Editor
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Heartfelt need

The Central Jersey Regional Health Planning Council, representing Mercer, Middlesex, Ocean, Monmouth, Hunterdon and Somerset counties, voted last month to endorse the certificate-of-need application filed with the state by St. Francis Medical Center to create an open-heart surgery unit. The regional council thus disagreed with the Mercer County H.P.C., which two weeks earlier had voted 7-6 to oppose the application.

The next stop for St. Francis is the State Health Coordinating Council, which is scheduled to vote in mid-November. Then the application will go to Health Commissioner Frances J. Dunston, who will make the final decision, based in part on the votes of the county, regional and statewide councils.

We believe the application should be approved because it would make open-heart surgery, angioplasty and related procedures more accessible to Mercer County residents and to people living in nearby counties. The undeniable need to regionalize health services in order to hold down costs doesn't mean that residents of a large and discrete population area must be subjected to major inconvenience in obtaining medical care.

Currently, a Trenton resident needing bypass surgery is sent to Camden, New Brunswick or Philadelphia — often to an unfamiliar hospital with doctors and nurses whom the patient never met before. That's a hardship for not only the patient, who must recover far from home, but for family and friends, who must travel a long distance to the hospital and schedule their arrivals during limited visiting hours. Much-needed support by loved ones during such a traumatic time would be facilitated if the heart patient was in a nearby hospital.

But if St. Francis' request is ultimately approved, as we hope it will be, the program will realize its full potential only with the cooperation and support of Mercer County's four other acute-care hospitals. It's no secret that the competition for patients among these hospitals is keen. And none of the other institutions has voiced support for St. Francis' application, even though St. Francis is the only institution in the county attempting to open a cardiac-surgery unit.

If they feel that St. Francis' program is of sufficient quality, doctors on staff at the other hospitals must be willing and free to offer St. Francis as an option to patients needing heart surgery or angioplasty. The only way for surgical teams to hone and maintain skills in any specific procedure is by performing the procedure over and over again.

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Unions are asked to pull together to control rising health care costs

By DONALD WARSHAW

Health fund trustees in the state's unionized construction industry were urged yesterday to join forces to combat projected annual 20 percent cost increases that threaten to bankrupt plans now providing coverage to tens of thousands of construction workers in New Jersey.

The invitation was issued by Project Build, a statewide, labor-management coalition promoting greater on-the-job efficiency and productivity in union construction, at a meeting of labor and management fund trustees in Jamesburg.

George Laufenberg, administrator for the New Jersey Carpenters Funds, said Project Build was ready to serve as the vehicle for the cooperative effort at cost control.

Laufenberg invited trustees interested in participating to inform Build prior to the organization's November meeting.

State AFL-CIO president Charles Marciante, the guest speaker, called on the trustees to lobby their state legislators for passage of the recommendations by the Governor's Commission on Health Care Costs to reform New Jersey's health care system.

The federation president also blasted a published statement this week by Assembly Health Committee Chairman Raymond Codey (D-Essex) that the commission's proposals will not be considered until after the 1991 legislative elections.

Marciante said media support for the commission's recommendations is having a positive effect in changing the minds of legislators reluctant to act due to the adverse public reaction to Gov. Jim Florio's tax and school aid distribution package.

Edward Peloquin, executive director of the Central New Jersey Health Planning Council, said the Taft-Hartley negotiated health care funds in New Jersey must seek cost control over the next three to seven years.

The explosion in health coverage costs since 1987 has been doctor- and hospital-driven, and not a result of New Jersey's often-maligned DRG (Diagnostic Related Group) system for rate-setting, Peloquin said.

Instead, subtle changes in rules and regulations and an absence of proper monitoring procedures have permitted health care cost-shifting within the DRG system to the state's labor-management negotiated health plans, he added.

"There has been a breakdown in the system since 1985," Peloquin said. "The monitors went out of business."

Peloquin, who served as consultant to Taft-Hartley funds in Connecticut, urged the labor and management fund trustees to follow the example of their counterparts in that state by uniting to seek a direct role in state "public policy-making" on health care.

By doing so, Taft-Hartley funds will be in a position to monitor and evaluate proposed rules and to counteract the powerful influence on the system from the insurance and medical industries, Peloquin said.

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Appeals court blocks drug abuse center

By TOM HESTER

A state ruling against a proposal to build a 90-bed alcohol and drug abuse center in Hillsborough near the Manville border was upheld yesterday by a state appeals court.

The court turned down an appeal by the non-profit Circle of Hope Center Inc. of North Brunswick. The center had been trying to reverse a state Health Department ruling that the proposed facility is unneeded in Central Jersey because there are enough similar centers within 30 miles to meet the demand for treatment.

"The (Health Care Administration) board's decision is supported by substantial credible evidence and, giving deference to its expertise in the health care domain, is neither arbitrary nor capricious," the court decision said.

Wilbert James, president of Fidelity Management Foundation Inc., the Circle of Hope Center's North Brunswick-based parent company, said he intends to ask the state Supreme Court to hear an appeal of the appellate panel decision.

"I am totally disturbed at this point," James said of his four-year-old effort to win a Health Department certificate of need for his project.

"I think it was collusion; I think it was a conspiracy." James, who is black, added, "I think it was racially motivated. There is no non-hospital affiliated (treatment) facility owned by any black minority in the state. They are maintaining the status quo and I believe they are in violation of federal law."

James wants to build the center on 58 acres between Sunny Mead and Western roads at a cost of $6.7 million. The center would have 60 beds set aside for alcohol abuse patients and 30 beds for drug abuse patients.

Initially proposed in 1986, the project has been turned down three times as unneeded by the Health Department and the state Health Care Administration Board and opposed by the Statewide Health Care Advisory Council and the Central Jersey Health Planning Council.

The proposal also did not have the support of the Local Advisory Committees on Alcoholism for Somerset, Hunterdon, Mercer, Monmouth and Ocean counties.

The Health Department action came during the administration of Gov. Thomas H. Kean and James listed former Health Commissioner Molly J. Coye as one of the respondents in his appeal.

A state administrative law judge also upheld the Health Department decision that James and the Circle of Hope Center Inc. failed to show a need for the center in Central Jersey.

James said his effort to gain a certificate of need has cost him $125,000, including a $100,000 deposit he made to buy the acreage if the project should gain state approval. James said he is a former fraud investigator for the Health Care Financing Association, which checked out possible abuse in Medicare and Medicaid programs. He described the Fidelity Management Foundation as a multi-ethnic, multi-disciplined consulting firm.

"I have nothing to lose at this point," James said of his decision to appeal to the Supreme Court.

Judges Geoffrey Gaulkin, Thomas F. Shebell and James M. Havey handed down the appeals court decision.

Steven Kropf of North Brunswick represented Circle of Hope and Elizabeth Zuckerman, a deputy attorney general, presented the state's case.

54X

Health panel vetoes St. Francis open-heart bid

Population size, crisis in financing cited as factors

By ROBIN LEVINSON
Staff Writer

LAWRENCE — A sharply divided Mercer County Health Planning Council yesterday voted to oppose St. Francis Medical Center's request to create the county's first open-heart surgery program.

The majority of council members agreed that, on a humanistic level, open-heart surgery should be available locally. But the 7-6 vote not to endorse St. Francis' request was based on Mercer County's relatively small population and the current crisis in health-care financing across the state and the country, officials said.

The council is a county-based panel that reviews applications for certificates of need for new medical services or the expansion of existing services.

Several witnesses told the panel that having to travel to Middlesex or Camden counties or to Philadelphia for bypass surgery or other open-heart procedures places a hardship both on the patients and on their families and friends.

One was Paul Pintella Jr., president and chief executive officer of the Urban League of Metropolitan Trenton. Pintella said his wife was forced to travel an hour each way every day for two weeks after he underwent triple-bypass surgery last June at Our Lady of Lourdes Medical Center in Camden. Only two friends were able to visit, he said.

"We're all drawn emotionally to this, but we read every day that the health-care costs in New Jersey are exceedingly high. When you lead with emotion, you end up with just this kind of a problem," said council member Walter Seligman, who made the motion not to endorse the application for a certificate of need from the state.

St. Francis estimates it would cost more than $3.1 million for renovations and equipment to establish a cardiovascular surgery unit in the 443-bed hospital. Once established, however, the hospital could do the surgery for a lower cost than can be done in Philadelphia hospitals, said St. Francis cardiologist Dr. Samuel Madiera. He cited a 1988 national survey that showed the total cost of bypass surgery was $29,100 in New Jersey and $32,000 in Pennsylvania.

Council President William Hogan, chief executive officer of rival hospital Helene Fuld Medical Center in Trenton, abstained from voting.

Before the vote, Hogan mentioned that under the state's regional planning criteria, there should be no more than one open-heart surgery program per 1 [illegible] lion population. The central New Jersey health reg[illegible] which includes seven counties, has slightly more tha[illegible] million residents and two cardiac surgery programs ready. One is at Robert Wood Johnson University Ho[illegible] tal. The other, at Jersey Shore Medical Center in N[illegible] tune, started earlier this year, Hogan said.

St. Francis currently is referring almost 200 patie[illegible] annually to other hospitals for heart surgery, said Ba[illegible] ra Taptich, director of St. Francis' Heart Institute. I[illegible] survey the hospital commissioned of 116 physicians [illegible] percent said they are at least fairly likely to refer he[illegible] patients to St. Francis if a quality open-heart surg[illegible] program were available.

Monmouth County's planning council unanimou[illegible] endorsed St. Francis' application on Monday. The ot[illegible] Central Jersey counties also must pass judgment on [illegible] application before it goes to regional and statew[illegible] health-planning councils.

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Before the vote, Hogan mentioned that under the state's regional planning criteria, there should be no more than one open-heart surgery program per 1 million population. The central New Jersey health region, which includes seven counties, has slightly more than 2 million residents and two cardiac surgery programs already. One is at Robert Wood Johnson University Hospital. The other, at Jersey Shore Medical Center in Neptune, started earlier this year, Hogan said.

St. Francis currently is referring almost 200 patients annually to other hospitals for heart surgery, said Barbara Taptich, director of St. Francis' Heart Institute. In a survey the hospital commissioned of 116 physicians, 85 percent said they are at least fairly likely to refer heart patients to St. Francis if a quality open-heart surgical program were available.

Monmouth County's planning council unanimously endorsed St. Francis' application on Monday. The other Central Jersey counties also must pass judgment on the application before it goes to regional and statewide health-planning councils.

56X

Central New Jersey
The Home News

BRUNSWICK, N.J.

FRIDAY, SEPTEMBER 28, 1990

Slower hospital growth possible

By LOUISE KRAMER
Home News staff writer

Major new projects from area hospitals, including modernizations of the Raritan Bay Medical Center in Perth Amboy and the Somerset Medical Center in Somerville, could be among the last for some time if recommendations by Gov. Jim Florio's health-cost advisory panel are put into effect.

The modernization projects were endorsed Wednesday by the Central Jersey Health Planning Council, a local body that reviews proposals for health-care facilities and makes recommendations to a state panel for approval.

According to Bruce Coe, co-chairman of Florio's Health Care Cost Commission, the commission's report, which is due on the governor's desk Monday, calls for a major overhaul of the current approval process. The report overall places more emphasis on patient treatment than on the expansion of facilities, Coe said.

Five-year plan

Part of the overhaul would be a five-year cap on new health-care facilities of perhaps $200 million each year statewide. The exact limit has not been specified, Coe said yesterday.

In 1989, out of $1.3 billion in new facilities proposed, $870 million won approval, said Edward Peloquin, executive director of the Central Jersey Health Planning Council.

Coe said the commission is recommending that the state, and not hospitals or medical groups, dictate the need for new facilities and services. Currently, hospitals and medical groups do respond to state requests — for the addition of beds for psychiatric patients with drug abuse problems, for example — but they also initiate and seek approvals for their own projects.

Sometimes, new facilities are not needed, Peloquin said. "Some of the best surgery in the world is done on the field by the military," he said.

The commission also will seek to change the makeup of local review bodies, such as the Central Jersey Health Planning Council, to include more consumers than health-care professionals, said Coe, who is head of the New Jersey Business and Industry Association.

A limit to new projects could go into effect Jan. 1, Coe said. That is the next scheduled submission date for major projects, said Peloquin.

"Everyone is concerned about the Jan. 1 cycle. There is no window to file now. There's not really an opportunity for anyone to file any long or big projects," Peloquin said. Although the governor's commis-

Plans submitted

Proposed hospital expansion & renovation projects:

Raritan Bay Medical Center Perth Amboy and Old Bridge	$53 million
Robert Wood Johnson University Hospital New Brunswick	$32 million
J.F.K. Medical Center Edison	$13 million
Somerset Medical Center Somerville	$37 million

Expansion & renovation projects under construction:

St. Peter's Medical Center New Brunswick	$95 million
Muhlenberg Regional Medical Center Plainfield	$43 million

REPORT

Continued from Page A1

sion does not have the power to enact its recommendations, a cap on construction would not require action from the state Legislature, Peloquin said.

Both Raritan Bay and Somerset medical centers must get state approval for their projects before they can proceed.

Another local project, which is further along in the approval process, is a $32 million expansion at Robert Wood Johnson University Hospital in New Brunswick. That project is on today's agenda of the state Health Coordinating Council. The final approval must come from the health commissioner.

Because all three projects are already in the approval process, they probably would not be affected by the possible limits, said Peloquin, who added that they all have been determined to meet a local need.

The $53 million modernization project for Raritan Bay Medical Center, dubbed "Renewal 2,000," is badly needed, Ronald Esser, the hospital's chief operating officer, told the Central Jersey council Wednesday.

The dietary department at the Perth Amboy Division, for example, was built in 1930 and has ceilings lower than 6 feet in some places.

Dr. Belardino Lupino, a member of the planning council and a physician at the hospital, said the building is like a labyrinth. He said the only reason he can find his way around it is because he has worked there for 30 years.

Plans call for a major renovation of the Perth Amboy Division on New Brunswick Avenue and an expansion of the hospital's division off Route 18 in Old Bridge to accommodate the quickly rising need for beds there, Esser said.

For the Old Bridge expansion, two floors would be added to the existing building on Hospital Plaza. One floor would house mechanical equipment, with the top floor for 33 new beds.

At the Perth Amboy Division, the emergency room would be expanded and the clinics re-housed in a new ambulatory care center, in addition to renovations and reconfigurations of existing facilities throughout the hospital.

Somerset Medical Center is proposing a $37 million modernization and renovation project plus an increase in its same-day surgery facilities.

Hospital President William Monagle said the work is needed to streamline the facility and the way health care is delivered. It takes more than an hour to clean up an operating room and prepare it for the next patient, he said. The renovations, which will include moving the location of the supply closet, for example, will cut that time to 15 minutes, he said.

The plans for Robert Wood Johnson University Hospital in New Brunswick call for new facilities on French Street (Route 27), including an expansion of the emergency department and the hospital's same-day surgery services, according to Peloquin. Harvey Holzberg, the hospital president, declined to comment on the expansion project Tuesday. He said he would formally release details if the project wins state approval.

Peloquin said the emergency department expansion is tied in to the hospital's recent designation as a Level I Trauma Center, one of three such centers in the state for the treatment of seriously injured patients.

Another major project, which is scheduled for hearing next month before the health council, is a proposed $13 million expansion at John F. Kennedy Medical Center in Edison. That project would add space for clinical services and would include a new conference center, said Patricia Bechtloff, a hospital spokeswoman.

Esser of Raritan Bay Medical Center said that he did not think his project would be impacted by the possible new construction limits "A lot is conjecture," he said, adding, "we've been working on this for a long time." Somerset Medical Center's Monagle declined to comment on the potential limits. Holzberg said Robert Wood Johnson has no additional plans for major projects. "Our current project would not be impacted," he said.

The proposed projects come in the wake of large renovations and improvements at other area hospitals. St. Peter's Medical Center in New Brunswick is well under way with a $95 million construction project. Muhlenberg Regional Medical Center in Plainfield is currently completing a new pavilion as part of an overall $43 million construction and renovation project.

Seniors gain a 'hotline' on Medicare rules

A new statewide toll-free telephone service began operation yesterday to answer senior citizens' questions about new Medicare reimbursement rules.

Beginning this month, the federal government has ordered a dramatic change in the way Medicare Part B claims are to be filed.

Under the change, physicians and other medical providers must prepare and submit claim forms themselves in order to obtain reimbursement. Up until now, it was the patient's responsibility to do the paperwork and send it in.

Part B of Medicare, the federal government's insurance program for senior citizens, pays for physician services, lab and diagnostic tets, ambulatory services, and medical equipment. This year, the government estimates that 450 million Medicare Part B claims will be filed.

Part A of Medicare pays for hospitalization.

Congress approved the new filing procedures last year. Since then, the federal government has publicized the change in flyers sent to Medicare beneficiaries.

In practice, many doctors and other medical providers already file claims for patients, said Edward J. Peloquin, director of the toll-free phone service. It was developed by the Central Jersey Health Planning Council, Inc., a non-profit, private health planning and consumer information organization.

The special phone number is 1-800-648-MTIS. It is accessible from any location in New Jersey, and is open from 9:30 a.m. to 12 noon, five days a week. Callers are not asked to identify themselves by name.

Peloquin said many senior citizens have questions about the new filing rule. "MTIS is prepared to answer all of them," he said.

One of the most frequently asked questions, Peloquin said, is whether medical providers can charge extra for preparing and submitting the claim. (They cannot, according to the federal government).

Congress authorized the change in the interest of increased efficiency, he said. "They decided it would be more efficient to process claims that came in from the providers, hopefully through electronic transfers," he said.

59X

THE STAR-LEDGER, Saturday, September 1, 1990

New Brunswick hospital named multiple-trauma treatment center

By GAIL FERGUSON JONES

The trauma center at Robert Wood Johnson University Hospital in New Brunswick has been granted official sanction for treating life-threatening injuries in Central New Jersey.

It joins University Hospital in Newark and Cooper Hospital in Camden as sites equipped to treat patients suffering multiple trauma. The unit at Robert Wood Johnson is the latest to be designated by the state Department of Health as a Level I trauma center and will treat patients injured in Middlesex, Somerset, Mercer, Hunterdon, Monmouth and northern Ocean counties.

Being cited as a Level I facility means the hospital is staffed and equipped to care for patients with multiple or life-threatening injuries and has educational, training and outreach programs as well.

Robert Wood Johnson's trauma center treated about 700 patients suffering life-threatening injuries last year, according to Gene Horan, the hospital's vice president for community relations. "We expect that to go up considerably with this designation," he said.

He said patients transported directly to the trauma center will be able to get treatment within the "golden hour," the first hour after being injured, when they are at highest risk of death or permanent disability. "Any time that's saved can be important," he said.

Horan also noted that the hospital is able to provide general surgery, neurological surgery, radiology, and clinical laboratory and blood bank services around the clock.

The hospital now must build a helipad, planned for the roof of its French Street building, so that patients can be transported by helicopter to the trauma unit. Until the helipad is built, one at Johnson & Johnson headquarters a few blocks away will be used.

Horan said the hospital's application for Level I status was supported by the Central New Jersey Trauma Network, which includes Robert Wood Johnson, Somerset Medical Center in Somerville, Helene Fuld Hospital in Trenton, the Perth Amboy and Old Bridge divisions of Raritan Bay Medical Center, and Central State Hospital, formerly Freehold Area Hospital, in Flemington.

The network has established guidelines for determining which patients should be transported from an accident scene to a trauma center and which can be treated adequately at the nearest hospital, he said.

Robert Wood Johnson was the only hospital in Central New Jersey to apply for the Level I designation, according to Judy Rotholz, a spokesperson for the department of health. Its application was endorsed by the Central Jersey Health Planning Council and the Statewide Health Coordinating Council, Horan said.

A letter from state Health Commissioner Frances Dunston, in announcing approval of the hospital's Level I application, noted that Robert Wood Johnson is a teaching hospital with an accredited surgical residency program and is engaged in research and educational activities related to trauma care.

60X

County endorses RWJ bid to build psychiatric unit

By RICHARD PLISKIN
Home News staff writer

NEW BRUNSWICK — Middlesex County would gain a $9.4 million facility to treat short-term psychiatric patients under a proposal put forward by Robert Wood Johnson University Hospital and endorsed last night by the county's Mental Health Board.

The plan, however, must now survive a series of reviews before gaining the final acceptance of the state health commissioner.

And though Robert Wood Johnson's proposal won the county board's recommendation, two other plans rejected by the board may ultimately win state approval. One of the rejected proposals was from the Perth Amboy Division of Raritan Bay Medical Center.

Under the plan endorsed unanimously by the 11-member county Mental Health Board last night, Robert Wood Johnson would construct a 5-story facility on French Street by Joyce Kilmer Avenue in downtown New Brunswick. Two stories would be set aside to accommodate 30 beds for use by short-term psychiatric patients.

The 30 spaces would be broken down into 13 beds for patients voluntarily seeking short-term treatment and 17 beds for those committed for short-term treatment against their will because they are a danger to themselves, to others or to property.

Under treatment guidelines, short-term commitment means inpatient commitment for up to 30 days.

The plan was developed in response to a the so-called Mental Health Screening law enacted by the Legislature two years ago, which called on government and health-care providers to develop short-term, acute-care psychiatric facilities, board members and staffers said.

Board member William Dice said the state health department has determined that Middlesex County's unmet needs for such short-term treatment amount to 29 beds — 17 for involuntary commitments and 12 for voluntary commitments.

Throughout the six counties that health authorities consider to make up Central New Jersey, the unmet need is projected to be 103 beds two years from now — 54 for involuntary commitments and 49 for voluntary, according to Edward J. Peloquin, executive director of the Central Jersey Health Planning Council Inc. The council must now review Middlesex County's endorsement of the Robert Wood Johnson plan.

The two proposals rejected by the county board last night came from Raritan Bay Medical Center and Psychiatric Institutes of America, or PIA, a private, for-profit outfit that Dice said owns 74 facilities nationally, including Fair Oaks Hospital in Summit.

Among the reasons board members cited for rejecting the 60-bed PIA proposal was that, being based in Tinton Falls in Monmouth County, it would not be easily accessible to Middlesex County residents.

Board members also were concerned by PIA's acknowledgement that patients there would not be able to use Medicaid insurance to pay for treatment costs, making it difficult for indigent patients to receive services.

The Raritan Bay plan calls for 17 beds for involuntary patients, including nine obtained through conversion of existing spaces elsewhere in the medical center. Rather than develop new spaces for voluntarily committed patients, Raritan Bay's plan applies 21 existing beds to meet that need, Dice said.

But Dice said the Robert Wood Johnson plan was superior in several respects, including its ability to draw on the resources of the Robert Wood Johnson Medical School, the University of Medicine and Dentistry of New Jersey and UMDNJ's Community Mental Health Center in Piscataway.

Board members said the Robert Wood Johnson facility could be operational by the spring of 1993.

The board's recommendation now goes to the Central Jersey Health Planning Council. Peloquin, the council's director, said the state health commissioner is expected to make a final decision on which proposal to accept by Nov. 15.

6/X

Wayside doctor given top award by Boy Scouts

By LORI ATKINS
Press Staff Writer

IN RECEIVING the Boy Scouts' highest honor, Jersey Shore Medical Center obstetrician Dr. Carl M. Marchetti has joined a select group that includes Nancy Reagan, Bob Hope and Neil Armstrong.

The Boy Scouts of America Silver Buffalo Award for Distinguished Service to Youth is presented every two years to honor service on a national level.

"I always thought this was beyond my grasp. It's usually given to well-known Americans," said Marchetti, Jersey Shore's senior vice president of medical affairs.

Marchetti, of the Wayside section of Ocean Township, was honored for more than 50 years of service to Boy Scouts and a national commitment to the organization.

His involvement has brought him across the nation and into the Oval Office to meet former Presidents Richard M. Nixon, Jimmy Carter and Gerald Ford.

He was in charge of the Boy Scouts' Report to the Nation for five years, when he annually accompanied about 10 Scouts to the White House to meet the president and members of the Supreme Court.

He said he was first involved in Cub Scouts when he was 9 years old and growing up in Union City.

"I became associated with an atypical, high-caliber group in a rough neighborhood. They were the future leaders and professionals," Marchetti recalled.

"More people in my high school class went to jail than college. All of the Boy Scout staff went to college," Marchetti said.

Marchetti said Scouting has been a major influence in shaping his early goals and decisions. He said he has made a lifelong commitment to "give back what I've received."

"Scouting has given me an appreciation for nature and people. Now I bring new life into the world," he said.

As a 21-year-old, he was elected by his peers to the Boy Scouts' national Order of the Arrow organization for "honor campers." The next year, he was president of the Order's Monmouth County Council, and at 25 he was the youngest to serve on its national policy-making committee.

The Boy Scout commitment to service and leadership is evident today in his medical career, as he is president of the Central Jersey Health Planning Council. This volunteer council determines the need for health services and reviews health care expansion and programs.

But as an obstetrician, Marchetti said, his medical expertise carried over only once into his Scouting duties.

CELESTE LA BROSSE/Asbury Park Press

Dr. Carl M. Marchetti, of Ocean Township, wears the Boy Scouts' highest honor, the Silver Buffalo Award.

He joked about an incident when he assisted a 7½-month pregnant woman adviser who nearly went into labor at a Boy Scout National Jamboree in Virginia.

Marchetti has served as an adviser for National Jamborees, gatherings of 50,000 Scouts every four years in Virginia. He also chaired the national Bicentennial celebration in Washington, D.C.

But he is especially outstanding in his work with Order of the Arrow, said James W. Kay, Monmouth County Boy Scouts Council executive.

"He brought personal leadership and direction to the Order," Kay said.

When Marchetti became president of the Order of the Arrow's Monmouth Council in 1978, it experienced a 2 percent to 3 percent membership growth, while Boy Scouting was declining nationwide, Marchetti said.

"In the late '70s, nationalism was out of style and the Boy Scouts lost about 25 percent of its members."

See DOCTOR, page B2

Asbury Park Press/Wednesday, August 29, 1990

Doctor

From page B1

Marchetti attributes the success of the council in that era to "good leaders and volunteers."

Kay said the growth was because of Marchetti's "reorganization and renewing the Order's sense of purpose." Marchetti also turned around an economic crisis in the Order and established a $1 million trust fund, Kay said.

Marchetti financially liberated the national Order of the Arrow from the rest of the organization and established it as a self-supporting entity. He said his next goal is to increase the trust fund, which supports Order of the Arrow activities, to $5 million by 1995.

Marchetti's other recognitions include Order of the Arrow Distinguished Service Award, Silver Beaver Award and Silver Antelope Award.

Other organizations also have noted Marchetti's service.

On Aug. 13 he was named Distinguished Alumni of 1990 for the service fraternity Alpha Phi Omega at Rutgers University. He also received the Silver Gull Award for community service from the Monmouth-Ocean Development Council.

62X

Smith plugs St. Francis for regional trauma center

Hospital vying with shore facility

By CHRISTIANE BIAMONTE
Staff Writer

TRENTON — The state Department of Health should designate St. Francis Hospital as a regional trauma center for the Mercer County area, Rep. Chris Smith, R-Washington Township, said yesterday.

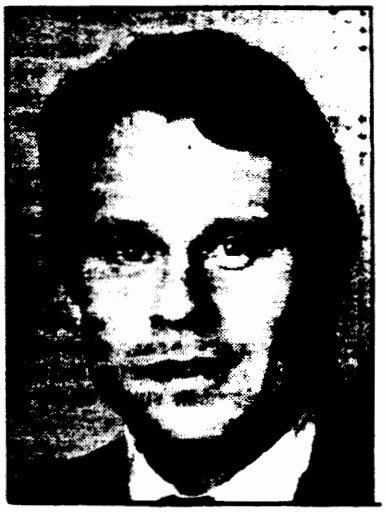
In a letter to state health Commissioner Frances Dunston, Smith said he felt that if the state designated the Jersey Shore Medical Center in Neptune, Monmouth County, as the area's trauma center, Mercer residents would not have "timely access to a designated center."

Dunston is expected to make a decision on whether to designate St. Francis or the Jersey Shore as a Level II trauma center for the Mercer area by September, said Marilyn Riley, a spokeswoman for the department.

New Jersey currently has two trauma centers that specialize in treating people critically injured in accidents, one at Cooper Hospital University Medical Center in Camden and the other at the University Hospital in Newark.

The state Health Department plans to designate two trauma centers in the central New Jersey area. The Robert Wood Johnson University in New Brunswick is expected to be chosen as a primary (Level I) trauma center, while St. Francis and Jersey Shore battle for the Level II designation.

The letter, which was co-signed by Trenton Mayor Doug Palmer, Hamilton Mayor Jack Rafferty, Trenton City Council President John Cipriano and County Executive Bill Mathesius, stressed that without a Mercer designation, the closest trauma center would be as far as 35.5 miles away.



Rep. Chris Smith

THE OFFICIALS said the state's guidelines of one trauma center per 1 million in population does not reflect the number of commuters, college populations or tourist visits. The state calculates that there are 2 million people in the central New Jersey area.

"Potential trauma injury sites include urban and suburban areas, several major highways, airport and heliport sites and flight patterns, the nearby train station and the (Delaware) river," they said.

So far, the Statewide Health Coordinating Council, the Central New Jersey Health Planning Council and the Mercer County Health Planning Council have voted for Jersey Shore's trauma center proposal, but the final decision is up to Dunston, Riley said.

"She's really the one who makes the final decision, and I can't prejudge what decision she'll make," Riley said.

Robert Wolleben, the executive vice president for St. Francis, said he is "encouraged" by the letter.

"The letter is not our handiwork, but we're encouraged that Mr. Smith went on the record with many of the views we hold," Wolleben said.

He said that he does not think St. Francis and Jersey Shore are in competition against one another.

"There really isn't a whole heck of a lot of overlap in the areas we cover," he said. "We don't think the state is looking at it logically. You have to look at the overall caseload for each hospital, and you'd see that they're really about equal. To designate a trauma center in one area and not the other would be an injustice to both."

63X

[redacted]

Psychiatric hospital proposed in Tinton Falls to be considered

4 other units seek to renovate, expand

By STACEY MC DONNELL
Press Staff Writer

A 60-BED psychiatric hospital planned for Tinton Falls is one of five psychiatric units proposed for Central Jersey that will be considered by the region's Health Planning Council in September.

The Tinton Falls facility, which would be built on 9.7 acres near the intersection of the Garden State Parkway and Route 18, is the only new structure proposed. Four area hospitals have applied for renovations.

Monmouth Medical Center, Long Branch, and CentraState Medical Center, Freehold Township, have applied to expand and renovate their psychiatric units. Also submitting applications were Robert Wood Johnson University Hospital, New Brunswick, and Raritan Bay Medical Center, Perth Amboy division.

The Psychiatric Institute of America, which owns the Summit-based Fair Oaks Hospital, wants to construct a 32,000-square-foot building in Tinton Falls at a cost of about $9.7 million, said Mary Ashenfelter, program director. Ms. Ashenfelter said the funds would come from a long-term loan from the institute's parent company, National Medical Enterprises, and would not be a burden to local taxpayers.

Tinton Falls Mayor Ann Y. McNamara said she was unaware of any plans for the facility, but said that may not be unusual.

"The company probably had to go to the health council for approval first, and then they would come to us," Ms. McNamara said. "It sounds interesting. We'll just have to look at it when it comes up."

Members of the borough's Planning Board also were unaware of the proposal.

Ms. Ashenfelter said the institute would begin working with the Tinton Falls Planning Board soon. She said she is hopeful all approvals would be obtained in January and that the hospital would be completed 18 months after that.

Edward J. Peloquin, the executive director of the Central Jersey Health Planning Council, said that before applying for the certificate, however, the hospital or company had to own, lease or have an option to buy the land on which the renovation or construction would take place.

Each hospital also had to submit a certificate of need application to the Health Planning Council by July 1, Peloquin said. He said the applications will be considered by the county Health Planning Commissions in early September and would go to the Board of Directors of Central Jersey Health Planning Council for approval Sept. 26.

If the proposals are approved there, they would then be considered by the Statewide Health Coordinating Council in October and then go to state Health Commissioner Frances Dunston for final approval.

According to Norman Reim, a spokesman for the Department of Human Services, that department and the Department of Health are interested in providing psychiatric care facilities within communities and in scaling down the major institutional settings that now exist.

"We want to develop facilities within the community so that people have a place to turn," Reim said. "This has not come on all of a sudden. Those who suffer from acute psychiatric problems in the Central Jersey region are part of a totally unserved population that the two departments have been trying to address for the past decade."

He said the council has received about 20 to 25 applications statewide for psychiatric projects.

The proposed Tinton Falls facility would treat both voluntary and detainer patients in both open and locked-door settings. Both in-patient and out-patient care will be given through what Ms. Ashenfelter termed "active therapy."

"The patients will hardly be in their bedrooms," Ms. Ashenfelter said. "They will be involved in occupational, recreational and on-going therapy programs that will last from the moment they get up until the moment they go to sleep."

The hospital would not be a residential hospital, she said. Those who would be housed at there would stay for an average of 15 to 18 days, she said.

Patients would be treated for acute depression, suicidal tendencies and drug addiction. These problems, she said, may result from severe feelings of loss or personal crisis.

"The type of care we can provide will be different from any type of care given elsewhere," Ms. Ashenfelter said. "The service will stabilize the patient's emotions, assess his or her situation and then begin a proper treatment for the patient. There is not an availability of the problematic care we can provide in this area."

Ms. Ashenfelter said about 97 full-time jobs would be created to staff the hospital. Most of the physicians, she said, would come from the community. Some would be employees of the institute, she added.

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REPORT OF THE
NEW JERSEY
HEALTH CARE FACILITIES FINANCING AUTHORITY

TO THE

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

November 28, 1990

REPORT OF
THE NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY
TO
THE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

EXECUTIVE SUMMARY

I. Overview of the Financing Authority
   A. Created by an act of the New Jersey legislature in 1972
   B. Legislative mandate is to ensure that modern, well-equipped health care facilities are available to New Jersey residents at reasonable cost
   C. Tax exemption on bonds issued by the Financing Authority reduces cost of borrowing which lowers overall cost of health care
   D. Function through a 7-member board which includes the Commissioners Health, Insurance, and Human Services as ex officio members and 4 public members appointed by the Governor
   E. Activities carried out by a staff of 28 which includes 18 professionals with experience in health care finance, administration, accounting, policy, and research
   F. Role in larger health care community
      1. Provide financing to projects approved through the planning process
      2. Monitor facilities after issuance to ensure repayment of debt
      3. Educate investment community to promote understanding of New Jersey health care environment

II. Assessment of current planning process
   A. "System view" of hospitals in the state by investors
      1. Investors have generally positive view of the trade-off between the costs and benefits of New Jersey regulatory system
      2. Investors evaluate not only individual hospital but the financial health and stability of system as a whole
      3. Result is lower capital costs than might be expected given financial performance of individual hospitals
   B. Health care planning process is a key factor in that system view
      1. Empowerment of local and state planning agencies to review projects provides for thorough evaluation of need and reduces possible duplication of services

2. Provides added assurance that unneeded projects which would have a higher risk of default do not reach the Authority for financing

C. Areas for improvement in the planning process
1. Process reacts to individual provider requests rather than evaluating specific requests within the context of a broader state health plan
2. Limited assessment of the financial feasibility increases the likelihood of approving a project that may be unable to make debt service payments
3. No planning process in place to manage the desired downsizing of the acute care system
4. Provider-based rather than service-based certificate of need regulations put regulated providers at greater financial risk

III. Assessment of changes proposed by Governor's Commission on Health Care Costs
A. Development of a statewide health plan
1. Would allow projects to be evaluated not only against competing projects but also in the broader context of the community's and the state's health needs
2. Reduces likelihood that duplicate or unneeded services would be approved
B. Service-based rather than provider-based certificate of need regulations could improve fairness of regulatory process
C. Identifying and working with high cost or potentially insolvent hospitals could facilitate a managed downsizing of the acute care system

IV. Additional changes to improve planning process
A. More intensive assessment of the financial feasibility of individual projects during the approval process to reduce likelihood that project will face financial distress
B. Provide the Financing Authority with formal notice of proposed and approved capital projects to assist in capital planning
C. Periodic review of previous planning approvals to ensure that service is still provided efficiently

REPORT OF
THE NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY
TO
THE ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

I. OVERVIEW OF THE NEW JERSEY HEALTH CARE FACILITIES FINANCING AUTHORITY

The New Jersey Health Care Facilities Financing Authority (NJHCFFA) was created in 1972 by an act of the New Jersey State Legislature (Chapter 29, NJSA 26: 2I-1 et seq.-attached as Appendix A). The legislation was a response to the belief that the state's health care system was obsolete and inadequate. It mandated a system of modern, well-equipped health care facilities available to all New Jerseyans at reasonable cost.

The Authority's function in the creation and maintenance of this system was and continues to be the issuance of tax-exempt revenue bonds for the state's not-for-profit health care industry. Tax-exempt financing lowers the cost of capital for Authority borrowers and ultimately reduces the overall cost of health care delivery in the state. For example, in today's market, an A-rated hospital would probably pay about 7.75% on bonds issued through the Financing Authority. Taxable borrowing for a similarly rated credit would be at approximately 10.10%. On a project of $25 million, this translates into savings to health care consumers of over $500,000 per year or over $15 million over the life of a 30-year issue.

The Authority functions through a seven-member board, three of whom are ex officio: the Commissioner of Health, who serves as Chairperson, the Commissioner of Insurance, and the Commissioner of Human Services. There are also four public members appointed to four year terms by the Governor with the advice and consent of the Senate.

The Authority's activities are implemented by a staff of 28, including 18 professionals with expertise and experience in health care finance, public administration, accounting, health policy, and research. Staff is organized into three operating divisions including Project Management, Operations, and Research and Development.

The Authority does not decide which projects should be financed. Rather, it provides financing for those projects that have received a certificate of need through the local and state planning process. A flowchart diagramming the complete planning process is attached as Appendix B. Authority involvement, however, does not begin and end with the sale of bonds.

Authority staff oversees a bond issue from the time a facility requests financing, to the actual sale of bonds. In some cases, hospitals will contact Authority staff for financing assumptions to be used in the certificate of need process. Staff works closely with a financing team comprised of investment

bankers, various legal counsels, the borrower, financial consultants, and other health care professionals to develop and execute an appropriate financing strategy consistent with state policy goals defined by the Governor and implemented by the Treasurer's Office and the Department of Health. Volume of issuance by the Authority since its creation is listed in Appendix C.

After the bonds are sold, staff helps the borrower comply with the covenants of its bond documents to ensure that bondholders' interests are safeguarded and the loan repaid on time. In addition to monitoring specific bond issues, the Authority maintains a statewide database on the financial and operating condition of all hospitals. This database, called the Apollo System, helps an individual hospital assess its performance in comparison with its peers, and serves the Authority as an early warning signal of possible financial or operating distress for any of its client facilities. Staff assesses existing capital markets, explores new ones, and anticipates and analyzes changes in the state health policy environment which may impact the creditworthiness of current and future borrowers.

As one component of a larger system, it is the Authority's practice to facilitate the flow of information about New Jersey's health care facilities and the environment in which they operate to all participants in the financing process. The market for

municipal bond issues such as those for New Jersey hospitals is characterized by sophisticated--and anxious--investors. Increasingly, this market is driven by information.

In response to the market's increased demand for timely and relevant information, Authority staff meet frequently with the bond rating agencies, bond insurers, investment bankers, and increasingly, with major investors both to present information about New Jersey's regulated health care environment and to hear their thoughts about the creditworthiness of New Jersey health care facilities.

The commercial and investment banks on the Authority's underwriting team use this knowledge in working with staff to structure innovative cost-effective financings, while investors gain confidence in the New Jersey health care industry's ability to service its debt. The bond rating agencies are able to look beyond the surface of financial data to understand not only the impact of regulation on New Jersey health care facilities, but also the safeguards it provides.

The Authority has undertaken this range of activities in the belief that each contributes to reducing the cost of capital for New Jersey health care facilities. As the provision of modern, well-equipped health care facilities at reasonable cost was the intent of the Legislature in approving the Authority's enabling statute, these activities are consistent with its legislative mandate.

II. ASSESSMENT OF CURRENT PLANNING PROCESS

New Jersey's hospitals are part of a highly structured and well-defined system that addresses both planning and rate setting issues as well as providing for a variety of oversight agencies. One specific consequence of this relatively stable, closely regulated environment is that when investors or bond rating agencies assess the creditworthiness of a New Jersey hospital, they evaluate both the individual facility as well as the system in which it operates. The health care planning process is a key component of this system approach.

SYSTEM VIEW OF HOSPITALS

The reimbursement and planning regulations present a number of tradeoffs that investors must weigh in evaluating a particular health care credit. On the positive side, the all-payer reimbursement system has insulated the state's hospitals from Medicare cutbacks while providing for the payment of uncompensated care. The powers of the Hospital Rate Setting Commission to address statewide and hospital-specific problems and the oversight provided by the various state agencies offer further comfort to investors that loans will be repaid. On the negative side, regulations have kept operating margins low,

leaving hospitals with limited cash reserves, more susceptible to unexpected events, and more dependent on debt financing. The complexity of and frequent changes to the regulations have created concerns about the timeliness of the system and uncertainty as to the true financial condition of the hospital industry.

In general, the financial community has a positive view of these tradeoffs which have to be made to keep the system functioning properly. The result is that New Jersey has been generally regarded by the financial community as a relatively "safe" state for investment in hospitals. This is in large measure due to the fact that when they examine New Jersey hospitals, bond-rating agencies and investors have looked not only at an individual hospital and its financial performance, but at the financial health and stability of the system as a whole.

The result of this "system scrutiny" has been that credit ratings for most of the state's hospitals have clustered in the middle of the investment grade range, with fewer high- or low-rated hospitals than in many other less regulated states. Appendix D compares the distribution of credit ratings from both of the major rating agencies for New Jersey hospitals with that of the United States.

Given their somewhat modest financial performance and thin operating margins, New Jersey hospital bonds have received higher

credit ratings than might otherwise be expected. The financial indicators for the median A-rated New Jersey hospital bond issue, for example, are weaker than those for the median A-rated issue nationwide because most states lack the "safety net" that the Chapter 83 reimbursement system has traditionally provided. Appendix E compares the financial performance of New Jersey hospitals by rating category with similarly rated facilities nationwide.

Consequently, New Jersey hospitals have enjoyed lower capital costs through attractive interest rates and competitive bond insurance premiums than their performance may have justified on a hospital-specific basis. Just as significantly, the ratio of downgrades to upgrades in the state has been better than the national experience. Further, Authority has been able to issue over $4 billion in debt without a provider defaulting on an Authority capital loan. However, it should be noted that there are an increasing number of New Jersey hospitals in varying degrees of financial distress. Further, there are a number of issues that will need to be addressed in the near future if this system approach and its attendant benefits are to be maintained.

ROLE OF THE PLANNING PROCESS IN PROMOTING THE SYSTEM VIEW

The state's comprehensive planning process which provides for local and state input through the Health Systems Agencies (HSAs), the Statewide Health Coordinating Council (SHCC), the

Health Care Administration Board (HCAB), and the Department of Health is an integral part of the New Jersey system. The process accomplishes several important objectives which provide added comfort to investors that any borrowing associated with a capital project will be repaid.

First, the need for each proposed project is scrutinized closely before approval at both the state and local levels to determine the service is truly required by the community. Approved projects therefore are more likely to be well-utilized and to generate sufficient revenues for payment of debt service. Further, because each approved project has gone through this thorough evaluation of need, there is likely to be a greater willingness to draw on the resources of the system if problems occur.

The planning process also reduces duplication or overprovision of costly services. By limiting the number of project approvals, the planning process encourages fewer but well-utilized providers instead of many underutilized providers that are more likely to face financial difficulties.

Thus, the analysis of hospitals' financial performance and the particular health care needs of the communities they serve undertaken by the various agencies that participate in the planning process provides added assurance that unneeded projects--or those which might overburden hospitals and even lead to

defaults--will not reach the Authority for financing. One result of this process is that occupancy rates of New Jersey hospitals are typically higher than those in the rest of the country. More importantly, the process has been an important factor in encouraging investors to accept the tradeoffs of the New Jersey system.

AREAS FOR IMPROVEMENT IN THE PLANNING PROCESS

Although strong capital planning processes are already in place in New Jersey, there are several improvements that could still be made.

Currently, most major capital projects are reviewed by the SHCC in batches every six months. Most of the major services are also reviewed in regular batching cycles. While batching does allow for more comprehensive planning, it does not provide a long-term plan for capital investment in health care facilities because each batch is essentially reviewed independently from the others. While projects are evaluated competitively with other projects in a batch, they are not evaluated in the context of a longer term health plan. Thus, it is possible that a project which could more appropriately meet an area's needs could be turned down because another project was approved in an earlier batch. Further, without a longer term assessment of state's health care needs it is not possible to determine whether projects in a current batch are appropriate to meet future needs.

Completing a capital asset inventory would be important in providing policy makers with the needed information to develop a long range capital plan. Such an inventory would assess the age and condition of the physical plants of the state's health care facilities. Instead of reacting to certificate of need applications as they are filed, policy makers would be able to responsibly plan and forecast future capital needs.

A second improvement would be to strengthen the financial feasibility analysis in the certificate of need process. While the current review process does include a preliminary assessment of feasibility, it is not at the level required at the time of financing. This creates the possibility that the Financing Authority will be faced with a project that has all the necessary planning approvals but forecasted revenues are insufficient to pay the debt service required to complete the project. Despite public support and the expenses incurred to get the project to that point, the project would not go forward without a favorable feasibility study.

In 1987 and 1989, the HCAB approved several changes to the rate setting system. In general, these changes were designed to reward efficient, well-utilized hospitals at the expense of underutilized, inefficient facilities. One goal of these changes was to create pressure for downsizing the acute care system; it is possible that some facilities will eventually need to close.

At this time there is no mechanism or plan to manage this desired downsizing.

While such a downsizing will strengthen the hospital system in the long run by leaving fewer but stronger facilities, managing the transition will be critical to maintaining investor confidence in the New Jersey system. A default on bonds by a closed hospital would cause investors to discount the system aspects and could lead to lower bond ratings and higher costs to health care consumers in the form of higher interest rates on future projects.

Managing financial distress and downsizing does not mean that the state should prop up or support underutilized or inefficient hospitals. Rather, state efforts should concentrate on identifying the reasons for financial distress and providing support in developing and implementing solutions, including mergers, conversion, and managed closures. In short, there should be planning procedures in place to assist in the desired downsizing.

Currently, certificate of need regulations are generally provider-based rather than service-based. Non-hospital providers can often add services or acquire equipment which if provided in a hospital setting would require a certificate of need. This distinction reduces many of the benefits of the planning process. If other types of providers can set up similar services in a

hospital's market area, there is added risk that all providers may be underutilized and face financial difficulties.

III. ASSESSMENT OF CHANGES PROPOSED BY THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS

Recommendations proposed by the Governor's Commission on Health Care Costs in its October 1, 1990 report would address many of the concerns highlighted above.

DEVELOP A STATEWIDE HEALTH PLAN

The Commission recognized the need for a more comprehensive planning process to "determine the adequacy of existing services and the need for future services." To attain this objective, the Commission recommended the development of a State Health Plan by a new State Health Planning Board with the assistance of local planning boards and the Department of Health. In the course of developing the State Health Plan, the Department of Health would conduct an inventory of the state's health care facilities. Only certificate of need applications that met unfulfilled needs as identified by the State Health Plan would be approved.

These proposals could significantly strengthen the existing planning process. The certificate of need process would become less reactive to individual applications or batches as each proposed project would be evaluated not only against competing

applications but against the health care needs as identified in the State Health Plan. Such a process could reduce the possibility of costly duplication of services and ensure that approved projects will be well-utilized and financially stronger.

SERVICE-BASED CERTIFICATE OF NEED REGULATIONS

The Commission also recognized that existing certificate of need regulations create an "unlevel playing field" across providers. Consequently, the Commission recommended that the definition of a health care facility be modified so that all providers offering a service that is subject to state planning regulations would need a certificate of need. In addition to strengthening the cost containment aspects of the planning process, the change would improve the financial and operating prospects for approved projects because there would not be unregulated providers offering a similar service that could diminish utilization at existing facilities.

IDENTIFY INEFFICIENT OR POTENTIALLY INSOLVENT HOSPITALS

The Commission proposed that hospitals with high costs or those in financial distress be officially identified. Once identified, those facilities would be expected to work with the Hospital Rate Setting Commission and the planning agencies to develop plans to improve their financial situations through cost containment efforts or to downsize, merge, or close as

appropriate. While not providing specific processes, the proposal is clear in its recommendation that the various oversight agencies should work together to manage any necessary downsizing.

In summary, the Commission's recommendations with respect to health planning generally would strengthen, not weaken, the system approach that has been in place in New Jersey since the early 1970's. By providing for more comprehensive and inclusive planning regulations as well as recognizing the need to carefully manage the downsizing of the system, the recommendations would provide investors with more reasons to evaluate individual hospitals in the context of the larger environment in which they operate.

IV. ADDITIONAL CHANGES TO THE PLANNING SYSTEM

STRONGER FINANCIAL FEASIBILITY STUDY IN PLANNING PROCESS

A stronger financial feasibility study at the beginning of the planning process would help identify potential financial problems earlier and provide a greater opportunity to address them concurrent with the planning approval. Although this would probably increase the cost of the planning process, the costs could be recovered in the future by eliminating delays and

reducing the resources required to deal with financially distressed hospitals. The Authority, in conjunction with the Department of Health and the SHCC may be able to coordinate the earlier analysis with the study required at the time of financing to help reduce costs.

FORMAL NOTIFICATION OF PROJECTS

It would also be advantageous for the Authority to receive formal notification from the Department of Health or the SHCC of project approvals. This would allow the Authority to plan more effectively and identify, in an organized fashion, future demand for capital. Also, when the Authority is not identified as the source of borrowing, applicants should be asked to justify the taxable alternative, given the cost advantages of borrowing on a tax-exempt basis.

PERIODIC REVIEW OF PREVIOUS PLANNING APPROVALS

To be effective, certificate of need approval essentially grants a "franchise" to a specific provider that limits the ability of other providers to offer competing services. This is done in the interest of cost containment, based on the belief that duplicate facilities, rather than encouraging competition and lowering costs, create incentives to over provide health care services, driving up the costs of health care.

Batching the certificate of need requests improves the likelihood that the best qualified provider receives the approval. However, over time, it is possible that other providers will make advancements that would allow them to provide the service more efficiently. Unless there is increased need in the area, these other providers may not get certificate of need approval because of the existing providers.

Therefore, some type of periodic reevaluation of previous certificate of need decisions may be appropriate to avoid building long term inefficiencies into the system. Under such a review process, the various planning agencies would review the performance of providers which had previously been granted approvals to ensure that the service was utilized and provided efficiently. Perhaps such review could be included as a condition of the original certificate of need approval. Alternatively, the planning agencies could periodically, for a given service, require a new round of applications in which those providers with existing certificates of need would have to reapply. In the long run, such a process could provide greater assurance that services were being provided by fiscally sound and efficient hospitals.

V. CONCLUSION

The state's managed health care system has thus far helped its hospitals obtain capital for needed projects at a reasonable cost. To date, a strong health planning system has been an integral part of that managed system and the planning recommendations of the Governor's Commission would appear to enhance that health care planning system. Given that the need for capital, judiciously used, will continue we are encouraged by these developments.

The Authority is committed now, as it has been in the past, to helping new Jersey's hospitals find the funds they need. It is also willing and eager to help this Commission to attain its objectives. Please call on us as a source of data and as a sounding board for future policy initiatives.

Thank you for the opportunity to present our views on New Jersey's health care planning system.

OC-D6
Sept. 72

New Jersey State
Department of Health
John Fitch Plaza, P.O. Box 1540
Trenton, New Jersey 08625

CHAPTER 29, LAWS OF NEW JERSEY 1972
HEALTH CARE FACILITIES FINANCING AUTHORITY

(Chapter 29)
(NJSA 26:2I-1 et seq.)

Approved May 25, 1972

AN ACT relating to the financing of health care facilities and equipment; creating the New Jersey Health Care Facilities Financing Authority and prescribing its powers and duties; authorizing the issuance of bonds and notes of the authority and providing for the terms and security thereof, and making an appropriation therefor.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

ARTICLE 1. PURPOSE

C. 26:2I-1 Preamble, purpose of act.

It is hereby declared that a serious public emergency exists affecting the health, safety and welfare of the people of the State resulting from the fact that many hospitals and other health-care facilities throughout the State are becoming obsolete and are no longer adequate to meet the needs of modern medicine. As a result of rapid technological changes, such facilities require substantial structural or functional changes. Others are unsuited for continued use by virtue of their location and the physical characteristics of their existing plants and should be replaced. Such inadequate and outmoded facilities deny to the people of the State the benefits of health care of the highest quality, efficiently and promptly provided at a reasonable cost. Their replacement and modernization is essential to protect and prolong the lives of the State's population and cannot readily be accomplished by the ordinary unaided operation of private enterprise. Existing hospitals and other health-care facilities must be adapted to accommodate new concepts of medical treatment and provide units for the treatment of alcoholism, narcotics addiction and other social ills.

It is the purpose of this act to encourage the timely construction and modernization, including the equipment, of hospital and other health-care facilities, which are necessary for the diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including mental illness and retardation, and of facilities incidental or appurtenant thereto to be administered in accordance with the provisions of the Health Care Facilities Planning Act, P.L. 1971, c. 136 (C. 26:2H-1 et seq.). It is hereby declared to be the policy of the State to encourage the provision of modern, well-equipped health-care facilities, and such provision is hereby declared to be a public use and purpose.

ARTICLE 2. SHORT TITLE; DEFINITIONS

C. 26:2I-2 Short title.

This act shall be known and may be cited as the "New Jersey Health Care Facilities Financing Authority Law."

C. 26:2I-3 Terms defined.

As used in this act, the following words and terms shall have the following meanings, unless the context indicates or requires another or different meaning or intent:

"Authority" means the New Jersey Health Care Facilities Financing Authority created by this act or any board, body, commission, department or officer succeeding to the principal functions thereof or to whom the powers conferred upon the authority by this act shall be given by law.

"Bond" means bonds, notes or other evidences of indebtedness of the authority issued pursuant to this act.

"Commissioner" means the State Commissioner of Health.

"Hospital facility" means a structure suitable to provide hospitals, hospital related housing facilities, doctors' office buildings or other health-care facilities for the prevention, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition or mental illness and retardation, and for facilities incidental or appurtenant thereto.

"Participating hospital" means a public hospital or private hospital which has entered into a regulatory agreement in accordance with this act.

"Private hospital" means a hospital or health-care institution, or an institution for the training of doctors, nurses, paramedical or other personnel engaged in the provision of health care, other than a State, county or municipal hospital or health care facility, or related institution including a health maintenance organization, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, special hospital, mental hospital, outpatient clinic, dispensary, home health agency, boarding home or other home for sheltered care situated within the State and which is a nonprofit institution providing hospital or health care service to the public.

"Public hospital" means a State, county or municipal hospital or health-care facility including health maintenance organization, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, mental hospital, outpatient clinic,

dispensary, home health care agency, boarding home or other home for sheltered care now or hereafter established or authorized by law.

"Project" or "hospital project" means a specific work, including lands, buildings, improvements, alterations, renovations, enlargements, reconstructions, fixtures and articles of personal property, acquired, constructed, rehabilitated, owned and operated by a participating hospital pursuant to this act, to provide hospital or health care facilities or facilities related, required or useful to or for the operation of a hospital facility, and "project" or "hospital project" may include any combination of the foregoing undertaken jointly by any participating hospital with one or more other participating hospitals.

"Project cost" or "hospital project cost" means the sum total of all or any part of costs incurred or estimated to be incurred by the authority or by a participating hospital which are reasonable and necessary for carrying out all works and undertakings and providing all necessary equipment for the development of a project, exclusive of the amount of any private or Federal, State or local financial assistance for and received by a participating hospital for the payment of such project cost. Such costs shall include, but are not necessarily limited to, interest prior to, during and for a reasonable period after such development, start-up costs and costs of operation and maintenance during the construction period and for a reasonable additional period thereafter, the cost of necessary studies, surveys, plans and specifications, architectural, engineering, legal or other special services, the cost of acquisition of land, buildings and improvements thereon (including payments for the relocation of persons displaced by such acquisition), site preparation and development, construction, reconstruction, equipment, including fixtures, equipment, and cost of demolition and removal, and articles of personal property required, the reasonable cost of financing incurred by a participating hospital or the authority in the course of the development of the project, reserves for debt service, the fees imposed upon a participating hospital by the commissioner and by the authority; others fees charged, and necessary expenses incurred in connection with the initial occupancy of the project, and the cost of such other items as may be reasonable and necessary for the development of a project. The commissioner's approval of estimated project cost in accordance with section 6 of this act shall include his approval, which shall be conclusive, as to the reasonableness or necessity of any item of cost and as to the reasonableness of any period of time in respect of which interest, start-up, operation and maintenance costs have included in project costs.

ARTICLE 3. AUTHORITY; MEMBERSHIP; OFFICERS; EMPLOYEES; GOVERNOR'S VETO

C. 26:21-4 Authority created; members; terms; organization meetings; Governor's veto power.

a. There is hereby established in the State Department of Health, a public body corporate and politic, with corporate succession, to be known as the "New Jersey Health-Care Facilities Financing Authority." The authority shall constitute a political subdivision of the State established as an instrumentality exercising public and essential governmental functions, and the exercise by the authority of the powers conferred by this act shall be deemed and held to be an essential governmental function.

b. The authority shall consist of seven members, three of whom shall be the commissioner, who shall be the chairman, the Commissioner of Insurance, and the Commissioner of the Department of Institutions and Agencies, who shall serve during their terms of office, or when so designated by them, their deputies or other representatives, who shall serve at their pleasure, and four public members who are citizens of the State to be appointed by the Governor, with the advice and consent of the Senate for terms of 4 years; provided that the four members first appointed by the Governor shall serve terms expiring on the first, second, third, and fourth, respectively, April 30 ensuing after the enactment of this act. Each member shall hold office for the term of his appointment and until his successor shall have been appointed and qualified. Any vacancy among the public members shall be filled by appointment for the unexpired term only.

c. Any member of the authoirty appointed by the Governor may be removed from office by the Governor for cause after a public hearing.

d. The members of the authority shall serve without compensation, but the authority may reimburse its members for necessary expenses incurred in the discharge of their official duties.

e. The authority, upon the first appointment of its members and thereafter on or after April 30 in each year, shall annually elect from among its members a vice chairman who shall hold office until April 30 next ensuing and shall continue to serve during the term of his successor and until his successor shall have been appointed and qualified. The authority may also appoint, retain and employ, without regard to the provisions of Title 11, Civil Service, of the Revised Statutes, such officers, agents, and employees as it may require, and it shall determine their qualifications, terms of office, duties, services and compensation.

f. The powers of the authority shall be vested in the members thereof in office from time to time and a majority of the total authorized membership of the authority shall constitute a quorum at any meeting thereof. Action may be taken and motions and resolutions adopted by the authority at any meeting thereof by the affirmative vote of a majority of the members present, unless in any case the bylaws of the authority shall require a larger number. No vacancy in the membership of the authority shall impair the right of a quorum to exercise all the rights and perform all the duties of the authority.

g. Each member and the treasurer of the authority shall execute a bond to be conditioned upon the faithful performance of the duties of such member or treasurer, as the case may be, in such form and amount as may be prescribed by the Attorney General. Such bonds shall be filed in the office of the Secretary of State. At all times thereafter the members and treasurer of the authority shall maintain such bonds in full force and effect. All costs of such bonds shall be borne by the authority.

h. No trustee, director, officer or employee of a hospital may serve as a member of the authority.

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i. At least two true copies of the minutes of every meeting of the authority shall be forthwith delivered by and under the certification of the secretary thereof, to the Governor. No action taken at such meeting by the authority shall have force or effect until 10 days, exclusive of Saturdays, Sundays and public holidays, after such copies of the minutes shall have been so delivered or at such earlier time as the Governor shall sign a statement of approval thereof. If, in said 10-day period, the Governor returns a copy of the minutes with veto of any action taken by the authority or any member thereof at such meeting, such action shall be null and of no effect. If the Governor shall not return the minutes within said 10-day period, any action therein recited shall have force and effect according to the wording thereof. At any time prior to the expiration of the said 10-day period, the Governor may sign a statement of approval of all or any such action of the authority.

The powers conferred in this subsection upon the Governor shall be exercised with due regard for the rights of the holders of bonds of the authority at any time outstanding.

ARTICLE 4. POWERS AND DUTIES; BONDS

C. 26:2I-5 Powers of authority.

The authority shall have power:

a. To adopt bylaws for the regulation of its affairs and the conduct of its business and to alter and revise such bylaws from time to time at its discretion.

b. To adopt and have an official seal and alter the same at pleasure.

c. To maintain an office at such place or places within the State as it may designate.

d. To sue and be sued in its own name.

e. To borrow money and to issue bonds of the authority and to provide for the rights of the holders thereof as provided in this act.

f. To acquire, lease as lessee or lessor, hold and dispose of real and personal property or any interest therein, in the exercise of its powers and the performance of its duties under this act.

g. To acquire in the name of the authority by purchase or otherwise, on such terms and conditions and in such manner as it may deem proper, any land or interest therein and other property which it may determine is reasonably necessary for any project; and to hold and use the same and to sell, convey, lease or otherwise dispose of property so acquired, no longer necessary for the authority's purposes for fair consideration after public notice.

h. To receive and accept, from any Federal or other public agency or governmental entity directly or through the Department of Health or any other agency of the State or any participating hospital, grants or loans for or in aid of the acquisition or construction of any project, and to receive and accept aid or contributions from any other source, of either money, property, labor or other things of value, to be held, used and applied only for the purposes for which such grants, loans and contributions may be made.

i. To prepare or cause to be prepared plans, specifications, designs and estimates of costs for the construction and equipment of hospital projects for participating hospitals under the provisions of this act, and from time to time to modify such plans, specifications, designs or estimates.

j. By contract or contracts with and for participating hospitals only, to construct, acquire, reconstruct, rehabilitate and improve, and furnish and equip, hospital projects. The authority, in the exercise of its authority to make and enter into contracts and agreements necessary or incidental to the performance of its duties and the execution of its powers, shall adopt standing rules and procedures providing that, except as hereinafter provided, no contract on behalf of the authority shall be entered into for the doing of any work, or for the hiring of equipment or vehicles, where the sum to be expended exceeds the sum of $5,000.00 unless the authority shall first publicly advertise for bids therefor, and shall award the contract to the lowest responsible bidder; provided, however, that such advertising shall be not be required where the contract to be entered into is one for the furnishing or performing services of a professional nature or for the supplying of any product or the rendering of any service by a public utility subject to the jurisdiction of the Public Utilities Commission and tariffs and schedules of the charges, made, charged, or exacted by the public utility for any such products to be supplied or services to be rendered are filed with said commission.

k. To determine the location and character of any project to be undertaken, subject to the provisions of this act, and subject to State Health and environmental laws, to construct, reconstruct, maintain, repair, lease as lessee or lessor, and regulate the same and operate the same in the event of default by a participating hospital of its obligations and agreements with the authority; to enter into contracts for any or all such purposes; and to enter into contracts for the management and operation of a project in the event of default as herein provided. The authority shall use its best efforts to conclude its position as an operator as herein provided as soon as is practicable.

l. To establish rules and regulations for the use of a project or any portion thereof and to designate a participating hospital as its agent to establish rules and regulations for the use of a project undertaken by such a participating hospital.

m. Generally to fix and revise from time to time and to charge and collect rates, rents, fees and other charges for the use of and for the services furnished or to be furnished by a project or any portion thereof and to contract with holders of its bonds and with any other person, party, association, corporation or other body, public or private, in respect thereof, subject to the provisions of the Health Care Facilities Planning Act, P.L. 1971, c. 136 (C. 26:2H-1 et seq.).

n. To enter into agreements or contracts, execute any and all instruments, and do and perform any and all acts or things necessary, convenient or desirable for the purpose of the authority or to carry out any power expressly given in this act.

o. To invest any moneys held in reserve or sinking funds, or any moneys not required for immediate use or disburse-

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ment, at the discretion of the authority, in such obligations as are authorized by resolution of the authority.

p. To obtain, or aid in obtaining, from any department or agency of the United States any insurance or guarantee as to, or of or for the payment or repayment of interest or principal, or both, or any part thereof, on any loan or any instrument evidencing or securing the same, made or entered into pursuant to the provisions of this act, and notwithstanding any other provisions of this act to enter into agreement, contract or any other instrument whatsoever with respect to any such insurance or guarantee, and accept payment in such manner and form as provided therein in the event of default by the borrower.

q. To obtain from any department or agency of the United States or a private insurance company any insurance or guarantee as to, or of, or for the payment or repayment of interest or principal, or both, or any part thereof, on any bonds, issued by the authority pursuant to the provisions of this act; and notwithstanding any other provisions of this act to enter into any agreement, contract or any other instrument whatsoever with respect to any such insurance or guarantee except to the extent that such action would in any way impair or interfere with the authority's ability to perform and fulfill the terms of any agreement made with the holders of the bonds of the authority.

r. To receive and accept, from any department or agency of the United States or of the State or from any other entity, any grant, appropriation or other moneys to be used for or applied to any corporate purpose of the authority, including without limitation the meeting of debt service obligations of the authority in respect of its bonds.

C. 26:21-6 Approval of project costs; regulatory agreements; expenses.

Notwithstanding any other provision of this act, the authority shall not acquire or authorize the acquisition, the commencement of construction or rehabilitation of any project or hospital facility to be leased to a participating hospital, in respect of any project where such acquisition or work is to be done by the authority, nor advance loan funds to any participating hospital, in respect of a project involving a loan to such hospital, until (i) the estimated project cost shall have been approved by the commissioner and (ii) the participating hospital shall have entered into a regulatory agreement with the commissioner. Such regulatory agreement shall contain such provisions as shall be deemed adequate by the commissioner to assure that the project shall be constructed, maintained and operated in a manner consistent with the purposes of this act and the Health Care Facilities Planning Act, P.L. 1971, c. 136 (C. 26:2H-1 et seq.).

The requirements of the preceding paragraph shall not preclude the authority from taking actions, and incurring expenses in connection therewith, preliminary to the actual acquisition or commencement of construction or rehabilitation of facilities or the advancing of loan funds in respect of any proposed project, provided, that all expenses incurred in carrying out the provisions of this act shall be payable solely from funds provided under the authority of this act and no liability or obligation shall be incurred by the authority hereunder beyond the extent to which moneys shall have been provided under the provisions of this act.

C. 26:21-7 Issuance of bonds authorized; maturity; terms.

a. The authority is authorized from time to time to issue its bonds for any corporate purpose and to fund and refund the same all as provided in this act. Such bonds may, at the discretion of the authority be designated as "bonds," "notes," "bond anticipation notes" or otherwise.

b. Except as may otherwise be expressly provided by the authority, every issue of its bonds shall be general obligations of the authority payable from any revenues or moneys of the authority, subject only to any agreements with the holders of particular bonds pledging any particular revenues or moneys. Notwithstanding that bonds may be payable from a special fund, they shall be fully negotiable within the meaning of Title 12A, the Uniform Commercial Code, of the New Jersey Statutes, subject only to any provisions of the bonds for registration.

c. The bonds may be issued as serial bonds or as term bonds, or the authority, in its discretion, may issue bonds of both types. The bonds shall be authorized by resolution of the members of the authority and shall bear such date or dates, mature at such time or times, not exceeding 50 years from their respective dates, bear interest at such rate or rates, be payable at such time or times, be in such denominations, be in such form, either coupon or registered, carry such registration privileges, be executed in such manner, be payable in lawful money of the United States of America at such place or places, and be subject to such terms of redemption, as such resolution or resolutions may provide. The bonds may be sold at public or private sale for such price or prices as the authority shall determine. Pending preparation of the definitive bonds, the authority may issue interim receipts or certificates which shall be exchanged for such definitive bonds.

d. Any resolution or resolutions authorizing any bonds or any issue of bonds may contain provisions, which shall be a part of the contract with the holders of the bonds to be authorized, as to:

(i) pledging all or any part of the revenues of a project or any revenue producing contract or contracts made by the authority with any individual, partnership, corporation or association or other body, public or private, to secure the payment of the bonds or of any particular issue of bonds, subject to such agreements with bondholders as may then exist;

(ii) the rentals, fees and other charges to be charged, and the amounts to be raised in each year thereby, and the use and disposition of the revenues;

(iii) the setting aside of reserves or sinking funds, and the regulation and disposition thereof;

(iv) limitations on the right of the authority or its agent to restrict and regulate the use of a project;

(v) limitations on the purpose to which the proceeds of sale of any issue of bonds then or thereafter to be issued may be applied and pledging such proceeds to secure the payment of the bonds or any issue of the bonds;

(vi) limitations on the issuance of additional bonds, the terms upon which additional bonds may be issued and

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secured and the refunding of outstanding bonds;

(vii) the procedure, if any, by which the terms of any contract with bondholders may be amended or abrogated, the amount of bonds the holders of which must consent thereto, and the manner in which such consent may be given;

(viii) limitations on the amount of moneys derived from a project to be expended for operating, administrative or other expenses of the authority; and

(ix) defining the acts or omissions to act which shall constitute a default in the duties of the authority to holders of its obligations and providing the rights and remedies of such holders in the event of a default.

e. Neither the members of the authority nor any person executing the bonds shall be liable personally on the bonds or be subject to any personal liability or accountability by reason of the issuance thereof.

f. The authority shall have power out of any funds available therefor to purchase its bonds. The authority may hold, pledge, cancel or resell such bonds, subject to and in accordance with agreements with bondholders.

C. 26:2I-8 Bonds secured by trust agreement.

In the discretion of the authority, any bonds issued under the provisions of this act may be secured by a trust agreement by and between the authority and a corporate trustee or trustees, which may be any trust company or bank having the powers of a trust company within or without the State. Such trust agreement or the resolution providing for the issuance of such bonds may pledge or assign the revenues or other moneys or securities to be received or proceeds of any contract or contracts pledged. Such trust agreement or resolution providing for the issuance of such bonds may contain such provisions for protecting and enforcing the rights and remedies of the bondholders as may be reasonable and proper and not in violation of law, including particularly such provisions as have hereinabove been specifically authorized to be included in any resolution or resolutions of the authority authorizing bonds thereof. Any bank or trust company incorporated under the laws of this State which may act as depositary of the proceeds of bonds or revenues or other moneys or securities may furnish such indemnifying bonds or pledge such securities as may be required by the authority. Any such trust agreement may set forth the rights and remedies of the bondholders and of the trustee or trustees, and may restrict the individual right of action by bondholders. In addition to the foregoing, any such trust agreement or resolution may contain such other provisions as the authority may deem reasonable and proper for the security of the bondholders. All expenses incurred in carrying out the provisions of such trust agreement or resolution may be treated as project costs.

C. 26:2I-9 Bonds not liability of state or political subdivision.

Bonds issued under the provisions of this act shall not be deemed to constitute a debt or liability of the State or of any political subdivision thereof other than the authority nor a pledge of the faith and credit of the State or of any such political subdivision, other than the authority, but shall be payable solely from the funds herein provided. All such bonds shall contain on the face thereof a statement to the effect that neither the State of New Jersey nor the authority shall be obligated to pay the same or the interest thereon except from revenues or other moneys of the authority and that neither the faith and credit nor the taxing power of the State of New Jersey or of any political subdivision thereof other than the authority is pledged to the payment of the principal of or the interest on such bonds. The issuance of bonds under the provisions of this act shall not directly or indirectly or contingently obligate the State or any political subdivision thereof to levy or to pledge any form of taxation whatever therefor.

C. 26:2I-10 Further powers of authority.

The authority is authorized to fix, revise, charge and collect rates, rents, fees and charges for the use of and for the services furnished or to be furnished by each project and to contract with any person, partnership, association or corporation, or other body, public or private, in respect thereof. Such rates, rents, fees and charges shall be fixed and adjusted in respect of the aggregate of rents, rates, fees and charges from such project so as to provide funds sufficient with other revenues or moneys, if any:

a. To pay the cost of maintaining, repairing and operating the project and each and every portion thereof, to the extent that the payment of such cost has not otherwise been adequately provided for.

b. To pay the principal of and the interest on outstanding bonds of the authority issued in respect of such project as the same shall become due and payable; and

c. To create and maintain reserves required or provided for in any resolution authorizing, or trust agreement securing, such bonds of the authority.

Such rates, rents, fees and charges shall not be subject to supervision or regulation by any department, commission, board, body, bureau or agency of this State other than the authority and the provisions of the Health Care Facilities Planning Act, P.L. 1971, c. 136 (C. 26:2H-1 et seq.). A sufficient amount of the revenues derived in respect of a project, except such part of such revenues as may be necessary to pay the cost of maintenance, repair and operation and to provide reserves for renewals, replacements, extensions, enlargements and improvements as may be provided for in the resolution authorizing the issuance of any bonds of the authority or in the trust agreement securing the same, shall be set aside at such regular intervals as may be provided in such resolution or trust agreement in a sinking or other similar fund which is hereby pledged to, and charged with, the payment of the principal of and the interest on such bonds as the same shall become due, and the redemption price or the purchase price of bonds retired by call or purchase as therein provided. Such pledge shall be valid and binding from the time when the pledge is made; the rates, rents, fees and charges and other revenues or other moneys or securities so pledged and thereafter received by the authority shall immediately be subject to the lien of such pledge without any physical delivery thereof or further act, and the lien of any such pledge shall be valid and binding as against all parties having claims of any kind in tort, contract or otherwise against the authority, irrespective of whether such parties have notice thereof. Neither the resolution nor any trust agreement by which a pledge is created need be filed or recorded except in the records of the authority. The use

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and disposition of moneys to the credit of such sinking or other similar fund shall be subject to the provisions of the resolution authorizing the issuance of such bonds or of such trust agreement. Except as may otherwise be provided in such resolution or such trust agreement, such sinking or other similar fund shall be a fund for all such bonds issued to finance projects of a participating hospital without distinction or priority of one over another; provided the authority in any such resolution or trust agreement may provide that such sinking or other similar fund shall be the fund for a particular project at a participating hospital and for the bonds issued to finance a particular project and may, additionally, permit and provide for the issuance of bonds having a subordinate lien in respect of the security herein authorized to other bonds of the authority and, in such case, the authority may create separate sinking or other similar funds in respect of such subordinate lien bonds.

C. 26:2I-11 Moneys of authority; trust funds.

All moneys received pursuant to the authority of this act whether as proceeds from the sale of bonds or as revenues, shall be deemed to be trust funds to be held and applied solely as provided in this act. Any officer with whom, or any bank or trust company with which, such moneys shall be deposited shall act as trustee of such moneys and shall hold and apply the same for the purposes hereof, subject to such regulations as this act and the resolution authorizing the bonds of any issue or the trust agreement securing such bonds may provide.

C. 26:2I-12 Bondholders; enforcement of rights.

Any holder of bonds issued under the provisions of this act or any of the coupons appertaining thereto, and the trustee or trustees under any trust agreement, except to the extent the rights herein given may be restricted by any resolution authorizing the issuance of, or any such trust agreement securing, such bonds, may, either at law or in equity, by suit, action, proceeding in lieu of prerogative writ, or other proceedings, protect and enforce any and all rights under the laws of the state or granted hereunder or under such resolution or trust agreement, and may enforce and compel the performance of all duties required by this act or by such resolution or trust agreement to be performed by the authority or by any officer, employee or agent thereof, including the fixing, charging and collecting of the rates, rents, fees and charges herein authorized and required by the provisions of such resolution or trust agreement to be fixed, established and collected.

C. 26:2I-13 Refunding bonds; additional purposes.

a. The authority is hereby authorized to provide for the isssuance of bonds of the authority for the purpose of refunding any bonds of the authority then outstanding, including the payment of any redemption premium thereon and any interest accrued or to accrue to the earliest or subsequent date of redemption, purchase or maturity of such bonds, and, if deemed advisable by the authority, for the additional purpose of paying all or any part of the cost of constructing and acquiring additions, improvements, extensions or enlargements of a project or any portion thereof and for making payments to reserve funds therefor.

b. The proceeds of any such bonds issued for the purpose of refunding outstanding bonds may, in the discretion of the authority, be applied to the purchase or retirement at maturity or redemption of such outstanding bonds either on their earliest or any subsequent redemption date or upon the purchase or at the maturity thereof and may, pending such application, be placed in escrow to be applied to such purchase or retirement at maturity or redemption on such date as may be determined by the authority.

c. Any such escrowed proceeds, pending such use, may be invested and reinvested as permitted by the applicable resolution or trust agreement. The interest, income and profits, if any, earned or realized on any such investment may also be applied to the payment of outstanding bonds to be refunded. After the terms of the escrow have been fully satisfied and carried out, any balance of such proceeds and interest, income and profits, if any, earned or realized on the investments thereof may be returned to the authority for use by it in any lawful manner.

d. All such bonds shall be subject to the provisions of this act in the same manner and to the same extent as other bonds issued pursuant to this act.

C. 26:2I-14 Bonds as legal investments.

Bonds and notes issued by the authority under the provisions of this act are hereby made securities in which the State and all political subdivisions of the State, their officers, boards, commissions, departments or other agencies, all banks, bankers, savings banks, trust companies, savings and loan associations, investment companies and other persons carrying on a banking business, all insurance companies, insurance associations, and other persons carrying on an insurance business, and all administrators, executors, guardians, trustees and other fiduciaries, and all other persons whatsoever who now are or may hereafter be authorized to invest in bonds or other obligations of the State, may properly and legally invest any funds, including capital belonging to them or within their control; and said bonds, notes or other securities or obligations are hereby made securities which may properly and legally be deposited with and received by any State or municipal officers or agency of the State for any purpose for which the deposit of bonds or other obligations of the State is now or may hereafter be authorized by law.

C. 26:2I-15 Act complete authority for issuance of bonds.

Bonds may be issued under the provisions of this act without obtaining the consent of any department, division, commission, board, bureau, agency or officer of the State, and without any other proceedings or the happening of any other conditions or things than those proceedings, conditions and things which are specifically required by this act.

C. 26:2I-16 Exemptions from taxes; bonds; property.

The exercise of the powers granted by this act will be in all respects for the benefit of the people of this State, for the increase of their commerce, welfare and prosperity, and for the improvement of their health and living conditions, and as the operation and maintenance of a project by the authority or its agent will constitute the performance of an essential public function, neither the authority nor its agent shall be required to pay any taxes or assessments upon or in respect of a project or any property acquired or used by the authority or its agent under the provisions of this act or upon the income therefrom, and any bonds issued under the provisions of this act, their transfer and the

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income therefrom, including any profit made on the sale thereof, shall at all times be exempt from taxation except for transfer, inheritance and estate taxes.

C. 26:2I-17 Restriction on alteration of powers.

The State of New Jersey does pledge to and agree with the holders of the bonds issued pursuant to authority contained in this act, and with those parties who may enter into contracts with the authority pursuant to the provisions of this act, that the State will not limit, alter or restrict the rights hereby vested in the authority and the participating hospital to maintain, construct, reconstruct and operate any project as defined in this act or to establish and collect such rents, fees, receipts or other charges as may be convenient or necessary to produce sufficient revenues to meet the expenses of maintenance and operation thereof and to fulfill the terms of any agreements made with the holders of bonds authorized by this act, and with the parties who may enter into contracts with the authority pursuant to the provisions of this act, or in any way impair the rights or remedies of the holders of such bonds or such parties until the bonds, together with interest thereon, are fully paid and discharged and such contracts are fully performed on the part of the authority. The authority as a public body corporate and politic shall have the right to include the pledge herein made in its bonds and contracts.

C. 26:2I-18 Annual report and audit.

On or before March 31 in each year, the authority shall make an annual report of its activities for the preceding calendar year to the Governor and the Legislature. Each such report shall set forth a complete operating and financial statement covering the authority's operations during the year. The authority shall cause an audit of its books and accounts to be made at least once in each year by certified public accountants and cause a copy thereof to be filed with the Secretary of State and the Comptroller of the Treasury.

ARTICLE 5. CONFLICT OF INTEREST

C. 26:2I-19 Contracts; conflict of interest.

Except as otherwise expressly provided in this act, any member, officer, agent or employee of the authority, or member of the immediate family thereof, who is interested, either directly or indirectly, in any contract or transaction of another with the authority, or in the purchase sale or lease of any property, either real or personal, to or from the authority, shall be guilty of a misdemeanor.

ARTICLE 6. EXAMINATION AND VISITORIAL POWERS OF STATE; ASSISTANCE OF STATE EMPLOYEES

C. 26:2I-20 Comptroller of Treasury; powers of examination.

The Comptroller of the Treasury and his legally authorized representatives are hereby authorized and empowered from time to time to examine the accounts, books and records of the authority, including its receipts, disbursements, contracts, sinking funds, investments and any other matters relating thereto and to its financial standing.

C. 26:2I-21 Visitorial powers; department of health; commissioner.

The Department of Health, or the commissioner or their representatives, may visit, examine into and inspect, the authority and may require, as often as desired, duly verified reports therefrom giving such information and in such form as such department or commissioner shall prescribe.

C. 26:2I-22 Services of State departments or agencies.

The authority shall be entitled to call to its assistance and avail itself of the services of such employees of any State department or agency as it may require and as may be available to it for said purpose.

ARTICLE 7. POWERS AND DUTIES OF INSTITUTIONS UNDER STATE, COUNTY AND MUNICIPAL JURISDICTION

C. 26:2I-23 Powers and duties of Department of Health as to institutions under State, county or municipal jurisdiction.

In order to provide new hospitals and to enable the construction and financing thereof, to refinance indebtedness hereafter created by the authority for the purpose of providing a hospital or hospitals or additions or improvements thereto or modernization thereof or for any one or more of said purposes but for no other purpose unless authorized by law, each of the following bodies shall have the powers hereafter enumerated to be exercised upon such terms and conditions, including the fixing of fair consideration or rental to be paid or received, as it shall determine by resolution as to such property and each shall be subject to the performance of the duties hereafter enumerated, that is to say, the State Department of Health as to such as are located on land owned by, or owned by the State and held for, any State institution or on lands of the institutions under the jurisdiction of the State Department of Health or of the State Department of Institutions and Agencies, or by the authority, the Commissioner of the State Department of Institutions and Agencies as to State institutions operated by that department, the board of trustees or governing body of any public hospital, the board of trustees of the College of Medicine and Dentistry of New Jersey, as to such as are located on land owned by such college, or by the State for such college, the State or by the particular public hospital respectively, namely:

a. The power to sell and to convey to the authority title in fee simple in any such land and any existing hospital facilities thereon owned by the State and held for any department thereof or of any of the institutions under the jurisdiction of the State Department of Health or the power to sell and to convey to the authority such title as the State or the public hospital respectively may have in any such land and any existing hospitals thereon.

b. The power to lease to the authority any land and any existing hospital facilities thereon so owned for a term or terms not exceeding 50 years each.

c. The power to lease or sublease from the authority, and to make available, any such land and existing hospitals conveyed or leased to the authority under subsections a. and b. of this section, and any new hospitals erected upon such land or upon any other land owned by the authority.

d. The power and duty, upon receipt of notice of any assignment by the authority of any lease or sublease made under subsection c. of this section, or of any of its rights under any such lease or sublease, to recognize and give effect to such assignment, and to pay to the assignee thereof

rentals or other payments then due or which may become due under any such lease or sublease which has been so assigned by the authority.

C. 26:2I-24 Additional powers and duties as to lands and State and public hospitals.

In addition thereto the Commissioner of the State Department of Institutions and Agencies as to institutions operated by that department, the chief executive officer and the board of trustees of other State institutions, and the board of trustees or governing body of county and municipal public hospitals shall have the following powers and shall be subject to the following duties as to their lands and hospital facilities

a. The power to pledge and assign all or any part of the revenues derived from the operation of such new hospitals as security for the payment of rentals due and to become due under any lease or sublease of such new hospitals under subsection c. of the preceding section.

b. The power to covenant and agree in any lease or sublease of such new hospitals made under subsection c. of the preceding section to impose fees, rentals or other charges for the use and occupancy or other operation of such new hospitals in an amount calculated to produce net revenues sufficient to pay the rentals due and to become due under such lease or sublease.

c. The power to apply all or any part of the revenues derived from the operation of any hospitals to the payment of rentals due and to become due under any lease or sublease made under subsection c. of the preceding section.

d. The power to pledge and assign all or any part of the revenues derived from the operation of any hospitals to the payment of rentals due and to become due under any lease or sublease made under subsection c. of the preceding section.

e. The power to covenant and agree in any lease or sublease made under subsection c. of the preceding section to impose fees, rentals or other charges for the use and occupancy or other operation of any hospitals in an amount calculated to produce net revenues sufficient to pay the rentals due and to become due under such lease or sublease.

C. 26:2I-25 Powers and duties, revenue producing facilities.

In addition to the powers and duties, with respect to hospitals given under sections 23 and 24, the board of trustees or governing body of any State institution or public hospital and the board of trustees of the College of Medicine and Dentistry of New Jersey shall also have the same powers and be subject to the same duties in relation to any conveyance, lease or sublease made under subsections a., b., or c. of section 24, with respect to revenue producing facilities: that is to say, structures or facilities which produce revenues sufficient to pay the rentals due and to become due under any lease or sublease made under subsection c. of section 24 including, without limitation, extended care and parking facilities.

C. 26:2I-26 Approval of plans, specifications and locations.

The State Department of Health shall approve the plans and specifications and location of each hospital undertaken for it or under its control or any public hospital prior to the undertaking thereof by the authority.

C. 26:2I-27 Powers and duties, exercises; instruments, execution.

To the extent not otherwise expressly provided under existing law, all powers and duties conferred upon any State institution or the College of Medicine and Dentistry or any county, city or municipal hospital pursuant to this act shall be exercised and performed by resolution of its governing body and all powers and duties conferred upon any of said hospitals pursuant to this act shall be exercised and performed by resolution of its board of trustees or governing body.

ARTICLE 8. PRIVATE HOSPITALS

C. 26:2I-28 Additional powers; private hospitals.

In addition to the foregoing powers, the authority with respect to private hospitals shall have power, but only upon approval by the commissioner of a regulatory agreement with such private hospital and subject to the terms and conditions of such agreement; and provided that no project will be undertaken pursuant to this act without the prior issuance of a certificate of need pursuant to P.L. 1971, c. 136 (C. 26:2H-1 et seq.):

a. Upon application of the participating hospital to construct, acquire or otherwise provide projects for the use and benefit of the participating hospital and the patients, employees and staff of such participating hospital. The participating hospital for which such a project is undertaken by the authority shall approve the plans and specifications of such project.

b. To operate and manage any project provided pursuant to this section, or the authority may lease any such project to the participating hospital for which such project is provided. At such time as the liabilities of the authority incurred for any such project have been met and the bonds of the authority issued therefor have been paid, or such liabilities and bonds have otherwise been discharged, the authority shall transfer title to all the real and personal property of such project vested in the authority, to the participating hospital in connection with which such project is then being operated, or to which such project is then leased; provided, however, that if at any time prior thereto such participating hospital ceases to offer hospital or health services, then such title shall vest in the State of New Jersey.

Any lease of a project authorized by this section shall be a general obligation of the lessee and may contain provisions, which shall be a part of the contract with the holders of the bonds of the authority issued for such project, as to:

(i) pledging all or any part of the moneys, earnings, income and revenues derived by the lessee from such project or any part or parts thereof, or other personal property of the lessee to secure payments required under the terms of such lease;

(ii) the rates, rentals, fees and other charges to be fixed and collected by the lessee, the amounts to be raised in each year thereby, and the use and disposition of such moneys, earning, income and revenues;

(iii) the setting aside of reserves and the creation of special funds and the regulation and disposition thereof.

(iv) the procedure, if any, by which the terms of such lease may be amended;

(v) vesting in a trustee or trustees such specified properties, rights, powers and duties as shall be deemed necessary or desirable for the security of the holders of the bonds of the authority issued for such projects;

(vi) the obligations of the lessee with respect to the replacement, reconstruction, maintenance, operation, repairs and insurance of such project;

(vii) defining the acts or omissions to act which shall constitute a default in the obligations and duties of the lessee, and providing for the rights and remedies of the authority and of its bondholders in the event of such default;

(viii) any other matters, of like or different character, which may be deemed necessary or desirable for the security or protection of the authority or the holders of its bonds.

C. 26:2I-29 Construction loans; terms.

The authority also shall have power:

a. To make loans to any private hospital for the construction of projects in accordance with a loan agreement and plans and specifications approved by the authority. No such loan shall exceed the total cost of such project as determined and approved by the authority. Each such loan shall be promised upon an agreement between the authority and the private hospital as to payment, security, maturity, redemption, interest and other appropriate matters.

b. To make loans to any private hospital to refund existing bonds, mortgages or advances given or made by such private hospital for the construction of projects to the extent that this will enable such private hospital to offer greater security for loans for new project construction.

C. 26:2I-30 Power of private hospitals to mortgage.

For the purpose of obtaining and securing loans under section 29 every private hospital shall have power to mortgage and pledge any of its real or personal property, and to pledge any of its income from whatever source to repay the principal of and interest on any loan made to it by the authority or to pay the interest on and principal and redemption premium, if any, of any bond or other evidence of indebtedness evidencing the debt created by any such loan; provided that the foregoing shall not be construed to authorize actions in conflict with specific legislation, trusts, endowment, or other agreements relating to specific properties or funds.

C. 26:2I-31 Moneys; separate account.

Moneys of the authority received from any private hospital in payment of any sum due to the authority pursuant to the terms of any loan or other agreement or any bond, note or other evidence of indebtedness, shall be deposited in account in which only moneys received from private hospitals shall be deposited and shall be kept separate and apart from and not commingled with any other moneys of the authority. Moneys deposited in such account shall be paid out on checks signed by the chairman of the authority or by such other person or persons as the authority may authorize, and countersigned by one other member of the authority.

C. 26:2I-32 Authority; construction, operation and management.

a. Whenever the authority under section 28 undertakes to construct, acquire or otherwise provide and operate and manage a project, the authority shall be responsible for the direct operation and maintenance costs of such projects, but each private hospital in connection with which such a project is provided and operated and managed shall be responsible at its own expense for the overall supervision of each project, for the overhead and general administrative costs of the private hospital which are incurred because of such project and for the integration of each project operation into the institution's hospital program.

b. Whenever the authority under section 28 undertakes to construct, acquire or otherwise provide a project and to lease the same to a private hospital, the lessee shall be responsible for the direct operation and maintenance costs of such project and, in addition, shall be responsible for the overall supervision of each project, for the overhead and general administrative costs of the lessee which are incurred because of such project and for the integration of each project operation into the lessee's hospital program.

c. Whenever the authority under section 29 makes loans for the construction of a project, the private hospital at which such project is located shall be responsible for the direct operation and maintenance costs of such project and, in addition, shall be responsible for the overall supervision of each project, for the overhead and general administrative costs of the private hospital which are incurred because of such project and for the integration of each project operation into the institution's hospital program.

C. 26:2I-33 Private hospitals; pledges.

Any pledge of moneys, earnings, income or revenues authorized with respect to private hospitals, pursuant to the provisions of this act, shall be valid and binding from the time when the pledge is made. The moneys, earnings, income or revenues so pledged and thereafter received by the pledgor shall immediately be subject to the lien of such pledge without any physical delivery thereof or further act. The lien of any such pledge shall be valid and binding as against all parties having claims of any kind in tort, contract or otherwise against the pledgor irrespective of whether such parties have notice thereof. No instrument by which such a pledge is created need be filed or recorded in any manner.

ARTICLE 9. PARTICIPATION IN EXISTING PROJECTS

C. 26:2I-34 Participation in existing projects.

Whenever any public or private hospital has constructed or acquired any work or improvement which would otherwise qualify as a project under the preceding portions of this act except for the fact that such construction or acquisition was undertaken and financed without assistance from the authority, the authority may purchase such work or improvement, and lease the same to such hospital, or may lend funds to such hospital for the purpose of enabling the latter to retire obligations incurred for

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such construction or acquisition, provided that the amount of any such purchase price or loan shall not exceed the project cost as herein defined, irrespective of such work or improvement. All powers, rights, obligations and duties granted to or imposed upon the authority, hospitals, State departments and agencies or others by this act in respect of projects shall apply to the same extent with respect to transactions authorized by this section, provided that any action otherwise required to be taken at a particular time in the progression of a project may, where the circumstances so required in connection with a transaction under this section be taken nunc pro tunc.

ARTICLE 10. CONSTRUCTION

C. 26:2I-35 Construction of act.

This act shall be liberally construed to effect the purpose thereof.

C. 26:2I-36 No liability or pledge of credit of State.

Nothing contained in this act shall be deemed or construed to create or constitute a debt, liability, or a loan or pledge of the credit, of the State.

C. 26:2I-37 Powers supplemental and not derogatory.

The foregoing sections of this act shall be deemed to provide an additional and alternative method for the doing of the things authorized thereby, and shall be regarded as supplemental and additional to powers conferred by other laws, and shall not be regarded as in derogation of any powers now existing: provided, however, that the issuance of bonds or refunding bonds under the provisions of this act need not comply with the requirements of any other law applicable to the issuance of bonds.

C. 26:2I-38 Inconsistent laws inapplicable.

All laws, or parts thereof, inconsistent with this act are hereby declared to be inapplicable to the provisions of this act, except as otherwise provided, and provided that no project shall be constructed pursuant to this act which does not comply with the Health Care Facilities Planning Act, P.L. 1971, c. 136 (C. 26:2H-1 et seq.).

C. 26:2I-39 Severability.

The provisions of this act shall be severable, and if any of the provisions hereof shall be held to be unconstitutional or otherwise invalid, such decisions shall not affect the validity of any of the remaining provisions of this act.

40. There is hereby appropriated to the authority from the General State Fund the sum of $100,000.00, or so much thereof as may be necessary, for the purposes of carrying out its function and duties pursuant to this act. Such appropriation shall be repaid to the General State Fund as soon as practicable out of the proceeds of the first bonds issued by the authority or other available funds.

41. This act shall take effect on the first day of the fourth month following enactment.

Approved May 25, 1972.

SENATE, No. 2394

STATE OF NEW JERSEY

INTRODUCED NOVEMBER 19, 1984

By Senators VAN WAGNER and GAGLIANO

(Without Reference)

AN ACT to amend the "New Jersey Health Care Facilities Financing Authority Law," approved May 25, 1972(P. L. 1972, c. 29).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 34 of P. L. 1972, c. 29(C. 26:2I-34) is amended to read as follows:

34. *a.* Participation in existing projects. Whenever any public or private hospital has constructed or acquired any work or improvement which would otherwise qualify as a project under the preceding portions of this act except for the fact that such construction or acquisition was undertaken and financed without assistance from the authority, the authority may purchase such work or improvement, and lease the same to such hospital, or may lend funds to such hospital *for the purpose of* enabling the latter to retire obligations incurred for such construction or acquisition, provided that the amount of any such purchase price or loan shall not exceed the project cost as herein defined, irrespective of such work or improvement. All powers, rights, obligations and duties granted to or imposed upon the authority, hospitals, State departments and agencies or others by this act in respect to projects shall apply to the same extent with respect to transactions authorized by this section, provided that any action otherwise required to be taken at a particular time in the progression of a project may, where the circumstances so required in connection with a transaction under this section be taken nunc pro tunc.

Matter printed in italics thus is new matter.

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b. Acquisition of hospital facilities from counties or municipalities. Notwithstanding the provisions of any law to the contrary, the authority may authorize the acquisition, and any county or municipality by resolution or ordinance may authorize a private sale and conveyance or leasing to the authority, of any interest of the county or municipality in any lands and existing hospital facilities which are then being operated by a private or public hospital upon such terms and conditions as may be agreed upon by the authority and the county and municipality. The authority may use its funds for the acquisition by providing for the retirement of obligations incurred for the acquisition of the land, and for the acquisition and construction of the existing hospital facilities, provided that the amount of the purchase price shall not exceed the project costs. Upon acquisition of the lands and existing hospital facilities, the authority may convey or lease the lands and existing hospital facilities to a participating hospital under such terms and conditions as the authority and participating hospital may agree.

2. This act shall take effect immediately.

APPROVED

day of

THOMAS H. KEAN
GOVERNOR

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SENATE No. 2324

SENATE.

Nov 19 1984

This bill having been three times read in the Senate,

RESOLVED, That the same do pass.

By order of the Senate.

President of the Senate.

GENERAL ASSEMBLY.

12/6 19 .

This bill having been three times read and compared in the General Assembly,

RESOLVED, That the same do pass.

By order of the General Assembly.

Speaker of the General Assembly.

SENATE.

19 .

This bill having been three times read in the Senate,

RESOLVED, That the same do pass as amended.

By order of the Senate.

President of the Senate.

GENERAL ASSEMBLY.

19 .

This bill having been three times read and compared in the General Assembly,

RESOLVED, That the same do pass as amended.

By order of the General Assembly.

Speaker of the General Assembly.

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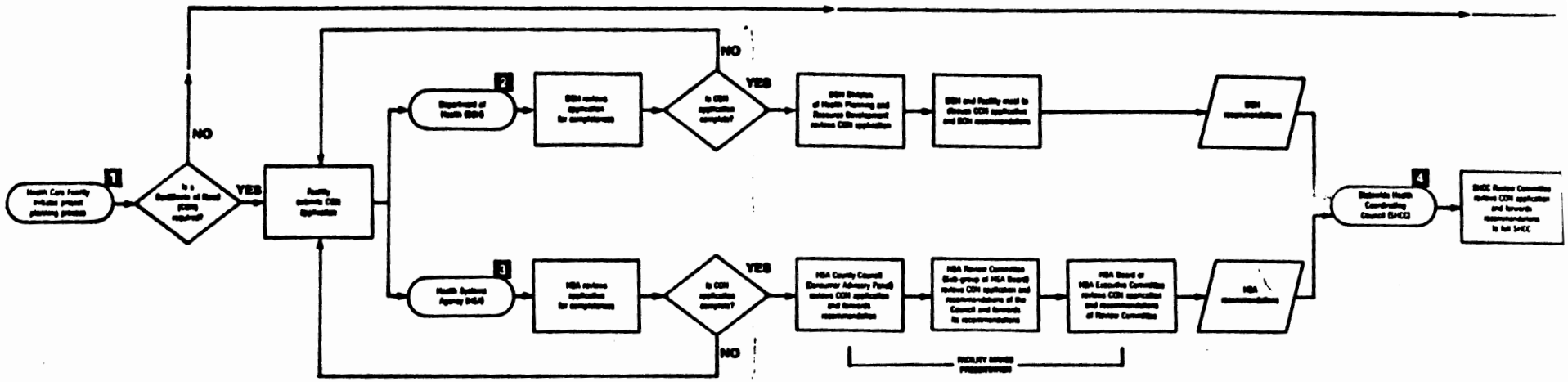
OBTAINING A CERTIFICATE OF NEED



For explanation of terms that appear in bold type refer to glossary.

OBJECTIVE:

The State of New Jersey has established, as a matter of public policy, "...that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided, properly utilized and at a reasonable cost are of vital concern to the public health ..." [N.J.A.C. 8:33-1.3]

The Certificate of Need (CON) process is the means by which the Department of Health, as the agency charged in New Jersey with the promotion of health as well as the fiscal solvency of health care institutions, fulfills these responsibilities.

The objectives of the Certificate of Need process are to ensure that:

1. the proposed project will result in high quality health care services;
2. there is a clear and demonstrable need for the project in the area being served;
3. there will be no unnecessary escalation in health care costs as a result of this project; and,
4. the project is consistent with the goals and objectives of the State Health Plan.

PARTICIPANTS:

1 HEALTH CARE FACILITY/APPLICANT

Within the CON process, the facility is known as the "applicant." Its interest is in gaining the approval of its project. To effect this approval, the applicant must demonstrate that the project is fulfilling a real need within the geographic area it serves, will result in a significant improvement in health care delivery in that area, and is financially feasible. The applicant seeks support from local community groups as well as other local health care institutions.

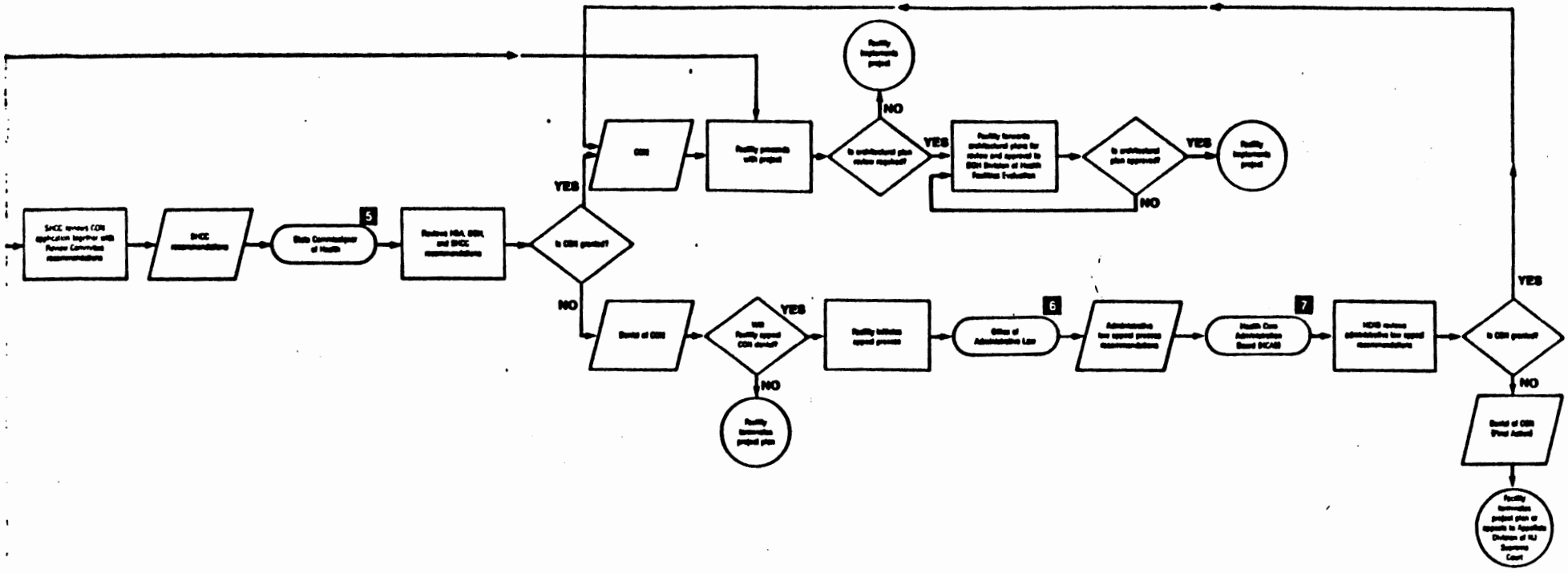
2 DEPARTMENT OF HEALTH (DOH)

The Department of Health has been designated as the sole agency of the State for comprehensive health planning under the "National Health Planning and Resources Development Act of 1974" (Federal Law 93-641) and as such, administers the Certificate of Need process.

An applicant files a CON application with the Department of Health at the same time it files the application with the local Health Systems Agency (HSA). The application is evaluated by numerous divisions of the Department to ensure that the application is complete, the project is beneficial and cost-effective, and that it complies with the State Health Plan.

3 HEALTH SYSTEMS AGENCY (HSA)

Health Systems Agencies are distributed throughout the State and provide for local input and involvement in the health planning process. The applicant initiates the CON process by filing an application with the HSA, where it may be reviewed by a County Council (a consumer advisory panel), the HSA Review Committee and then, finally, passed on to the HSA Board with the Review Committee's recommendations for the Board's final action. The HSA's perspective in the process is a local and a participatory one. It ensures that all local views and interests



are aired and conveyed throughout the CON approval process. (It should be noted that funding for HSAs has been discontinued by the federal government. At the time this report was printed, only two out of the five original HSAs were still in operation.)

4 STATEWIDE HEALTH COORDINATING COUNCIL (SHCC)

The Statewide Health Coordinating Council acts as the coordinating agency for the recommendations of the local HSAs and of the Department of Health. The SHCC Review Committee first evaluates the application and then passes it on together with recommendations for review by the full SHCC. The SHCC's objective is to reconcile the interests of the State Health Plan with the needs of the applicant and the requirements of the local community the applicant serves.

5 COMMISSIONER OF HEALTH

As the chief health officer of the State, the Commissioner of Health reviews and takes action on all CONs after receiving a recommendation from the SHCC. The overall congruence of the applicant's project with what the Commissioner perceives to be the objectives of the State Health Plan and the needs of the local service area provides the basis for the Commissioner's decision to approve or deny the project.

6 OFFICE OF ADMINISTRATIVE LAW

If the application is denied or if the Commissioner makes a decision contrary to the recommendation of the SHCC, the applicant may appeal under the uniform Administrative Procedure Rules of Practice. This process is a legal entitlement to all applicants and examines the applicant's petition and determines whether the CON process was adhered to as required by law and whether any due process guarantees were violated.

7 HEALTH CARE ADMINISTRATION BOARD (HCAB)

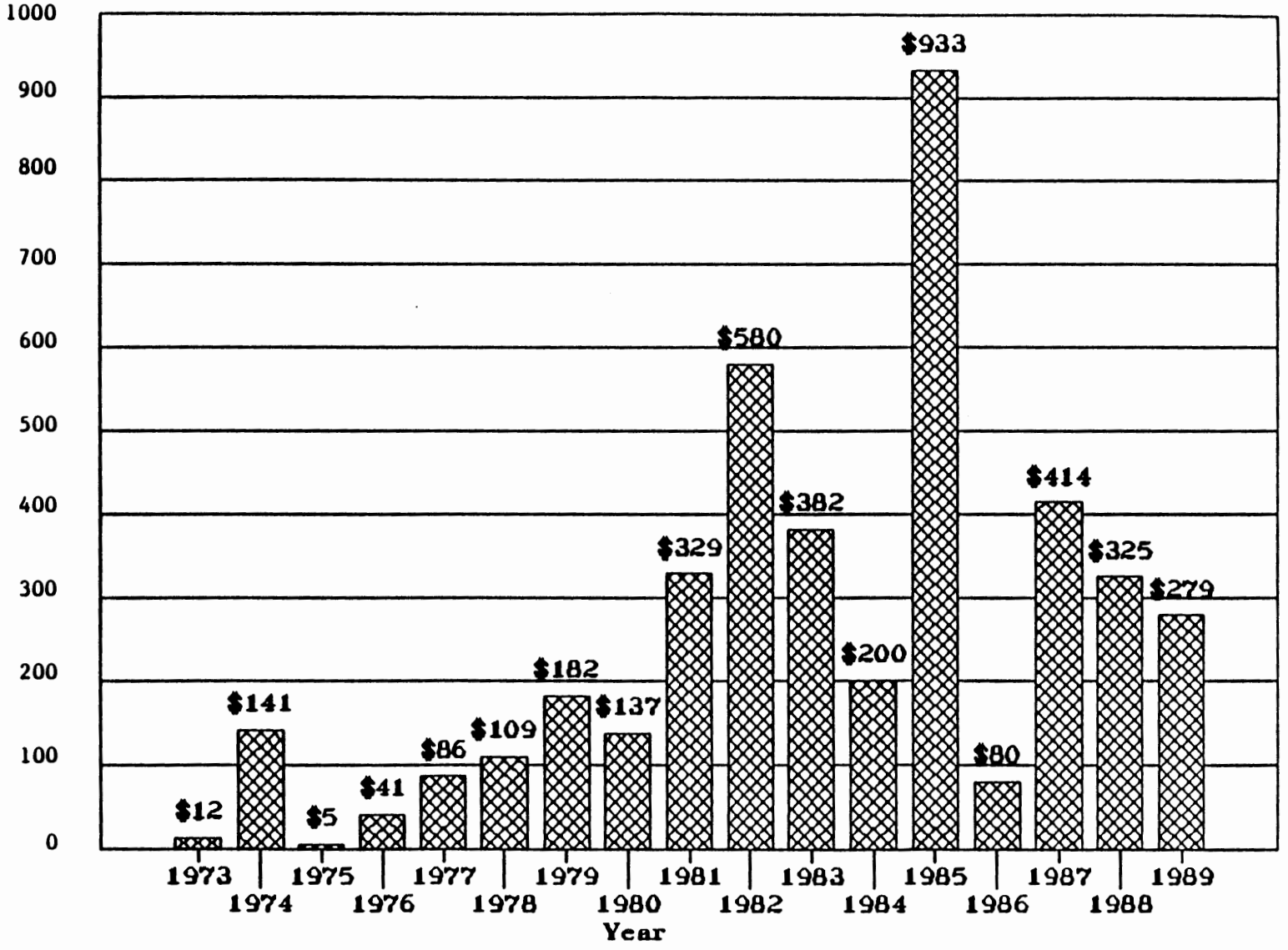
The HCAB reviews recommendations from the administrative law appeal process and determines the final action to be taken on a CON application. The HCAB is a group of twelve providers and consumers of health care appointed by the Governor, whose purpose is to review, comment on and adopt health care regulations issued by the New Jersey Department of Health.

Once completed, the recommendations derived from the administrative law appeal process are forwarded to the HCAB which will determine the final action to be taken on the CON application.

hcfa

Appendix C

NJHCFFA VOLUME OF BONDS ISSUED



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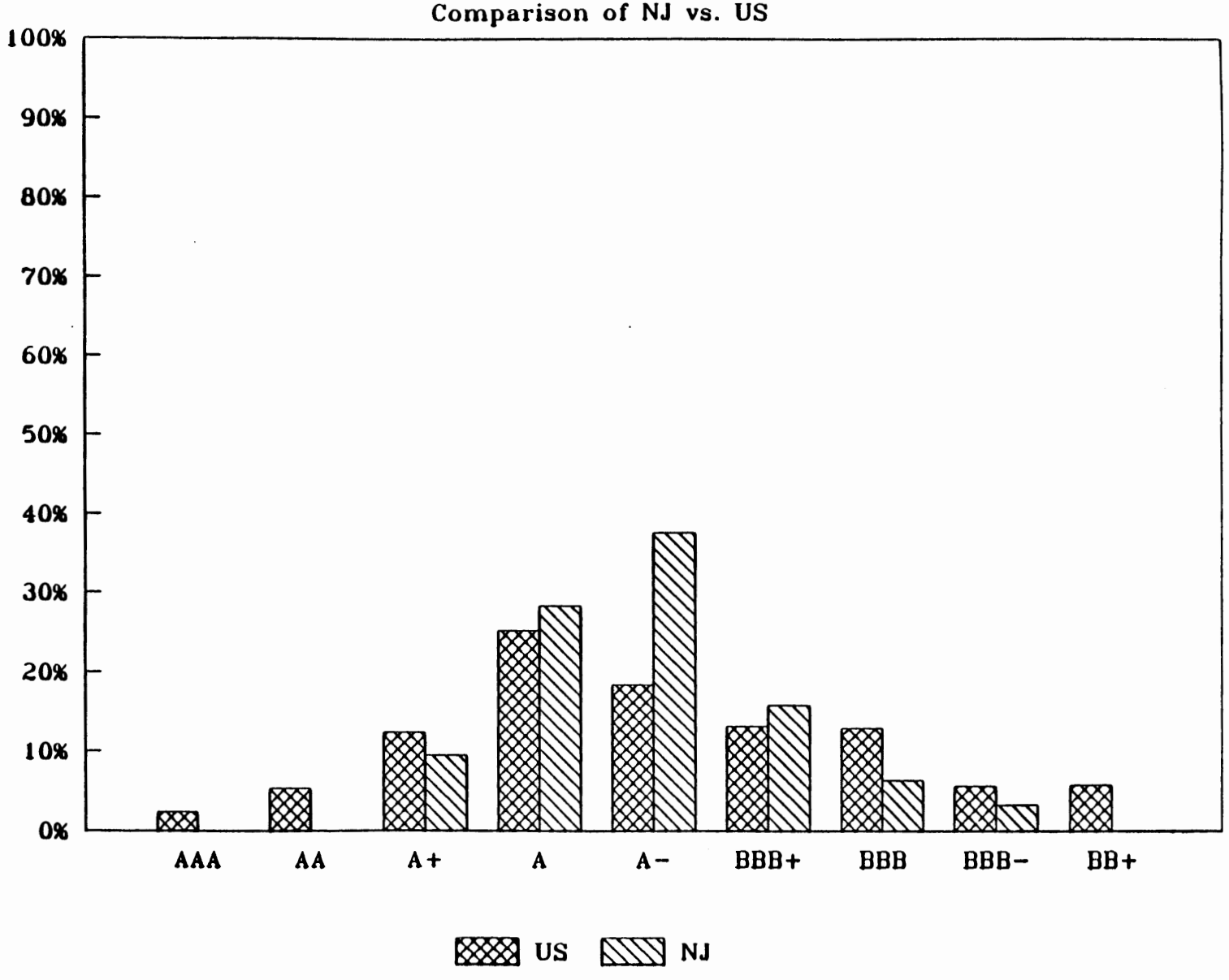
Distribution of S & P's Credit Ratings



SOURCE: U.S.- S&P; N.J. NJHCFFA AS OF 1990

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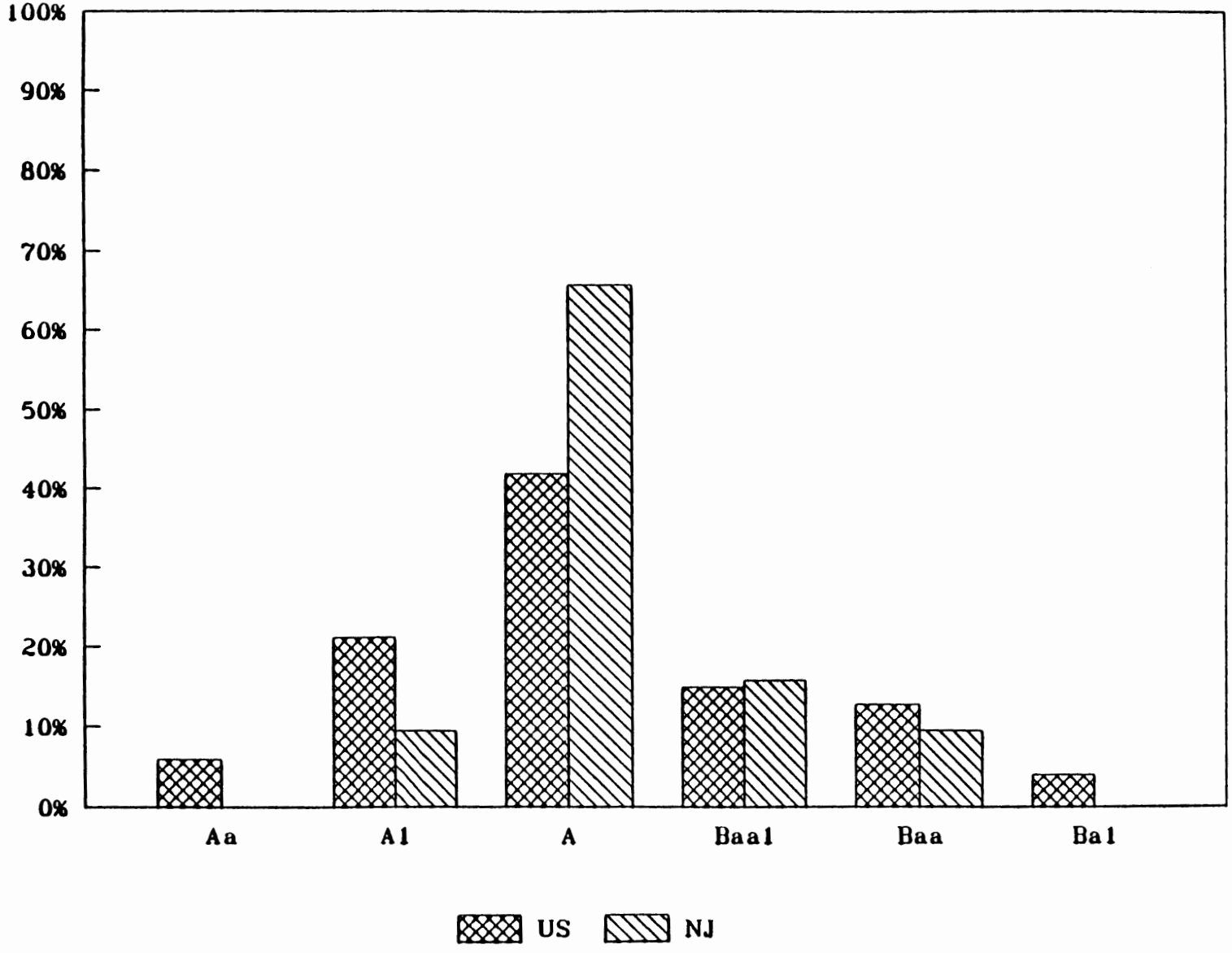
Distribution of Moody's Credit Ratings

Comparison of NJ vs. US



SOURCE: U.S.- MOODY'S ; N.J.- NJHCFFA AS OF MAY 1990

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Appendix E

COMPARISON OF FINANCIAL PERFORMANCE
NEW JERSEY VS. UNITED STATES
BY RATING CATEGORY
1989

	A		A-	
	NJ	US	NJ	US
Number of hospitals reporting	11	195	10	134
Operating margin	2.55	2.86	1.5	2.38
Profit margin	3.91	4.91	2.63	3.6
Debt service coverage ratio	2.22	2.94	1.99	2.56
Long term debt to equity	0.87	0.67	1.11	0.89

Sources: New Jersey-NJHCFFA, Apollo System and audited financial statements
United States-HCIA, Sourcebook, 1990 Edition

NEW JERSEY PUBLIC HEALTH ASSOCIATION
Statement to the
Assembly Health Care Policy Study Commission

Chairman McGreevey and Commission members (Impreveduto, Menendez, Mattison, Cohen, Felice and Kelly), on behalf of the New Jersey Public Health Association I thank you for this opportunity to share our perspective on Health Care Planning in our state. My name is Mary Stevens and I am on the Executive Board of the NJPHA.

Our organization, an affiliate of the American Public Health Association, was founded more than a century ago to promote the cause of public health. More people are alive today because of advances in public health than because of advances in any other field of medicine.

Yet, as a society, we became complacent, more than that, negligent in our attention to the fundamentals of preventive and primary health care. Who would have believed, ten or even thirty years ago that we would today be facing an unchecked syphilis epidemic, or outbreaks of tuberculosis or measles? These diseases are communicable and they are eminently preventable; it was unquestioned 30 years ago that these scourges were things of the past. But, lo and behold, they are here again today. And why? There is no profit in preventive care, no constituency. Clinical medical intervention is part of the system of reimbursement and insurance; prevention is a public expense. A medical cure is dramatic, prevention is not. Today, only the failure to invest in the public health is dramatic.

Preventive health care is not only essential for the well being and productivity of the community, it is cost-effective. Every dollar spent on WIC's prenatal care program saves three dollars in averted medical care for low birth weight babies. Not every public health program can boast a 200% return on investment, I grant you, but it is the rare public health program which does not save more than it costs. If you want to save acute care dollars, invest in public health.

Our state has a health plan, well thought-out, running to some 1000 pages; our state has competent health planners, well-qualified to improve upon it, to revise it perhaps and to monitor our progress. We do not lack a plan on paper so much as we lack a plan in action.

We have the infrastructure for an exemplary preventive health care system -- the system we used to have, remember? When TB was a thing of the past. We have trained personnel. We could again have mass health screening and routine vaccination in the schools. This was a system that served us well. Today clinical intervention is in part a mopping up operation; much of what we treat today we could prevent at less expense.

I turn now to specific recommendations of the Governor's Committee on Health Care Costs and its CARE Report.

By and large we support CARE and we commend the Governor's Commission on Health Care Costs. Similarly we have the greatest respect for our new Commissioner of Health who holds, among others, an earned degree in public health.

We applaud the emphasis on wellness as against acute care.

We support an epidemiologically and demographically based health plan. The planning process should include the local health officer and should draw upon the expertise and experience of local volunteer citizen and provider groups for local initiatives.

Not mentioned in the CARE Report but central to efficient health care is the use of alternative providers of primary and secondary care, including physical therapists, occupational therapists, pharmacists, chiropractors, clinical nurse practitioners, nutritionists and physicians assistants.

In one important respect we dissent from the CARE Report: we are astonished at the omission of any reference to local health officers, whose jurisdiction comprises the very items most likely to save the most dollars and most improve the state of our citizen's health.

We support the CARE recommendations regarding the Certificate of Need process; we have in New Jersey more MRIs than there are in all of Canada. As taxpayers and as consumers, we pay far more than we can afford for these medical Cadillacs. This is a shocking misallocation of financial resources when our women, our young children, our minorities, our elderly don't have bus fare. The non-institutional facility loophole should be closed and the process tightened up.

With regard to Blue Cross, it has been suggested that Blue Cross should behave more like the commercial insurance companies. We disagree. The solution to the Blue Cross problem is for the commercial insurers to behave more like the old Blue Cross. Specifically, experience and demographic rating should be prohibited as should pre-existing illness exclusion clauses. Too many insurance companies profit by segmenting the market, picking off the good risks and dumping the poor risks or 'demarketing' them. It is of no benefit to New Jersey that high cost procedures and high risk consumers be excluded. The uninsured reappear in the system later on: sicker, more expensive to treat and with poorer health outcomes. Instead, all insurers should use a standard <u>community rating</u> based on health care costs for the population as a whole. Let the arena of competition be efficiency not exclusion.

We see no alternative to the Uncompensated Care Trust Fund but for the state to develop a broad-based revenue source to replace the current costly, inefficient and inequitable system of public taxes and private premiums.

Under the current system, too much money goes to 'bad debt' for people who fail to meet their co-payments and deductibles and on Medicaid eligibles who neglect to obtain coverage. While we must address the legitimate concerns of under-insurance and inaccessibility, we need not be taken advantage of by people who abuse the system. In this area, as in many others in the health care industry, there is too little enforcement and too little public accountability.

In conclusion we emphasize our concern about the public health threat presented by people entering the health care system too late or not at all. Encouragement of good health practices, prevention of disease and early intervention not only improves the health, well-being and productivity of all New Jerseyans, but it is cost-effective, bringing people into the system at an earlier time when care is both less intense and less expensive.

We urge you, our elected officials, to reverse this tragic and wasteful pattern of ignoring the public health; spend where it will do the most good, not where the wheel squeaks the loudest.

One Gateway Center Suite 2600
Newark, New Jersey 07102-5311
(201) 642-5100

CATHEDRAL HEALTHCARE SYSTEM

Testimony by

Margaret J. Straney, R.S.M.
President and Chief Executive Officer
Cathedral Healthcare System

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

COMPREHENSIVE STATE HEALTH PLAN - CERTIFICATE OF NEED PROCESS

NOVEMBER 28, 1990
10:00 A.M.

State House Annex
Trenton, New Jersey

Sponsored by the Archdiocese of Newark

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TESTIMONY ON HEALTH CARE PLANNING

CHAIRMAN MCGREEVEY, MEMBERS OF THE COMMITTEE, MY NAME IS SISTER MARGARET J. STRANEY. I AM THE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF CATHEDRAL HEALTHCARE SYSTEM, A MULTI HOSPITAL SYSTEM LOCATED IN NEWARK. I WELCOME THE OPPORTUNITY TO SPEAK TO THE ISSUE OF HEALTH PLANNING AND ITS IMPORTANCE TO HEALTH CARE REFORM IN NEW JERSEY.

REFORM OF THE HEALTH PLANNING PROCESS IS THE SECOND RECOMMENDATION IN THE REPORT ISSUED BY THE GOVERNOR'S COMMISSION ON HEALTH CARE COSTS, THUS REFLECTING ITS SIGNIFICANCE TO THE OVERALL EFFORT TO DEVELOP A MORE RATIONAL, REALISTIC AND EQUITABLE APPROACH TO HEALTH POLICY AND HEALTH CARE DELIVERY.

THERE IS LITTLE DOUBT THAT A SIGNIFICANT SHIFT IN FOCUS IS REQUIRED IF HEALTH PLANNING IS TO CONTRIBUTE TO A RE-ORDERING OF PRIORITIES IN THE DELIVERY OF HEALTH SERVICES. AS I STATED BEFORE THE GOVERNOR'S COMMISSION, OUR HEALTH CARE SYSTEM HAS BEEN FOCUSED MORE ON DOLLARS THAN ON PEOPLE, MORE ON BUILDINGS THAN ON SERVICES, MORE ON PROVIDERS THAN ON CONSUMERS. HEALTH CARE REFORM REQUIRES

TAKING A BOLD POSITION EVEN THOUGH THE INDUSTRY MAY NOT BE READY FOR IT. HOWEVER, TO FAIL TO BE A LEADER IN HEALTH CARE REFORM IS A MUCH GREATER RISK.

WE MUST, THROUGH ANY EXISTING OR PROPOSED REGULATORY PROCESS, CONTINUE TO ENCOURAGE A FUNDAMENTAL SHIFT IN HEALTH CARE FROM ACUTE CARE TO AMBULATORY CARE, FROM A SICKNESS MODEL TO A WELLNESS MODEL, FROM A LOCAL TO A REGIONAL PERSPECTIVE, AND FROM A PROVIDER FOCUS TO A CONSUMER FOCUS. AS THE AMERICAN HOSPITAL ASSOCIATION SECTION FOR HEALTH CARE SYSTEMS RECENTLY NOTED, THE NEEDS OF THE POPULATION MUST DRIVE HEALTH CARE REFORM. "POPULATION IS A BROADER TERM THAN PATIENT," THE AHA NOTES. "WE SHOULD ALL COMMIT TO A HEALTHY POPULATION AS OUR FUNDAMENTAL OBJECTIVE, THEN ORGANIZE OURSELVES TO SUPPORT THAT OBJECTIVE. THE MEASURE OF OUR SUCCESS SHOULD BE HEALTH STATUS, NOT FULL HOSPITALS; MANAGEABLE COST PER CAPITA, NOT PROFITABILITY FOR THOUSANDS OF SEPARATE PROVIDER UNITS; VALUE, NOT JUST CONTROL.

WHAT IS REQUIRED IN DEVELOPING A COMPREHENSIVE STATEWIDE HEALTH PLAN IS A NEW VISION OF HEALTH CARE DELIVERY IN NEW JERSEY. THAT VISION MUST REFLECT WHAT WE AS A SOCIETY BELIEVE IS REALISTIC AND ATTAINABLE IN PURSUING A HEALTH CARE SYSTEM THAT WILL RESULT IN PRODUCING A HEALTHIER NEW JERSEYAN. IT SHOULD ARTICULATE BASIC

ISSUES SUCH AS ACCESS, COST, NEED AND QUALITY AND INCORPORATE THE ROLE OF PAYORS, PROVIDERS, CONSUMERS, LABOR AND GOVERNMENT IN ANY NEW HEALTH CARE STRUCTURE.

THIS VISION SHOULD ALSO IDENTIFY A REGULATORY PHILOSOPHY THAT WILL IN PART GOVERN SUBSEQUENT ACTIONS AND POLICIES. FOR EXAMPLE, SHOULD THERE BE A MARKET-BASED FOCUS OR A PURE REGULATORY-BASED FOCUS? MOST LIKELY THERE SHOULD BE A BALANCE BETWEEN THE TWO. HOWEVER, WITH A REGULATORY FOCUS, SPECIAL ATTENTION MUST BE PAID TO IMPLEMENTATION PROCESSES. FREQUENTLY, REGULATION HAS THE POTENTIAL TO PROTECT BUT THE ADMINISTRATIVE PROCESS NEGATES THE BENEFIT THROUGH INCREASED COST AND COMPLEXITY. FURTHER, AS THE TRANSITION IS MADE TO A NEW DELIVERY SYSTEM FINANCIAL ACCOMMODATION MUST BE MADE TO SUPPORT THAT TRANSITION.

CLEARLY, THIS MATTER MUST BE PLACED IN PROPER CONTEXT. IT HAS BEEN SAID THAT EMPLOYERS, GOVERNMENT, LABOR AND INDIVIDUAL CONSUMERS ENVISION A LESS EXPENSIVE PACKAGE OF HEALTH CARE SERVICES DELIVERED WITH GREATER EFFICIENCY AND MORE CARING. WE KNOW FROM CURRENT LITERATURE AND FROM OUR OWN EXPERIENCES THAT THE CONSUMER IS NOW A KEY PLAYER IN THE HEALTH CARE DEBATE, FEELING THE COST CRUNCH BUT ALSO SEEKING QUALITY OF CARE. IN CONSTRUCTING A STATE HEALTH PLAN IT HAS BEEN SAID THAT, LIKE POLITICS, HEALTH CARE IS

VERY MUCH A PERSONAL DYNAMIC, WHERE HOSPITAL, DOCTOR, PATIENT AND EMPLOYER/INSURER MEET FACE TO FACE.

IN DEVELOPING A STATEWIDE HEALTH PLAN WE ENVISION A TIGHTLY LINKED REGIONAL SYSTEM WITH COMPREHENSIVE, VERTICALLY INTEGRATED SYSTEMS OF SERVICES FOR DEFINED POPULATIONS.

SOMETIMES A HOSPITAL CLOSURE OR CONVERSION MAY BE NECESSARY TO BEST FULFILL THE COMMUNITY'S NEEDS. AS ONE WHO HAS EXPERIENCED THIS FIRST HAND, I RECOMMEND EVALUATING THE CONCEPT OF A HOSPITAL CLOSURE/CONVERSION COMMISSION SIMILAR TO THE ONE ESTABLISHED IN MASSACHUSETTS. THIS COMMISSION TAKES HOSPITAL CONVERSIONS OUT OF THE ESTABLISHED REGULATORY PROCESS, AND HAS THE AUTHORITY TO ALLOT FUNDS AND GRANT APPROVALS IN A MORE EXPEDITIOUS MANNER THAN THROUGH THE EXISTING PROCESS. NEED MUST BE BASED ON FACT, NOT ON EMOTION, AND SELF-INTEREST, REGARDLESS OF ITS SOURCE, MUST BE IDENTIFIED AND CHALLENGED.

I STRONGLY ENDORSE THE COMMISSION'S RECOMMENDATION TO ESTABLISH A COMPREHENSIVE STATE HEALTH PLAN, BUT FOR IT TO BE SUCCESSFUL AND TRULY RESPONSIVE TO COMMUNITY NEEDS, THE HEALTH PLAN MUST REFLECT THE BASIC SHIFTS IN FOCUS I ALLUDED TO EARLIER: FROM ACUTE CARE TO AMBULATORY CARE, FROM A SICKNESS MODEL TO A WELLNESS

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MODEL, FROM A LOCAL TO A REGIONAL PERSPECTIVE, AND FROM A PROVIDER FOCUS TO A CONSUMER FOCUS. THE STATE HEALTH PLAN MUST REFLECT CURRENT TRENDS IN THE NATURE AND TREATMENT OF ILLNESS, RATHER THAN MERELY FOCUS ON FORECASTING THE NEED FOR ACUTE CARE BEDS.

IT MUST ALSO TAKE INTO CONSIDERATION THE VERY DIVERSE HEALTH STATUS OF CERTAIN HIGH RISK GROUPS, SUCH AS MINORITIES, CHILDREN, THE ELDERLY, THE CHRONICALLY ILL AND THE HOMELESS.

OF CRUCIAL IMPORTANCE IS ENSURING ACCESS TO PRIMARY CARE AND CHRONIC CARE. THE PLANNING PROCESS MUST BUILD IN INCENTIVES TO HEALTH CARE PROVIDERS TO RESPOND TO THESE NEEDS.

THE STATE HEALTH PLAN SHOULD ALSO ENCOURAGE THE DEVELOPMENT OF A MODEL OF TREATMENT THAT ENCOMPASSES A CONTINUUM OF CARE, WHICH BEGINS WITH PREVENTION AND EDUCATION AND RESPONDS TO HEALTH CARE NEEDS THROUGHOUT A PERSON'S LIFETIME. A CONTINUUM OF CARE ALSO PROVIDES CARE IN A VARIETY OF SETTINGS AND AT APPROPRIATE LEVELS.

I WOULD LIKE TO TAKE A FEW MOMENTS TO ADDRESS SOME OF THE COMMISSION'S SPECIFIC RECOMMENDATIONS REGARDING HEALTH CARE PLANNING:

• AS THE COMMISSION RECOMMENDS, THE STATE HEALTH PLAN SHOULD BE REVISED ANNUALLY AND SHOULD GIVE CAREFUL CONSIDERATION TO THE ISSUES OF CONSUMER ACCESS AND DELIVERY OF HEALTH CARE SERVICES. I AM FURTHER SUGGESTING THAT THE PLAN SHOULD NOT ONLY IDENTIFY UNMET HEALTH CARE NEEDS, BUT PRIORITIZE THESE NEEDS, AND THAT SHOULD FORM THE BASIS UPON WHICH CERTIFICATE OF NEED APPLICATIONS ARE REVIEWED.

• THE COMMISSION REPORT DELINEATES A PLANNING STRUCTURE AT THE STATE AND LOCAL LEVEL WHICH IN ESSENCE REPLICATES THE CURRENT STRUCTURE. THE LOCAL ADVISORY BOARDS, AS OUTLINED IN THE REPORT, WOULD ADD AN ADDITIONAL LAYER OF BUREAUCRACY WITHOUT ANY APPARENT SUBSTANTIVE BENEFITS TO THE PLANNING PROCESS. WE MUST ASK WHETHER OR NOT A MORE COST EFFECTIVE WAY TO OBTAIN THIS LOCAL INPUT, CAN BE ACHIEVED.

• AS THE COMMISSION REPORT STATES, CURRENTLY ONLY A LIMITED NUMBER OF HEALTH CARE PROVIDERS ARE COVERED BY STATE PLANNING REGULATIONS. TO CREATE A LEVEL PLAYING FIELD AND FURTHER ENCOURAGE COST CONTAINMENT, THE DEFINITION OF A HEALTH CARE FACILITY MUST BE BROADENED. THIS WOULD HELP TO REDUCE DUPLICATION, PROTECT QUALITY, AND CONSERVE SCARCE RESOURCES.

• THE COMMISSION'S RECOMMENDATION FOR AN ANNUAL CAP ON CAPITAL

PROJECTS IS CERTAINLY REASONABLE AND NECESSARY IN LIGHT OF SPIRALING HEALTH CARE COSTS. HOWEVER, WE WOULD URGE THE DEPARTMENT OF HEALTH IN ESTABLISHING THE CAP, TO BE SENSITIVE TO THE AGE AND CONDITION OF MANY OF THE FACILITIES IN THE STATE, AS WELL AS TO THE MISSION OF THE INSTITUTIONS. FOR EXAMPLE, TEACHING HOSPITALS HAVE A BROADER MISSION THAN COMMUNITY HOSPITALS AND THERE ARE CONCOMITANT COSTS IN PROVIDING THAT SERVICE. THE CAP SHOULD BE HIGH ENOUGH TO ACCOMMODATE THE VERY REAL NEEDS OF THE POPULATIONS SERVED.

- IN THE COMMISSION REPORT, IT IS RECOMMENDED THAT THE DEPARTMENT OF HEALTH WOULD HAVE THE AUTHORITY TO DECERTIFY PAPER BEDS BASED UPON THE UTILIZATION OF THOSE BEDS OVER TIME. I WOULD CAUTION AGAINST MOVING TOO QUICKLY IN THIS DIRECTION AND WITH THIS FOCUS: BEDS SHOULD BE DECERTIFIED BASED ON IDENTIFIED NEED WITHIN THE REGION, AND HOSPITAL CEO'S AND BOARDS SHOULD BE CHALLENGED TO A MORE CREATIVE RESPONSE TO THEIR POPULATION'S NEEDS.

AS FOR THE CERTIFICATE OF NEED PROCESS, IT MUST BE TIMELY, RESPONSIVE, RELEVANT AND CONSISTENT WITH THE OVERALL GOAL OF REORDERING PRIORITIES. THE PROCESS SHOULD ENCOURAGE AN OPEN AND CONTINUING DIALOGUE BETWEEN APPLICANTS, THE STATE HEALTH PLANNING BOARD, AND OTHER AFFECTED PARTIES TO ENSURE THAT PROJECTS ARE

CLEARLY UNDERSTOOD AND THE INTERESTS OF THE COMMUNITY ARE BEST SERVED. THE CERTIFICATE OF NEED PROCESS SHOULD ALLOW THE APPLICANT SUFFICIENT OPPORTUNITY AT ALL LEVELS TO EXPRESS ITS VIEWS AND NEEDS.

I WOULD ENCOURAGE LEGISLATORS, PROVIDERS AND OTHERS TO WORK TOGETHER TOWARD A NEW VISION OF WHAT THE NEW JERSEY HEALTH CARE SYSTEM SHOULD BECOME. WE MUST STRIVE FOR REAL REFORM RATHER THAN MERELY SUSTAINING THE SYSTEM THROUGH THE TRANSITION WITH AN "OUCHLESS BANDAID." THERE MUST BE A WILLINGNESS TO SACRIFICE BY ALL PARTIES IF WE ARE TO ACHIEVE MEANINGFUL REFORM.

IN CONCLUSION, I WOULD LIKE TO STATE MY SUPPORT FOR THE FOLLOWING INITIATIVES PROPOSED BY THE GOVERNING COUNCIL OF THE SECTION FOR HEALTH CARE SYSTEMS OF THE AMERICAN HOSPITAL ASSOCIATION:

- SHIFTING THE EMPHASIS OF THE HEALTH CARE SYSTEM TO INITIATIVES TARGETED TO PROMOTE THE HEALTH STATUS OF THE POPULATION RATHER THAN ACUTE ILLNESS AND THE ASSOCIATED TECHNOLOGY WHICH IS THE SYSTEM'S CURRENT FOCUS.

- EMPHASIZING THE ELIMINATION OF WASTE IN THE SYSTEM, NOT ONLY

WASTE BY PROVIDERS BUT BY INSURERS, BEFORE NEW FUNDING IS ADDED TO THE SYSTEM TO ENSURE ACCESS FOR THE ENTIRE POPULATION. IF WE USE OUR RESOURCES BETTER AND ELIMINATE MUCH OF THE WASTE THAT CURRENTLY EXISTS, WE WOULD HAVE THE RESOURCES TO ENABLE A FAR GREATER PERCENTAGE OF OUR CITIZENS TO HAVE ACCESS TO BASIC SERVICES THROUGH THE REALLOCATION OF DOLLARS THAT HAVE BEEN SAVED.

- CREATING TOTAL DELIVERY ORGANIZATIONS TO PLAN, TO SPREAD RISK, TO ENSURE THAT SERVICES ARE ADAPTED TO WHERE PEOPLE WORK AND LIVE, AND THAT HAVE THE SCOPE TO DEAL WITH ALL LEVELS OF CARE NEEDED BY THE COMMUNITY, THROUGH INTEGRATED PROGRAMS, FINANCING MECHANISMS, AND PUBLIC POLICY DEVELOPMENT.

THESE ORGANIZATIONS NEED TO INTEGRATE THE WORK OF HOSPITALS, PHYSICIANS AND OTHER PROVIDERS, NOT CONTINUE THE SEPARATION AND COMPETITION THAT NOW EXISTS AND THAT NO INDIVIDUAL UNIT IS ABLE TO OVERCOME.

INTEGRATION OF HOSPITALS, PHYSICIANS, AND OTHER PROVIDERS IS SO DESIRABLE AS TO CALL FOR SPECIAL PROGRAMS TO ACCOMPLISH IT.

- ORGANIZING THE FLOW OF FUNDS SO THAT THEY CAN BE ALLOCATED TO THEIR BEST USE, TOWARD THE INTEGRATION OF HOSPITAL, PHYSICIAN AND

OTHER PROVIDER SERVICES; TOWARD HIGHER QUALITY, APPROPRIATENESS, AND VALUE OF CARE; AND TOWARD THE REMOVAL OF OBSOLESCENT PORTIONS OF THE SYSTEM, TO GENERATE INNOVATION IN DELIVERY AT A LARGE SCALE IN A RELATIVELY SHORT TIME. THE OVERRIDING AND MOST FUNDAMENTAL STRUCTURAL PROBLEM OF THIS COUNTRY'S HEALTH CARE SYSTEM IS THE PERVERSE INCENTIVE ENVIRONMENT CREATED BY THE CURRENT FINANCING SYSTEM.

- REQUIRING ACCOUNTABILITY FOR COST AND QUALITY ON THE PART OF ALL STAKEHOLDERS - BUSINESS, GOVERNMENT, PAYERS, HOSPITALS, PHYSICIANS, EDUCATORS, REGULATORS, OTHER PROVIDERS, AND PEOPLE. THE INDUSTRY'S MEASURES ARE GENERALLY INAPPROPRIATE, AS THEY CENTER ON UTILIZATION OF SERVICES RATHER THAN IMPROVEMENT IN HEALTH.

A STATE HEALTH PLAN AND A CERTIFICATE OF NEED PROCESS CANNOT BE DEVELOPED IN A VACUUM OR OUTSIDE OF A CLEAR PHILOSOPHICAL BASE. IT IS IMPORTANT THAT THE DECISION-MAKERS AND THE PARTICIPANTS ALL COME TOGETHER REGARDING A VISION FOR HEALTH CARE IN NEW JERSEY AND THE REGULATORY ENVIRONMENT THAT WILL BE ESTABLISHED TO ACTUALIZE THAT VISION.

THANK YOU.

Testimony to the

Assembly Health Care Policy Commission

on

State Health Planning

Wednesday, November 28, 1990

by

Maureen E. Lopes
New Jersey Business and Industry Association

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My name is Maureen Lopes and I am here to testify on behalf of the New Jersey Business and Industry Association. Thank you for this opportunity to comment on proposed changes to the State's health planning process. My remarks will be brief because a review by NJBIA's Health Affairs Committee of the Governor's Commission report in this area raised more questions than answers. Today's hearing presents the business community and other interested parties with an excellent opportunity to better understand the issues.

Before proceeding with a major overhaul of the State health planning process, it would be wise to clearly establish the criteria for evaluating the current process and any proposed changes. Which system is more effective at controlling costs, providing access and ensuring quality? I would like to raise a number of questions and concerns which I hope you will keep in mind as you hear testimony from individuals and groups which are more knowledgeable about health planning.

1. It will not surprise you that the business leaders of NJBIA philosophically support free market solutions to public issues, wherever possible. On the other hand, we recognize that the health care system often does not respond to economic factors in a manner similar to other industries. Therefore, it is important that you question whether there is a <u>need</u> for a government-sponsored health planning process. Does a centralized, controlled planning process better address cost, access and quality concerns? Can it be expected to respond in a timely fashion to a rapidly changing environment?

2. As a related issue, we urge you to carefully consider how the health planning process interacts with the proposed changes to New Jersey's

hospital rate setting process. These processes are not well-integrated today. Over the next several years the Department of Health is proposing to increase the percentage of Statewide average costs in each hospital's DRG rates. This rate-setting process will have the effect of increasing competition among hospitals. It is crucial that a health planning system move, to some degree, in tandem with these changes.

3. The increased competition among hospitals, and between hospitals and other providers, raises a third concern--how can a state health planning process be protected from undue political influence? With hundreds of millions of dollars at stake each year, there would be a large number of parties interested in each certificate of need decision. The Commissioner of Health, under the proposal of the Governor's Commission, would have the authority to make final certificate of need decisions. This is a significant amount of power in the hands of one official. On the other hand, providing for an appeal process could severely hamper the system.

4. We also ask you to consider whether a State-controlled health planning process would assist or hamper the continuing development of managed care plans. For example, what would be the financial and political repercussions of the following scenario: The State plan awards Hospital A the right to expand a surgical service. On the other hand, a preferred provider organization, having determined that a competing facility is already a center of excellence, is directing an increasing number of its patients to this surgicenter. Which service would, or should, survive? Should the State be the only entity which measures cost, access and quality, and uses these criteria to award operating franchises?

As you proceed with your deliberations, we ask you to bear in mind these questions. Our previous testimony before this Commission supported encouraging managed care options, expanding Medicaid coverage and revising underwriting practices for small business insurance. These recommendations for reforming other areas of the health care system meet three basic goals--control costs, provide access and ensure quality. The health planning process must meet the same standards.

Southern New Jersey Health Systems Agency, Inc.

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TESTIMONIAL STATEMENT
OF THE SOUTHERN NEW JERSEY HEALTH SYSTEMS AGENCY
IN SUPPORT OF TRANSITIONAL AND PERMANENT FUNDING
OF LOCAL HEALTH PLANNING AGENCIES
BEFORE THE ASSEMBLY HEALTH CARE POLICY COMMISSION
CHAIRED BY THE HONORABLE JAMES E. MCGREEVEY
November 28, 1990

The Southern New Jersey Health Systems Agency is a private, non-profit, voluntary organization of consumers and providers of health care working together to improve the health care delivery system in southern New Jersey. Created under the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), the Agency has a mandate to study the health status and needs of the residents of southern New Jersey and to develop plans to improve the health care system and restrain rising health care costs.

On May 8, 1987, the Governor of New Jersey approved S-2372 and State Law P.L. 1987; Chapter 118 established a new statewide local health planning program. Effective July, 1987 the existing health systems agencies were designated as the local health planning agencies to carry out the purposes of P.L. 1987, Chapter 118.

The new law required funding the local health agencies at 12 cents per capita, or $920,000 for the entire statewide program. The agencies have not received these dollars and presently are funded only to December 31, 1990.

On October 1, 1990, the Governor's Commission on Health Care Costs presented specific recommendations for the future local health planning system. In short, the health systems agencies would be reorganized into local advisory boards or "Labs". These Labs would be responsible for Certificate of Need review and participate in the development and implementation of the state health plan.

There are many issues which should be addressed in the creation and development of the new state plan and process; and particularly with regard to Certificate of Need review at both the local and state levels. Issues such as sufficient capacity of services for specific service areas, underutilization of existing services, not just "paper beds" but equipment and programs such as MRIs and cardiac catheterization facilities, a "real" working definition and formula for accessibility and availability of services to our diverse communities and populations, the steady migration of New Jersey residents to Pennsylvania and Delaware facilities due to lack of services in the immediate community, demonstration projects reflective of new technology and the new delivery systems for this new technology, a revamping of the completeness process for Certificate of Need review, and the local advisory boards' right to formally present their positions regarding appealed projects before the state planning board in view of the proposal to eliminate their traditional appeal rights.

The existing health systems agencies with their historical participation and frontline experience in the health planning arena should be actively involved in the evolution of their future. The Labs will be the new vehicle for the voice of the community. Presently, the Southern New Jersey Health Systems Agency has been structured and organized through the review mechanisms of our local county council and regional review board to provide the necessary systems to address the local and regional perspectives of our health care consumers and to scrutinize, develop, establish and/or link crucial services that will meet the specific needs of the service population.

The geographical service area of the Southern New Jersey Health Systems Agency embraces the seven southern counties of the state of New Jersey, namely: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem counties. According to the State of New Jersey, Department of Labor, Population Projections for New Jersey, 1990-2020, July 1985, our regional service population will equal 1,682,680 residents in our seven counties.

The focus of health planning and the review of existing health resources for new, and expanded services becomes crucial not just for the local communities but for the entire region as a whole. Competitive plans from health care providers must be reviewed and studied to insure that the local and regional health care goals are fully served as various medical and health care institutions address their service and facility objectives.

This review process becomes essential in light of current political, economic and tax projections now being focused upon at all levels of government.

If the Labs are to replace the HSAs, then funding should be available during the transitional and development phase to ensure 1) continuity and that the utilization of existing resources, experience and knowledge are incorporated during this reorganization period and 2) that the resulting system is effective in meeting the common goals of an efficient and tax effective health planning system.

In times of budgetary constraints, the rising cost of health care insurance and the swelling of the uncompensated care population, crucial and cost effective resources should not be abandoned. Local health planning agencies since 1976 have served the taxpayers of the state of New Jersey well. The agencies have saved millions of dollars through the non endorsement of health care projects that were ill conceived, a duplication of service or did not address the issues of cost, accessibility, responsibility and efficiency.

The local health planning agencies need transitional dollars as the need for health planning continues during this period. Permanent funding of local health planning agencies as non profit entities is a must to ensure an independent, non partisan organization void of conflicts of interest. It is a must if the people of our communities, townships, cities and boroughs are to have a "free" and separate role in establishing and expanding health care services.

In closing, the Agency recently endorsed a mobile cardiac catheterization project in our service area because residents in certain parts of southern New Jersey do not have proper access to this service. It did not receive a unanimous recommendation from all the reviewing agents in the Certificate of Need process but an endorsement was necessary. The Agency supported the project, because services are desperately needed. We are the voice of our communities. We have served our communities well. Let the communities continue to be heard through the continued funding of local health planning agencies as independent voices for quality and accessible health care.

Respectfully Submitted,

MICHELLE PALMER LEE
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Southern New Jersey
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CentraState Medical Center

Jack De Cerce, F.A.C.H.E.
President

NOVEMBER 28, 1990

HEALTH CARE POLICY STUDY COMMISSION
Assemblyman Jim McGreevey, Chairman

My name is Jack De Cerce, I have been President of CentraState Medical Center since 1972 (one year after our hospital in Freehold opened). With the help of our volunteers, trustees and Medical Staff of over 300, we have continually developed strategic plans for more comprehensive services. Over the last 20 years, our hometown hospital has filed dozens of Certificate of Need applications and been in almost constant interaction with a variety of health planning officials at the local and state level.

Dr. Ira Rutkow (member of the Governor's Commission) is an attending physician on our Medical Staff so I have reviewed the proposals in the Report of the Governor's Commission on Health Care Costs. Substantial questions should be raised regarding

the State Health Plan concepts to establish capital cost objectives based on specific areas of need. All New Jersey hospitals need to continually plan renovation of old facilities to maintain excellence and addition of new technology to provide appropriate access for all residents of their community.

A major worry of the centralized control concepts under discussion is that communities and hospitals such as mine will be shunted aside. Large bureaucracies are naturally more conservative and tend to focus on political or headline issues. The basic bread and butter concerns of access, renovation and updates for new technology are in danger of being overlooked. Impacted areas affected by economic conditions, lack of medical service or significant population growth need hometown advocates. The genius of American Medicine lies in community hospitals governed by volunteer trustee fund-raisers, not central bureaucracy which tends to stifle innovation.

Based on my experience with the growing New Jersey bureaucracy, I would caution that a solution does not lie in more extensive regulation. The backlog in appeals faced by the Hospital Rate Setting Commission typifies the dilemma faced in using state wide policy objectives to govern all elements of hospital operation. Even the well armed European Socialists are abandoning central planning which could not provide even basic food and housing for their people.

I would like to plead for local initiative in providing hometown health care. Our Medical Center has a long record of innovation, for example:

.Short Stay Unit (Hospital's article 9/16/81)

Our pioneering ambulatory care service for outpatient medical and surgical care had to overcome major regulatory obstacles. New Jersey Department of Health codes required a bath and window for each two beds and reimbursement would not approve any patient not listed on the midnight census.

.Applewood Estates (see brochure)

Our Life Care facility (240 apartments & 90 nursing beds) is the first hospital affiliated Continuing Care Retirement Center in New Jersey. We were scheduled for financing with N.J.H.C.F.F.A. until an Assistant Attorney General ruled us ineligible.

.Health Awareness Center (see brochure)

We are working with school districts in surrounding counties to create a unique "hi-tech" health education program. Our nationally recognized Wellness Center provides support for thousands of local residents. Volunteer fund-raisers are working to raise nearly a half million dollars to equip this new center.

These innovations would not have been listed in a State Health Plan. How can you encourage creative approaches while working to control health care costs? One obvious solution is to liberalize existing statutes and eliminate CON regulation for all but the largest projects. Our stringent Hospital Rate Setting System inhibits all but the most feasible projects. Unless adequate patient volume exists, no new service can pay for itself. Based on the enclosed American Hospital Association panel survey, our hospital receives $1,000 less per admission than other hospitals our size in the regional and national comparisons. Chapter 83 has forced New Jersey health care reimbursement down to a point where proposed programs are cut by hospitals unless a very strong economic feasibility can be demonstrated. CON requirements for new, less costly services only add expense to hospitals and government alike.

A good place for oversight to begin would be a review of the heavy regulatory load imposed on New Jersey hospitals. Despite best intentions, the regulatory mandate seems to expand each year. The cost to hospital patients and taxpayers must be examined versus the benefit. We have experimented with nationally unique health care regulations for several decades. It is time for legislative oversight to critically examine the definition and structure of our statutory intent and determine which regulation best serves the public interest.

In summary, local initiative in health planning should not be eliminated. History and logic would indicate that even the broad public interest would not be served best by centralizing all health care decisions in cumbersome bureaucracy. Like most other states, we should eliminate Certificate of Need for all but the largest projects. The severe cost controls under Chapter 83 will continue to inhibit all but the most needed service. Please let hospitals and their volunteer boards control community health care. New Jersey is a prosperous state with the ability to create excellence in health care on a community by community basis.

Short-stay unit serves overnight medical and surgical patients

BY JACK DE CERCE AND JOHN B. REISS, J.D., Ph.D.

In a funded and state-authorized alternative care experiment, a hospital expanded its same-day surgery unit to also serve overnight medical and surgical patients with various diagnoses that are noninfectious and not life threatening

Hospitals throughout the nation have demonstrated the utility and the convenience of "short-stay" elective surgery, in which patients undergo surgery under anesthesia and then are discharged the same day, following a recovery period. A community hospital in central New Jersey has expanded the "short stay" concept to include overnight admission of medical as well as surgical patients. During 1979, in an experiment that was authorized by the New Jersey Department of Health, the hospital treated and discharged more than 2,600 patients within 24 hours of their admissions.

Freehold (NJ) Area Hospital first admitted short-stay surgical patients in 1973. As physicians' and patients' acceptance of the 12-stretcher unit grew, crowding developed, with the unit handling more than 1,500 same-day admissions by 1977. Discussions between the hospital staff and John Reiss, J.D., Ph.D., who at that time was assistant commissioner of the New Jersey Department of Health, led to plans for an expanded medical/surgical unit with space and overnight facilities for 18 patients. The new short-stay unit was built with the assistance of a $100,000 grant from the Kresge Foundation, Troy, MI, and it was opened in December 1978.

Featuring an open space design (see figure on page 142), the unit has standard inpatient facilities and two nurses' stations. One section, which is staffed 12 hours per day, manages a schedule for as many as nine elective surgery patients. The other section, which has 24-hour staffing, provides care for a wide variety of medical and surgical patients who must be held overnight. The unit's

The 18-bed short-stay medical/surgical unit has an open-plan design and two nurses' stations—one for monitoring same-day surgery patients and the other for providing care for medical and surgical patients who stay overnight.

—Photo by Jeffrey Hirsch, Freehold, NJ

Jack De Cerce *is administrator of Freehold (NJ) Area Hospital, and* **John B. Reiss, J.D., Ph.D.**, *is associated with the law firm of Baker & Hostetler, Washington, DC.*

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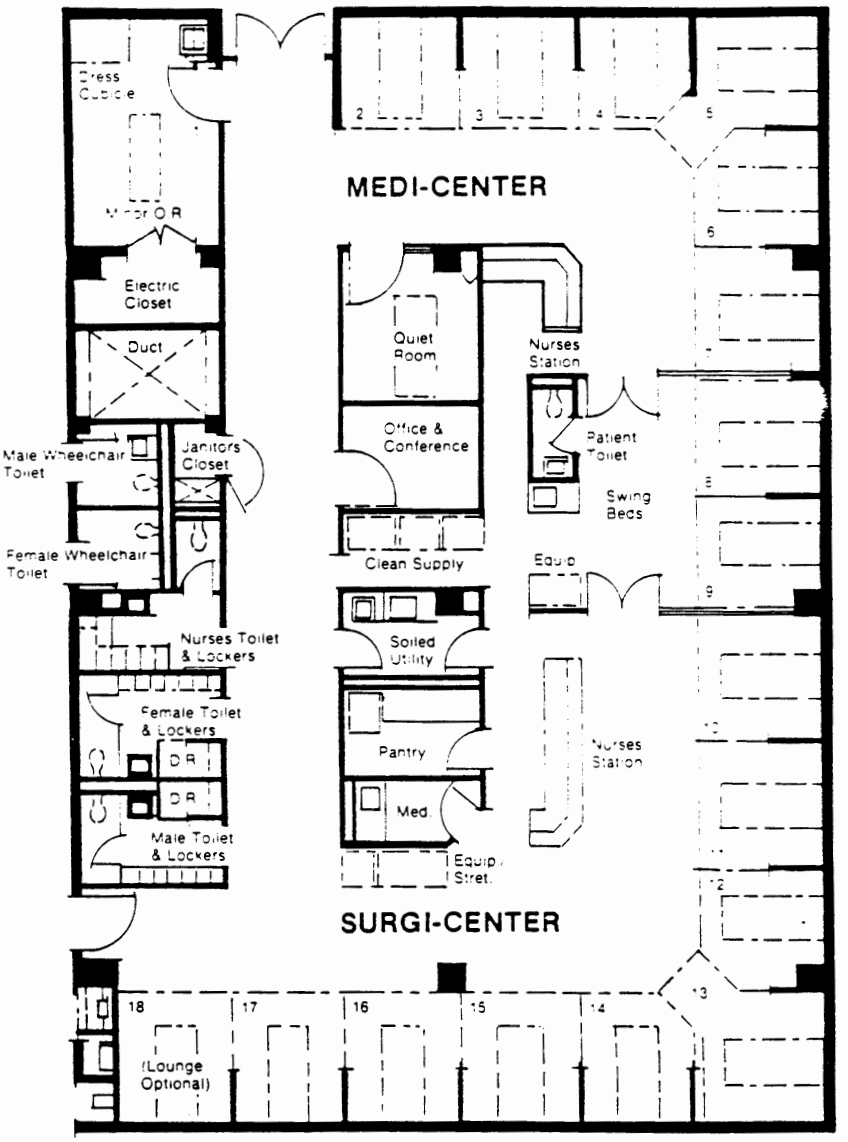
operations are governed by a strict protocol, under agreement with the New Jersey Department of Health, that limits admissions to specific diagnoses that are noninfectious and not life threatening. The listing of typical diagnoses in table 1, page 143, illustrates the range of the types of patients who meet the criteria for admission to the short-stay unit.

In all hospitals, newly admitted patients, including those with less serious ailments, generally receive standardized care that requires several days to accomplish. For example, physicians write orders for diagnostic tests, consultations, and treatment procedures that must be completed prior to discharge. In contrast, the new unit attempts to provide essential care on the first day: to discharge the patient within 24 hours, when possible; and to allow further testing and follow-up to be accomplished on an outpatient basis.

For this funded experiment, the hospital has studied the admissions and the financial impact of the new unit. Table 2, page 143, summarizes 1979 admissions by medical specialty and distinguishes routine same-day surgery patients from patients who were held overnight for surgery or medical treatment. As shown, 1,471 patients were discharged the same day, and 1,190 were held overnight. Of the latter group, 768 patients were discharged within 24 hours, and 422 patients required transfer to regular inpatient facilities because further treatment was necessary, their conditions changed, or complications arose.

Proper utilization of services also was reviewed. An obvious concern was to ensure that these 24-hour admissions were necessary and that hospitalization was justified. A sample of 197 patients' charts were reviewed using standard criteria for appropriate utilization.* The review showed that all but one of these patients received treatment that was available only in a hospital setting. Of the 197 cases reviewed, 103 patients were discharged within 24 hours, and 94 patients were transferred to regular inpatient facilities for further treatment.



Short-stay medical/surgical unit, Freehold (NJ) Area Hospital

The economic advantages of this medical/surgical short-stay concept have been highlighted by the DRG (diagnosis-related group) reimbursement experiment that is under way in New Jersey. This rate-setting system is attempting to pay hospitals on the basis of the resources needed to treat individual diagnoses rather than on the basis of how many days patients are hospitalized. Thus, any reduction in patient stay, such as that in the short-stay program, provides economic incentive to the individual hospital under the DRG system.

Patients respond positively, as do all informed consumers, to logical cost containment, and families appreciate the convenience and the reduced costs of shortened hospital stays. In 1979, patients who were admitted to the short-stay unit mostly were middle-aged (80 percent under age 60) and were distributed equally according to sex (53 percent, male; 47 percent, female). Patients even accept the relative lack of privacy in the unit's open space design as soon as they understand

*Commission on Professional and Hospital Activities. *Concurrent Review Screening-Criteria for Hospital Admission and Assignment of Length of Stay.* Ann Arbor, MI: CPHA, 1978, p. v-vii.

Table 1—Examples of typical diagnoses for patients admitted to short-stay medical/surgical unit, Freehold (NJ) Area Hospital

Diagnoses	*ICD number*
Epistaxis	784.7
Detached retina	361.9
Foreign body, eye	930.9
Endometriosis	617.9
Threatened abortion	640.03
Incomplete abortion	634.91
Cerebral concussion	850.9
Drug overdose, conscious	977.9
Vertigo	780.4
Suspected seizure disorder	780.3
Urinary retention	788.2
Fractured ankle	824.8
Fractured elbow	812.40
Renal colic	788.0
Bladder calculi	594.1

Table 2—1979 admissions to short-stay medical/surgical unit, Freehold (NJ) Area Hospital

Medical specialty	*Number of same-day surgery patients*	*Number of overnight surgical patients*	*Number of overnight medical patients*
Ear, nose, and throat	526	335	39
Eye	66	5	33
Gynecology	402	56	66
Medicine	28	0	175
Oral surgery	160	19	3
Orthopedics	80	11	108
Plastic surgery	15	3	5
Podiatry	15	3	4
General surgery	116	18	83
Urology	63	14	37
Gastroenterology	0	0	163
Respiratory	0	0	9
Neurology	0	0	1
Totals	1,471	464	726

that patients with infectious or life-threatening conditions do not meet the criteria for admission.

Partly because of the hospital's shortage of inpatient beds, physicians have accepted the short-stay unit very positively and are willing to admit less serious cases to this unit. The range of medical specialties listed in table 2 is evidence of this acceptance by physicians. Even though all hospital services are available to the unit, the physicians write "stat" orders that can be accomplished within 24 hours. After a patient stays overnight, physicians evaluate him to determine if discharge is possible.

Public policy aimed at limiting hospitals' growth and containing health care costs is currently in vogue. Nonetheless, patient demand for health services inevitably will grow. Creative alternatives must be found to help institutions relieve overcrowding, and short-stay medical/surgical units may become increasingly important as such an alternative. ■

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Applewood

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Because Maturity Has Its Rewards

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It began with a genuine concern for people-- people who have worked hard all their lives and deserve the best for those special years of retirement. Out of this concern grew The Center for Aging, a non-profit affiliated organization of ***Centra****State Medical Center*, and the idea of building a Life Care community in Freehold was born.

Applewood Estates is that community. Located on a beautiful 45-acre site in Freehold Township, the community serves people age 62 and over. Its concept is based on the Life Care program, a new and unique approach to retirement that is increasingly becoming the choice of many people across the country.

Applewood Estates represents a promising future built on a solid past.

What is Life Care? Put very simply, Life Care is a special program that provides care for life. It is unique because it considers the needs of senior adults--not only for today but also for tomorrow.

Applewood Estates features attractive, private apartment units plus many convenient facilities and activity areas. In addition, a nursing care center is part of the complex.

Freehold Township was chosen as the setting forApplewood Estates primarily because of its central location. It is in Western Monmouth County and is near many areas of interest. The excitement of New York City is only an hour away to the north, and world famous Atlantic City is an hour to the south. The beautiful New Jersey shore is 30 minutes to the east, while the allure of historic Philadelphia is a little more than an hour and 15 minutes to the west.

In addition to the many appealing areas surrounding Freehold, the town itself offers several historical and cultural attractions.

The Life Care program and the prime location of Freehold combine to make Applewood Estates the most desirable retirement residence in Central New Jersey. Read further and discover all that the Life Care program offers.

You will see that it truly provides care for life.

A special place because you deserve it.

Each of the 240 apartments at Applewood Estates features wall-to-wall carpeting, individually controlled heating and air conditioning, your own balcony or patio to enjoy the outdoors, plus an all-electric kitchen with convenient appliances. All utilities are paid except telephone and cable television. Special features have been included so that you may feel safe and secure. Safety bars have been installed in each bath; an Emergency Call System is located in the bedrooms and baths. It is comforting to know that the Emergency Call System summons assistance within minutes at any time, day or night. Also for your safety, smoke detectors and alarms are located in each unit.

Regular housekeeping and flat laundry services are graciously provided for you because we know you have better things to do with your time. Washers and dryers are located in each wing for your convenience. And there's no need to worry about mowing the lawn or painting your residence because all building and grounds maintenance are provided.

At Applewood Estates you'll even have regularly scheduled transportation to take you on errands and other trips. Of course, you may drive yourself if you prefer.

Your friends and family members are always welcome at Applewood Estates. There is even a guest apartment available for such visits.

A special service provided at Applewood Estates is 24-hour security. This is comforting not only while you sleep, but also when you vacation.

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Mealtime is a great opportunity to visit with your new neighbors. And you'll enjoy your meals in the beautifully decorated Dining Room. For your special parties, you may choose to use the Private Dining Room to entertain with a touch of elegance.

The Crafts Room is the place where you can put your talents to work and create beautiful and unique items for gifts or even for your own apartment. The Game Room is quite busy with bridge games, billiards tournaments and other favorites. And if you have a sweet tooth, you can treat yourself to your favorite ice cream in the ice cream shop.

At Applewood Estates, you can take in a special presentation or lecture in the Meeting Room, work on your grandchild's Christmas gift in the Woodworking Shop or relax with a good book in the Library. To get some good hearty exercise, swim a couple of laps in the enclosed swimming pool or work out in the Fitness Center. And if you have a green thumb, grow your favorite vegetables and flowers at the gardening sites.

In addition to having plenty of activity at Applewood Estates, you also have convenience. A country store and beauty parlor/barber shop are on the premises.

The goal of those who have planned Applewood Estates is to provide many conveniences and exciting things to do at your new home. You'll have almost everything you need within walking distance.

Your retirement years.
A time to let others serve you with the utmost respect and grace.

Healthful living has been important throughout your life--but perhaps now more than ever it becomes a primary consideration. The Life Care program at Applewood Estates features special provisions to care for your health like no other retirement program can.

A nursing staff is on duty and a physician is on call 24 hours a day. If you need assistance at any time, all you have to do is activate the Emergency Call System in your apartment. Helpful personnel will be there within minutes.

Applewood Estates is special because it offers two levels of care. A 30-bed assisted living center is located on the site. Assistance in daily living is provided in this center.

In addition, a 60-bed nursing care center is part of the Applewood Estates complex.This center is available should you ever need skilled nursing center care for any period of time. If needed, you will receive unlimited nursing care at no increase to your monthly service fee. And you'll be close to your own apartment so it will be convenient for your spouse and friends to visit you often.

Our staff consists of healthcare professionals who have the skills to provide quality care with respect, dignity and compassion. Their ultimate goal is to return you to your private residence and your active lifestyle.

These provisions for healthful living are special ways Applewood Estates gives you the peace of mind that will let you truly enjoy your retirement years.

Your new American lifestyle.

Applewood
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CentraState, the caring people

140X

Applewood Estates
Applewood Drive
Freehold, NJ 07728

(201) 780-7370

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CentraState
Medical Center

Building on a Tradition of Excellence

142X

HEALTH AWARENESS CENTER

Where Learning is an Adventure

The promotion of positive lifestyles is the mission of the ***Centra****State Medical Center* Wellness Center. Since 1979, this nationally acclaimed health education center has encouraged thousands of people to adopt healthy lifestyles through active participation in education/screening programs.

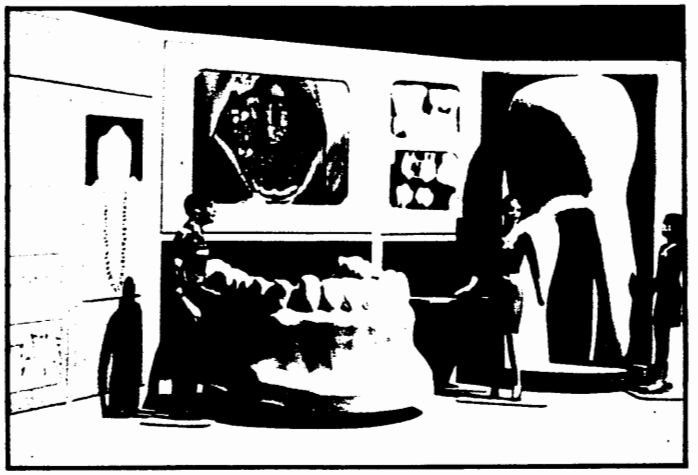
The *Health Awareness Center* is being developed as an integral part of the Wellness Center. This new program focuses on school children, grades K-12, who can best benefit from lifestyle decisions. By helping young children realize that today's health decisions will have a lasting impact on their future physical and emotional well-being, the Health Awareness Center offers a dynamic learning experience. The Center surrounds children with contemporary tools for decision-making, and most importantly it makes learning enjoyable.

The existing Wellness Center has outgrown its present location due to an increase in programs, participants and staff. Over 100 programs are currently offered and they involve more than 27,000 participants annually. There are presently developmental plans underway to construct a new Wellness Center. Part of this new building will house the Health Awareness Center - the only one in the State.

Goals of the Health Awareness Center

The overall goal of the Center is to help children make the most informed decisions about their own lifestyles. Specific objectives of the Center provide for:

- ☐ a stimulating, thought-provoking environment for preschool through high school students.
- ☐ a positive learning experience which is unique to any school or learning facility in the State.
- ☐ educational programs directed at issues concerning today's youth and society. These programs include such topics as Substance Abuse, Family Life Education, Nutrition, and General Health.
- ☐ specially designed, state-of-the-art educational technology and highly trained instructors.
- ☐ decision-making that results in a lifetime of healthy lifestyle choices.



What is a Health Awareness Center?

It is a facility that houses high-tech classrooms, specially-trained staff; and state-of-the art educational exhibits and audio-visual programs to teach children and adults about their bodies and how to keep them healthy. "Performances" are staged in mini-amphitheaters specifically designed for comfort and function. Students are seated on carpeted, tiered risers where the colorful, animated exhibits come to life through the teaching skills of the instructor.

"TAM," short for Transparent Anatomical Mannequin, is just one of the many exciting exhibits that will be featured in the new Health Awareness Center. "TAM" is a lifesize mannequin who "teaches" the "Incredible Machine" programs which vary in complexity with the age of the child. Instructional emphasis is placed on the different organ systems which illuminate as *TAM* "speaks" to the children.

This Center will serve as a regional facility for children K-12 from Monmouth and adjoining counties. Programs can also be easily adapted for adult audiences. Although there are presently twelve other similar centers throughout the United States, this will be the first center in New Jersey. Existing health education centers are visited by more than 100,000 children during the school year. Freehold's central location will attract children from around the State.

Exciting Programs Specifically Designed for Student and Community Needs

With the assistance of the exhibit-oriented teaching aids, specially trained educators bring the varied programs to life. Each curriculum is carefully prepared to meet the needs of both the children and the community. For example, programs at other health education centers include such topics as "Drug — Choice or Chance;" "Life Begins;" "The Eating Machine;" and "I'm Some Body." All the programs feature high-tech, computerized models which heighten the student's interest and excitement in the learning experience.

CentraState
Medical Center

West Main Street
Freehold, N.J. 07728

CentraState, the caring people

145X

Facility and Equipment Needs

The Health Awareness Center will include three large classrooms that could each accommodate 50-60 children. A multi-use auditorium, office space and large lobby to promote the easy flow of traffic, would be part of the basic architectural plans.

Each classroom would be equipped with three dimensional computerized models and exhibits which illuminate and animate various organs and systems of the body. The auditorium would provide exhibit space for "TAM," a lifesize transparent anatomical mannequin. Ideally, classrooms are designed in amphitheater fashion with tiered seating to accommodate large groups of children with minimal maintenance.

The "Exhibit Oriented Teaching Aids" would be designed and developed by Richard Rush Studios, Inc. of Chicago, Illinois, which has developed exhibits for health education centers and museums throughout the world. Each exhibit would have a theme consisting of equipment specific to the program being presented. For example, a large illuminated 3D brain and human model demonstrate the effects of drugs or alcohol on the brain and body systems.

The Health Awareness Center is a "high tech" approach to education utilizing the latest in computerized equipment. Learning becomes an adventure and traditional health education courses take on an excitement and interest that can be seen in the child's active involvement in the learning process.

Making the Center a Reality

The Health Awareness Center has already caught the imagination of many individuals. An ad hoc committee consisting of Hospital trustees, educators, politicians and community representatives has been meeting to discuss preliminary plans, curricula and funding sources. A bill has been introduced into the Senate and General Assembly of New Jersey to partially fund the project as a demonstration site for this innovative approach to health education. The Freehold Optimists have "adopted" the program and have pledged substantial support toward this end.

We need your help to make the Health Awareness Center a reality. Our goal is to raise $500,000, so that the Center can be ready to open for the Fall 1991 school year. ***Centra****State Medical Center* has always been a forerunner in providing innovative ideas and progressive attitudes regarding wellness and prevention. What began with the Wellness Center in 1979 will be brought into the 1990's with all the technological advances that this new decade represents. This Center provides a marvelous educational opportunity for all the children of New Jersey.

For more information about how you can become involved in making the Center a reality, call the Wellness Center at ***Centra****State Medical Center* (908) 780-6050.

CENTRASTATE MEDICAL CENTER
ATTN JACK DECERLE, PRES
WEST MAIN STREET
FREEHOLD NJ 07728
201-4312000

COMPARATIVE STATISTICS FOR HOSPITAL EXECUTIVES

220322

NATIONAL HOSPITAL PANEL SURVEY

JUNE 1990

VARIABLES	DATA REPORTED BY YOUR HOSPITAL	SIMILAR REGIONAL MEAN DATA (1)	SIMILAR NATIONAL MEAN DATA (1)
BED	240	287 (38)	289 (277)
ADMISSIONS	1,313	919 (38)	915 (277)
INPATIENT DAYS	6,150	6,524 (38)	5,798 (277)
OUTPATIENT VISITS	9,142	8,363 (34)	8,741 (233)
NET PATIENT REVENUE	4,287,727	3,780,030 (36)	4,490,735 (262)
NET OUTPATIENT REVENUE	590,234	1,151,154 (36)	1,443,525 (262)
TOTAL NET REVENUE (2)	4,932,822	5,119,749 (36)	6,249,117 (261)
PAYROLL EXPENSES	2,258,075	2,501,560 (36)	2,661,467 (260)
EMPLOYEE BENEFITS	533,706	483,551 (36)	537,236 (258)
OTHER EXPENSE	1,709,607	1,666,459 (36)	2,227,544 (263)
TOTAL EXPENSES (3)	4,803,153	5,058,536 (36)	5,883,805 (252)
65+ ADMISSIONS	466	339 (32)	305 (235)
65+ INPATIENT DAYS	3,263	3,439 (32)	2,684 (235)
ADJUSTED EXPENSES PER INPATIENT DAY (4)	$686.50	$594.37	$767.95
ADJUSTED EXPENSES PER ADMISSION (4)	$3,215.51	$4,219.43	$4,866.18

(1) YOUR HOSPITAL'S DATA, WHEN REPORTED, ARE INCLUDED IN THESE MEANS FOR:

METRO 200 - 399 BEDS MIDDLE ATLANTIC (COLUMN 2)
NATIONAL (COLUMN 3)

THE NUMBER OF RESPONDENTS IS GIVEN, IN PARENTHESES, WITH EACH MEAN ITEM.

(2) NOTE THAT "OTHER REVENUE" IS NOT INCLUDED AS A SEPARATE ITEM.

(3) NOTE THAT "DEPRECIATION EXPENSE" AND "INTEREST EXPENSE" ARE NOT INCLUDED AS SEPARATE ITEMS.

(4) ADJUSTED-EXPENSES PER INPATIENT DAY AND ADJUSTED-EXPENSES PER ADMISSION ARE CALCULATED USING THE MEAN VALUES FROM THE ABOVE TABLE.

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Testimony Of The
New Jersey Association of
Health Care Facilities
before the
Assembly Health Care Policy
Study Commission

November 28, 1990

Chairman McGreevey and members of the Committee:

My name is Rick Abrams and I am the Vice-President of the New Jersey Association of Health Care Facilities (Association). The Association appreciates the opportunity to comment on the areas of Health Planning and the Certificate of Need (CON) process in New Jersey.

I would first like to discuss the health planning and CON recommendations set forth in the Report of the Governor's Commission on Health Care Costs. The Association supports the health planning and CON recommendations in the Commission's report. We support a health care planning system that is driven by the health planning process; not the CON process. We support the retention of local health planning bodies that will <u>finally</u> have a stable, adequate funding source. We support the placement of discreet periods of time on CON's, that will reflect the actual time that it takes to implement a particular CON. However, care must be given to ensure that these periods of time reflect the realities of a changing economy and governmental and legal interventions.

We have, however, several suggestions that we believe will improve the Health Planning and CON processes in New Jersey:

1. We recommend that in developing the State Health Plan, additional long term care CON's should not be available in any region having a bed vacancy rate in excess of 10% and/or that utilizes temporary nursing agency labor in excess of 10%. If one or both of these components is present in a region, this signals that there is no need for additional long term care beds in that region or that there is insufficient staff to man additional facilities which would cause a deterioration in the quality of care;

2. If the State Health Plan is to be a multi-year plan, the number of beds projected to be needed over the life of the plan should be spread out over the life of the plan. Total projected bed need should not be awarded during the first year of a multi-year plan;

3. In determining bed need, adjustments that reflect an assumption that a certain number of approved beds will never be built should not be used. If an adjustment for a region underestimates the number of beds that are actually built, the result will be severe overbedding for that region. I note that the Department of Health's health planning methodology currently does <u>not</u> contain these adjustment factors. The Association hopes that it remains this way;

4. In determining long term care bed need for a region, the State Health Plan should take into consideration approved and funded slots in the Community Care Program for the Elderly and Disabled (CCPED). By including CCPED slots, the State Health Plan will more accurately reflect long term care services that are available in a particular region; and

5. We see no need to disband the current Health Systems Agency (HSA) and State Health Coordinating Council (SHCC) health care planning infrastructure. However, refinements are necessary and should be made. One refinement that we recommend would be to include at least one member with long term health care expertise on the SHCC or its successor. However, we see no need to totally disband a health planning structure that already exists.

6. Finally, to assist in streamlining the system and to save State government valuable revenue, we recommend that CON transfer of ownership applications be transferred from the CON program within the Department of Health to the licensure division within the Department. In such trans-

fers, bed need is not the issue; the reliability of the new ownership is the issue. This inquiry is routinely performed by the licensure function. Inordinate delays have been experienced in the past with this function residing in the CON process. The current State policies of streamlining government and reducing the cost of government would be greatly enhanced by the implementation of this recommendation.

The Association believes that the implementation of these recommendations will foster efficiency and cost containment in the health care delivery system in New Jersey and will ensure that the quality of care and quality of life will continue to be the best that it can be for persons residing in long term care facilities in our State.

Once again, the New Jersey Association of Health Care Facilities appreciates the opportunity to comment on the areas of Health Planning and Certificate of Need.

I would be happy to answer any questions that you may have.

NEW JERSEY hhsa

Home Health Services and Staffing Association of New Jersey

Reid W. Stroud
Executive Director
(609) 291-1144

TESTIMONY BEFORE THE

ASSEMBLY HEALTH CARE POLICY STUDY COMMISSION

"The Certificate of Need Process"

November 28, 1990

REID W. STROUD, M.A., M.Div.
Executive Director

HOME HEALTH SERVICES & STAFFING ASSOCIATION
of NEW JERSEY

P.O. Box 8736 • Trenton, New Jersey 08650-0736

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Good morning, Chairman McGreevey, and members of the Study Commission. I am Reid W. Stroud, Executive Director of HOME HEALTH SERVICES & STAFFING ASSOCIATION of NEW JERSEY. This state-wide ASSOCIATION represents more than 300 Home Health Care Services, all of them registered by the Division of Consumer Affairs, providing home care services to over a quarter million tax-payers/clients in every town of the state.

Today I come before you to recommend that the Certificate of Need process be repealed in New Jersey in order for professional, quality home health care services to re-enter the free enterprise marketplace. Doing so would be ***an advantage*** to the potential clients of the system since more sources of service would be available to them; ***an advantage*** to state government in being able to eliminate job titles devoted to administration of the Certificate of Need Program; and ***an additional advantage*** to both the state and potential clients in reduced costs for the services provided.

If the Committee desires, at a later date to be scheduled at mutual convenience, we would be pleased to bring before you a national expert in the field who would come from out-of-state.

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Unfortunately, arrangements could not be made for that special testimony to be presented at this time. In the meantime, we direct your attention to a report prepared by the Bureau of Economics of the Federal Trade Commission: **"CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE -- An Economic Policy Analysis."** This document was published in January 1986, and the results are valid today, as they were when they were written.

In releasing the document, the Acting Director of the FTC's Bureau of Economics said: "Certificate of Need regulations impose barriers to entry into the home health care field, resulting in reduced competition and increased costs and prices. In addition, there is no evidence that the regulations provide any benefits." The report continues: "Regulations requiring that new home health care firms justify the need for their services before receiving state approval result in higher home health costs with no apparent benefits." The authors found that "the regulations do not improve home health care firms' economic efficiency and that they may decrease competition and increase costs".

The report states that "the Certificate of Need regulations, by retarding or stopping entry of new firms, may deny consumers the benefits of innovative or cheaper services that could lower the cost or improve the quality of home health care."

Proponents of CON regulations argue that competition in this industry would result in too many firms, each providing too few units of each service at a cost higher than necessary. However, the authors of this report point out that "small firms in this industry can operate efficiently because the capital costs necessary to establish a home health care firm "... are not prohibitive (as for instance the construction costs of a hospital, or its equipment). The study also concluded that home health care firms subject to Certificate of Need regulations do not achieve greater economies when the firm is larger than do firms in unregulated markets.

"On the average, the study found, home health care firms' costs are two percent higher in markets with Certificate of Need regulations than in unregulated markets. The additional costs are not accounted for by any other factors examined, such as difference in wage rates."

The final paragraph of the 107 page report speaks for itself, speaks for our Association, and speaks for the citizens of New Jersey: "In conclusion, we found no evidence that Certificate of Need regulation contributes to lower costs for the provision of home health care services. If anything, CON regulation appears to be associated with higher costs. Further, a Certificate of Need program for home health firms involves

administrative costs. Perhaps more importantly, by retarding or stopping entry of new firms, CON regulation of home health markets may be denying consumers the benefits of innovative or low cost services that could lower the cost or improve the quality of health care. There is no reason for not allowing the market to function unencumbered by these regulations."

TESTIMONY

Mr. Chairman, Members of the Committee:

My name is Edwina Cuddihy, and I would like to share with you our experiences over the past 8 years.

Until 1982, my husband and I obtained health insurance through Employer Group Plans. In 1982, my husband's job was eliminated due to a takeover of his company, and we could not afford the conversion rate available from Prudential at that time.

In 1984, while I was employed at a small firm that did not offer health insurance to its employees, I suffered a heart attack and was hospitalized for about two weeks. At that time, we could not afford individual health insurance premiums, and consequently had to obtain a home equity loan to pay hospital and doctors' costs.

By early 1988, my husband's income as a self-employed consultant had improved. We called brokers and every insurance company in the Yellow Pages, but no one would insure us because of my heart attack.

In March, 1988, Blue Cross/Blue Shield, the only insurer available to us, sold us the only policy for which they said we were eligible: Co-op Coverage with Major Medical. This policy required us to pay $500 as a deductible per family member, has a $100,000 lifetime cap, and pays only 80 percent of doctors' fees, etc.

Our annual premium in 1988 was $2815. In January, 1989, the premium was increased to $4415.88 a year. In the same year, our son John, who was born on September 27, 1970, was no longer eligible for coverage under our policy, although he is a full-time student and dependent on us for support. (In most Group plans, full-time students are covered until graduation.) We now buy his health insurance from his college at a cost of $565 per year.

In June, 1990, Blue Cross/Blue Shield received another increase, for a new total of $6000 per year for two people, my husband and myself. We have received no increased coverage despite the huge premium increases. In fact, we have paid almost $11000 in premiums in two and a half years.

We are now faced with another premium increase, of possibly $4000 or $5000 per year on top of the $6000 we are currently paying.

We have reached a point where we simply can not afford to pay these premiums. Over and over again, individuals in this state have borne the brunt of exhorbitant health premiums, and more and more of us are now uninsured because we can't obtain health insurance, or if it is available, can't afford to pay the premiums.

We are middle income people, used to working hard to pay for what we get. We do not want charity. We do want to pay a reasonable amount for insurance--but $11000 or even $6000 is not reasonable. In fact, my current health premiums--without any increases--already cost more than our taxes. It is more than all my utility bills combined. It is enough to cover tuition for 2 students at Rutgers for a year.

It is meaningless for Blue Cross/BLue Shield to be "insurer of last resort" if the cost to individuals is beyond their pocket book. In August, 1990 Consumer Reports dealt with the "Crisis on Health Insurance." In one of their stories, David Curnow, who at 47 has a health problem, asks, "How many sick and disabled people do you know who can afford to pay $6000 a year for health insurance? How many middle class people, without health problems, can pay that amount?

I do have health problems. Since 1984, I have developed a heart condition, asthma, and a severe hearing loss. The very idea of not having insurance terrifies me.

A relatively short hospital stay--two weeks--could run into thousands of dollars, and without insurance we could lose our home.

There is very little I can do to redress or change the situation. But the legislatures in the Assembly and the Senate can help me and the other middle class people in this state. We do want to pay for our health insurance, but we need a health policy that is affordable, that meets our health care needs. We need your help.

Thank you for your consideration.

I have attached the transcript of a MacNeil/Lehrer Newshour report on "Insurance Policy in New Jersey," which aired on Wednesday, July 4, 1990.

MAC NEIL/LEHRER NEWSHOUR

Wednesday, July 4, 1990

WNET, New York, New York

SHOW #3758

ANCHOR:	JAMES LEHRER
CORRESPONDENT:	TOM BEARDEN, FOCUS - BABY ON BOARD (Report on Controversy over Infant Seats on Airliners)
FOCUS - BABY ON BOARD: (Debate over Infant Seats on Airliners)	SAM KAZMAN, Competitive Enterprise Institute
	CHRISTOPHER WITKOWSKI, Aviation Consumer Advocate
CORRESPONDENTS:	ELIZABETH BRACKETT, FOCUS - INSURANCE POLICY - POOR HEALTH (Health Insurance Problems and Spiral Costs)
	JUDY WOODRUFF, FOCUS - SERVING THE PUBLIC (Interview of Ms. Newman Covering Public Officials, Low Wage Problems in Government, etc.)
CONVERSATION - SERVING THE PUBLIC:	CONSTANCE BERRY NEWMAN, Director, Office of Personnel Management
CORRESPONDENT:	JOANNA SIMON, FINALLY - COLLABORATING COMRADES (Report on and Interview of Two Soviet Emigre Artists, ALEXANDER MELAMID & VITALY KOMAR, who Paint on the Same Canvas)

TRANSCRIPT BY:

"STRICTLY BUSINESS"
P.O. BOX 12361
OVERLAND PARK, KANSAS 66212
913-649-6281

Funding for this program has been provided by this and by grants from American Telephone & Telegraph Company and the Corporation for Public Broadcasting.

A co-production of MacNeil-Lehrer Productions, WNET and WETA.

TRANSCRIPT CHARGES: $4.00 each copy ordered by mail (ADDITIONAL CHARGE FOR RUSH ORDERS). Be sure to indicate air date and subject or participants. All orders must be prepaid.

MR. MUDD: So you wouldn't have to walk on with this cumbersome seat?

MR. WITKOWSKI: Well we are going to in our comments suggest that the FAa require the airlines to provide it or allow the parent to bring on their own seat if they desire to.

MR. MUDD: Would the child have to be strapped into the seat at all times?

MR. WITKOWSKI: Absolutely not. The film that used to describe the issue the parents thought they would have to be strapped in the whole flight. It is only on takeoff. landing or if their is turbulence encountered in the flight.

MR. MUDD: Mr. Kazman?

MR. KAZMAN: That is right the fact that these children will not have to be in their seats all the time under this rule only undercuts the very limited effectiveness of child seats in airlines.

MR. MUDD: We are out of time. Thank you both very much. Buckie up.

MR. LEHRER: Still to come on the Newshour tonight problems getting health insurance, Constance Newman and two Soviet artists.

FOCUS - INSURANCE POLICY - POOR HEALTH

MR. LEHRER: Now the spiraling cost of health insurance. Elizabeth Brackett reports on two groups having trouble getting and keeping medical insurance, individuals and small businesses.

MS. BRACKETT: John Schmilepfenig and his father, Jack, run their own coffee trading company. It's a small, but profitable business with five employees. When Mutual Benefit, their major medical insurance company, increased their rates by 50 percent in one year, John Schmilepfenig decided to do what any entrepreneur would do, he shopped around.

JOHN SCHIMELPFENIG, Small Business Owner: We looked at another program which was with the Chubb Group, and it was the first choice, their rates seemed good, coverage seemed to be adequate, covered, in fact, was even a slightly better program than what Mutual Benefit offered in terms of the deductibles and the overall coverage, but we were turned down and we were turned down for the reason that one of the dependents here had had an operation three years ago. She had a kidney removed.

MS. BRACKETT: Molly Ward works for the New Jersey insurance agency which handles the Schimelpfenigs' business.

MOLLY WARD, Insurance Broker: If I have a group that does have health problems, then it's certainly our recommendation that they just remain where they are. So in that respect, you don't feel too badly, but you do feel badly at renewal time when you have to call up a company and say, well, you got a rate renewal, but it was only 45 percent. That's pretty upsetting.

MS. BRACKETT: The Schimelpfenigs are paying some $50,000 a year for their company's health care package, which includes major medical, dental, and hospital. That comes to $10,000 a person.

JOHN SCHIMELPFENIG: It appears that Mutual Benefit has made some sort of a decision where they would prefer not to be insuring small companies, and one way to get the message across is to make it very expensive for small companies to continue with them.

ED BULL, Mutual Benefit Life: Well, that's certainly not the intent because from a business standpoint, if we didn't want to be in the business, we'd just go out of the business. We sell lots of

products and our purpose is to provide the insurance at a reasonable cost. The fact that the consumer may feel that the cost is too high may be a part of the fact that he doesn't recognize what happens when someone goes into a hospital for an appendectomy or a gall bladder.

MS. BRACKETT: As medical costs have gone up, small groups have borne the brunt of rate hikes. Premium costs per employee can be 20 to 40 percent higher for small groups than large. Insurers say small groups present risks and costs that larger groups don't.

MS. WARD: When you're talking about a group of 10 people with maybe an annual premium of 20,000, one hospital stay could certainly wipe out that entire year's premium. So you're finding quite a few insurance companies that are just getting out of the business altogether.

MS. BRACKETT: Other insurers are severely restricting the companies they'll cover. Guardian Insurance won't insure such businesses as florists, barber shops, liquor stores, trucking firms, parking lot attendants, tree surgeons, churches. The reasons for the restrictions vary. Some of these companies are more likely to go out of business. Others have a higher risk of medical problems or injury.

MS. WARD: The first step of the underwriting process is just telling the agent these are groups that we won't even look at, so don't even bother sending them in.

MS. BRACKETT: It's so bad that even insurers are beginning to question the system.

MR. BULL: The small employer is not going to be able to afford to just keep tacking on 20 percent a year, assuming that everybody in his firm is in good health. It reaches a point where he can't afford it any longer and there must be a better way to provide health coverage and to pay for health coverage than they way we're doing it.

MS. BRACKETT: The Schimelpfenigs say that they can still afford to pay their health insurance bills, but other small companies are dropping their medical insurance as too expensive. Others find it hard to get coverage. As a result, more and more individuals are forced to purchase their own or go uninsured. Edwina Cuddihy worked for a small New Jersey firm that didn't offer health benefits. She pays for her own health insurance. In the last year, her bill from New Jersey Blue Cross has doubled to more than $6,000 a year.

EDWINA CUDDIHY: It's very frustrating. It makes me angry. It makes me wonder what do people like us do. You know, you don't want charity, you want to buy your health insurance, but you also have to be prepared to pay a reasonable amount, and $6,100 a year for two people is not a reasonable amount of money.

JOAN BOYLE, New Jersey Blue Cross/Blue Shield: I feel for that person, and I understand the problem she has. Is the solution to cause Blue Cross to lose money because we alone offer coverage to all? I don't think so.

MS. BRACKETT: Blue Cross, which is a non-profit organization, is required by New Jersey state law to insure everyone, even Mrs. Cuddihy, who had a heart attack a few years ago. Prior to 1988, Blue Cross charged high risk individuals like Mrs. Cuddihy the same rates as its younger and healthier policy holders. This approach called community rating differed from the methods used by commercial insurers. Uwe Reinhardt, a professor at Princeton University and expert on health care economics explained the differences to producer Tim Smith.

UWE REINHARDT, Princeton University: The commercial insurance industry prices what is known as actuarially fair, which means that prices are based on the health status of the individual subscriber. Actuarially fair insurance pricing really means I don't wish to be my brother's keeper, that's what that means in plain English, while community rating means we're all in this together.

MS. BRACKETT: Because they could get lower rates from commercial insurers, healthy and younger individuals turn to them, leaving Blue Cross with a pool of more and more older and less healthy policy holders.

MS. CUDDIHY: I've had a heart attack. No commercial insurer will take somebody with this kind of pre-exist condition. I've called just a few, Prudential, Metropolitan, Aetna, Travelers. I've gone through insurance brokers; I've asked them to find, and they all will tell me I have to use Blue Cross/Blue Shield, they're the insurer of the last resort.

MS. BRACKETT: In 1988, with its back to the wall and some $300 million in debt, New Jersey Blue Cross got the state's permission to rate policy holders based on their health status, just like commercial insurers. Immediately, rates for high risk people like Mrs. Cuddihy skyrocketed. Blue Cross attributed the increases to health cost inflation. Prof. Reinhardt sees it differently.

PROF. REINHARDT: The real problem is how inequitably we share this burden. See, even if we spend only 9 percent of GNP on health, say as Canada does, it would still be the case with our insurance systems, a system that some families would really be aching with enormous premiums and other healthy yuppies would pay very little.

MS. BRACKETT: One other element is driving up medical insurance premiums, the growing numbers of people without health insurance. In New Jersey, some 800,000 people have no medical insurance. Their bills are paid out of a special fund that private insurers are obligated to contribute to. Blue Cross says that 24 cents out of each dollar they pay out in health insurance benefits goes to this fund.

PROF. REINHARDT: One way to pay to pay for health insurance for the poor is to put a surcharge on private insurance, and we do that by telling the hospital you take care of the poor, and you stick it to Blue Cross and Prudential. Prudential then has to pay not only for their own insured but for the uninsured, and then charges us, the insured, the premium, so really we're paying taxes, but for some reason we Americans like it that way.

SEN. JAY ROCKEFELLER, (D) West Virginia: (March 2) The American health system in our judgment is at a crossroads. Either we face up to the problems and to the costs, understand what they are, what the consequences may be, or we fail to be honest with ourselves and with millions and millions of people.

MS. WOODRUFF: In Trenton and Washington, numerous committees and commissions are wrestling with ways to resolve the problems of the high costs of health insurance and what to do about the growing numbers of uninsured. Meanwhile, people like Edwina Cuddihy wonder when the politicians will stop talking and actually fix the problems.

MS. CUDDIHY: I'd like somebody in government to stop talking about it and start doing something about it. They could talk around it forever and ever like I've been doing. I can't change it, but somebody out there must be able to. Isn't there anybody that cares?

CONVERSATION - SERVING THE PUBLIC

MR. LEHRER: Next, public service. Over the last several years polls have consistently shown that the American public has a pretty negative image of the federal government and of a lot of the people who work for it. Recently, Judy Woodruff talked with Constance Berry Newman, who as director as the Office of Personnel Management, runs the federal bureaucracy.

MS. WOODRUFF: Has the role of government changed, is that what part of the problem is?

CONSTANCE BERRY NEWMAN, Director, Office of Personnel Management: Yes. See, I think

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NJDA
New Jersey Dental Association

TO: Assembly Health Care Policy Study Commission

FROM: New Jersey Dental Association
Jack L. Roemer DDS, Past President

SUBJECT: State Health Planning

Mr. Chairman, members of the Assembly Health Care Policy Study Commission, I am Dr. Jack L. Roemer, past president of the 5,000 member New Jersey Dental Association (NJDA).

I testified before you on October 9, 1990 and presented a historical perspective on the decaying Dental Medicaid program. At that time I testified that over the last five years over 30% of the participating dentists have dropped out of the program. That fees have increased only 36% for selected procedures over a twenty year period. That there are portions of New Jersey where Medicaid recipients cannot find treatment and have to travel for an hour or more before finding a dentist who will treat them. HCFA and the Department of Human Services have acknowledged that New Jersey is out of compliance with the requirement of Title XIX. Abysmally low fees have led to a small population of providers that denies patients statewide availability, equal access, timely and quality care, free choice of providers and comparable service among recipients.

A study released last month by the Congressional Office of Technology Assessment on "Children's Dental Services Under the Medicaid Program", reported that state programs provide inadequate services to children on Medicaid - and in some instances, fail to meet federal requirements. New Jersey is a prime example - less than 1% of our Medicaid budget is spent for dental care for children and adults.

I have read the report of the Governor's Commission on Health Care Costs, I did not find one reference to dentistry or the Dental Medicaid program. When is New Jersey going to realize that they can no longer use the Dental Medicaid Program as a budgetary scapegoat and dump the responsibility for the program on the backs of the provider community? We are no longer willing to take out-of- pocket losses to participate in Medicaid. Currently only 25% of the eligible Medicaid population is receiving care. For New Jersey to say that dental fee increases are not a priority flies in the face of common sense and responsibility.

Pamela Simerly, Director of the study for the Office of Technology Assessment stated, "Poor oral health has a real impact on the health of the population at risk: the kids who are not getting services, . . . and its amazing that so little money and attention has been spent on something so basic."

In the epilogue of Governor's Commission's report it states, "The issues that confront this nation with regard to health care policy require major systemic reform. To neglect the need for this reform only insures that the pressures that cause rising costs and declining access will continue." It is truly a shame that the Governor and the Commission did not see fit to include dentistry in their deliberations nor did they think it enough of a problem to address it in any of their necessary reforms. Our system is broken and only with increased funding can a realistic effort to stabilize the Dental Medicaid Program begin in earnest. A return to the five year plan begun in 1988, but terminated after one year, of targeted increases in key areas of the program would be a start. However, for Dental Medicaid to attract the necessary number of participating dentists, we will have to see a major infusion of funds.

NJDA remains committed to the goal of an efficient and effective Dental Medicaid health care delivery system in New Jersey. I thank you for the opportunity to testify on this important matter.

STATEMENT OF DAVID A. WAGNER
SENIOR VICE PRESIDENT
STRATEGIC PLANNING & CORPORATE DEVELOPMENT
November 28, 1990

Thank you for giving me the opportunity to present my views to the Assembly Health Care Policy Study Commission concerning the Governor's Commission Report as it pertains to planning and certificate of need issues.

My name is David A. Wagner. I am Senior Vice President for Strategic Planning and Corporate Development at Saint Barnabas Medical Center. I am also a member of the Regional Health Planning Council and Chairman of its Review Committee. From 1975 through 1982 I was Deputy Commissioner of Health for the State of New Jersey. My responsibilities included planning, certificates of need, rate setting, licensure and inspections.

The Commission Report on Planning and the Certificate of Need process may well be entitled "Back to the Future". Until 1982 there were active local health planning agencies, an involved statewide health coordinating council, a state health plan and a state facilities inventory. While the process which was sometimes criticized as being unrealistic, it was, none-the-less, regarded as being fair and honest. Subsequently, the local health planning agencies were systematically starved for funds and the state health plan and state facilities inventory were never updated. The Governor's Commission seeks to restore much of the former structure and process and also seeks to restore its virtue through some of the recommended changes.

A nation-wide flirtation with a "competitive" healthcare delivery system has proven to be a mistake. Healthcare facilities tend to compete on services, not on price. Even if the reverse were true, lower prices are not necessarily determinants of quality. From the standpoint of the best interests of the consumer, we at Saint Barnabas believe that a planning model is preferred to wide open competition. We do not believe, however, that the planning model should revert to that which we knew in the 1970's, because that tended to be too rigid and stifled initiative and imagination. So while, in general, we support of the recommendations of the Commission, we do wish to remind those who will be building the planning system that they must build into the system sufficient flexibility to allow providers to respond promptly to the needs of their communities.

We do support the creation of a new State Health Planning Board and local advisory boards (LABs). The Commission has suggested a number of individuals who would sit on the planning board as exofficio members. While we do not disagree that the chairpersons of the various health department boards would be valuable members, we question whether these private citizens will have the time to devote to two boards.

We do not believe that the Public Advocate should be a member of the planning board. We believe that the Advocate functions best and most effectively outside of the government structure. However, the Advocate's role as spokesperson for the public should be ensured and enabled by the legislation and/or regulations. The inherent conflicts of the Advocate as a board member are apparent in Recommendation CR9 in which the advocate is assigned the responsibility for representing the State Health Planning Board in appeal situations.

We believe that the suggestion that the Department of Health consider placing rule making authority within the State Health Planning Board and/or combining the State Health Planning Board and the Healthcare Advisory Board into a single board is inadvisable . We should not turn the State Health Planning Board into a regulatory agency. The State Health Planning Board and the Healthcare Advisory Board have entirely different responsibilities. The Healthcare Advisory Board is a rule making body (a regulatory agency) and an appellant body for certificates of need.

As expressed in Recommendation CR7, we agree that the planning process generally should drive the certificate of need process, not vice-versa. The suggestion regarding the certificate of need process is neat and tidy -- too neat and tidy. The fact is that healthcare requirements do not always fit into a neat formula such as a long term care bed formula. Judgments have to be made by informed and responsible persons based upon arguments presented by proponents and opponents in the community. Sufficient flexibility must be granted the Commissioner to make some of those decisions without sending the Commissioner down a path of reviews and changes to the health plan.

We agree with Recommendation CR10 which requires all providers, including those who purport to be involved in the private practice of medicine, to participate in the certificate of need process.

We would like to see some further consideration of Recommendation CR11 which raises the new construction/modernization and major movable equipment threshold to $1,000,000. It is inappropriate to lump hospitals, nursing homes and

ambulatory care facilities together under one threshold. The threshold should really be indexed to the operating budgets of the respective facility. For example, a large hospital with an operating budget of $150,000,000 should not be subject to the same threshold as a smaller hospital with a budget of $20,000,000. The impact on operations and debt capacity are totally different.

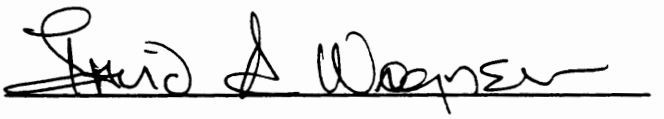
We believe that Recommendation CR12 is almost a knee-jerk reaction and needs further consideration. It is very difficult to establish a capital cap that is based on any rational set of criteria. We are not sure that capping the replacement of hospital facilities and equipment makes any more sense than capping the replacement of industry's facilities and equipment.

Recommendation CR13, which attempts to establish priorities for replacing physical plants, is another idea which sounds good on paper, but which, in reality, would be much harder to implement. It is the kind of process which, unfortunately, is going to lead to political jockeying and considerable infighting. We do agree, however, that it is valuable to have a good, state-wide inventory of all healthcare facilities and their current condition. Such an inventory would help in the process and would be only one of many determinants in the decision to grant a certificate of need.

Recommendation CR15 in reference to the certification of "paper beds" is of little consequence. Hospitals do not staff for paper beds. They can not afford to do so. We do not have strong objections to this recommendation, but we are confident that there is little benefit attached to it. Of greater consequence would be the Health Department's ability, under certain terms and conditions, to

close hospitals. This we believe should be investigated more thoroughly. The elimination of paper beds does not reduce overcapacity and does not discourage or encourage the expenditure of additional healthcare dollars.

We thank you for the opportunity to present our views and we look forward to further participation in this dialogue.



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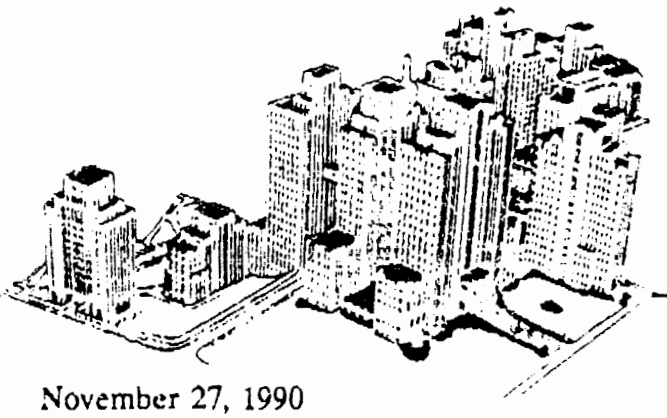

Executive Office

November 27, 1990

The Honorable James E. McGreevey
Chairman
Assembly Health Care
Policy Study Commission
New Jersey State Legislature
State House Annex, CN 068
Trenton, New Jersey 08625-0068

Dear Chairman McGreevey:

Thank you for the opportunity to comment on the planning and certificate of need reforms contained in the Governor's Commission on Health Care Costs report. I regret that I am not able to participate in tomorrow's public hearing on this subject. I hope that you will enter this letter into the record.

As you know, Jersey City Medical Center is a voluntary, not-for-profit 608-bed inner city teaching hospital. The Medical Center predominantly serves residents of Jersey City and greater Hudson County and provides a wide range of services and programs. In 1989, the Medical Center had over 18,000 admissions, 65,000 emergency room visits and 158,000 clinic visits. The Medical Center has over 105 residents and fellows in freestanding and integrated graduate and post-graduate medical education programs in a variety of disciplines and is a core hospital of the Seton Hall University School of Graduate Medical Education.

The following comments on the proposed reforms are offered for consideration:

The Development of a State Health Plan.

The Medical Center wholeheartedly supports the development of a State Health Plan. It is unconscionable that new and expanded programs and services are being approved without consideration of how these initiatives fit into a broader, more global perspective. Certificate of Need applications should only be accepted if there is a demonstrated need for a specific service in a designated geographical area.

The proposed Local Advisory Boards (LABs) will have a significant role in developing the Plan. Providers and consumers must be well represented on the LABs and must play an active role in identifying the needs of the community to ensure access to high quality services.

More sophisticated methods need to be developed to quantify the need for particular health care services. It is often not possible to blindly apply a rigid formula to compute need without giving consideration to other factors.

The Plan must also recognize that the health care needs within a given geographical area are not static. The Plan must be updated on an ongoing basis. There must be a clearly defined process to amend the Plan to meet changes in supply and demand, technology and professional practice patterns.

The Medical Center is now in a situation which never would have occurred if CNs were only accepted for identified, needed services. A few years ago, the Medical Center received CN approval for a regionalized service A local acute care hospital applied unsuccessfully for CN approval for that same service before the Medical Center's program reached the required minimum utilization threshold; that is, before there was a need for additional providers in the region. This local hospital is now appealing the State Health Department's denial and has drawn the Medical Center into unnecessary, timely and expensive litigation.

Local providers must be encouraged to utilize CN-approved regionalized services and not boycott services in an effort to undermine the attainment of minimum utilization standards so that they can file a Certificate of Need application.

Designation of Local Planning Areas.

HSA I/III is now comprised of Bergen, Passaic and Hudson counties. The plan to be filed in 1991 by the State Health Department to designate local planning areas must designate Hudson County as one discrete planning area. This would afford Hudson County the status that it once had as its own Health System Agency. HSA I and III were merged for budgetary, not planning, purposes. Hudson County has its own health planning needs which have often been obscured when considered together with Passaic and Bergen counties. I urge the State Health Department to recommend that Hudson County be designated as one local planning area.

Definition of a Health Care Facility.

The Medical Center endorses the proposal to amend the definition of a health care facility under Certificate of Need requirements to include any service which is the subject of a State-adopted health planning regulation or any service or acquisition with a total project cost exceeding $1 million. It is time that a level playing field is established so that those who heretofore were able to bypass Certificate of Need regulations must prove that their plans are efficacious. This proposal has the potential to dramatically contain the proliferation of high cost technology, to achieve real savings in the health care system and in particular, to help inner city teaching hospitals.

The Financial Feasibility of a Certificate of Need Application.

The proposed Certificate of Need reforms do not adequately address the issue of affordability. There are instances in which an applicant is first required to obtain Certificate of Need approval, and then to submit its proposal to the State Department of Human Services for the development of a Medicaid rate. There must be better coordination and improved communication between the Departments of Health and Human Services in the financing of health services and programs. It is contradictory for the State to endorse the need for a program and then not agree to fund it adequately.

Medicaid.

The Medical Center supports efforts to reform the State's Medicaid system. In particular, it is essential for the State to develop the capability to provide on-site Medicaid eligibility determinations. The current system is costly, time consuming and bureaucratic. Patients are required to navigate a very complex system, at a time when they are ill and in need of medical assistance. The eligibility of many potential Medicaid patients is never determined and the cost of providing care to these patients is ultimately reimbursed from the Trust Fund. When Medicaid eligibility is determined, the federal government contributes to the care provided, thus reducing the State's financial burden.

The Medical Center also endorses the recommendation to expand the participation of Medicaid recipients in managed care programs. At this time, the majority of services for Medicaid recipients is provided by the State's inner city teaching hospitals. Managed care programs for the State's Medicaid population should be coordinated with those institutions which have historically provided care to these patients. This should not be an opportunity for acute care providers who have not had a substantial commitment to meeting the needs of Medicaid patients to capture new patients and sources of revenue.

AIDS.

The problem of AIDS in New Jersey is severe and continues to increase at an alarming rate. Institutions in Jersey City, Essex and Camden counties have been severely impacted. Selected institutions in these areas manage a disproportionate level of care for AIDS patients. While you consider major changes to the current Certificate of Need regulations, the Medical Center encourages you to add language that would require all institutions to do their Fair Share in meeting the broad and complex needs of persons with AIDS. This Fair Share obligation to meet the needs of persons with AIDS should be a condition of approval for all Certificate of Need applications.

Each institution's capability to provide AIDS services and programs should be evaluated against what it is providing. Just as there will be an annual review of statewide plant conditions, there should be a review of each institution's AIDS services relative to its capability. Some institutions may choose to establish or expand selective niche AIDS services when they are capable of providing much more of the services needed to complete the continuum of care and/or relieve others of disproportionate workloads. Provider must not only pursue what they choose to do; rather, they should be required to do what they are

capable of doing.

The following principles should be incorporated in the State Health Plan:

- Every hospital in the State must be mandated by regulation to establish and maintain a minimum AIDS care capability.

- Patients with AIDS should be admitted for AIDS care to the hospital with which their primary care physician is associated, or next, to a hospital in the community where they live. In larger communities, admissions should be determined by primary care catchment areas.

- Over time, every acute care hospital should admit its Fair Share of AIDS patients. Every hospital should maintain a ratio of AIDS average daily census to medical/surgical average daily census equal to that ratio for all hospitals in its service area.

Thank you for this opportunity to discuss the State health care planning and certificate of need reforms. I would be happy to meet with you and the members the Assembly Health Care Policy Study Commission to discuss the Medical Center's recommendations in greater detail.

Sincerely,

Jonathan M. Metsch, Dr.P.H.
President & CEO

c: Mr. Anthony Impreveduto
Mr. Robert Menendez
Ms. Jackie Mattison
Mr. Neil Cohen
Mr. Nicholas Felice
Mr. John Kelly