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The Christie Administration's Department of Health:

Failures in Enforcement, Accountability and Transparency

Health Professionals and Allied Employees
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SUMMARY:

Lax Oversight and Inadequate Safeguards Amid Dramatic Health Care Changes

The health care landscape has changed dramatically in the past decade, driven by reimbursement changes, hospital consolidations, health reform, and hospital and health system competition. In New Jersey, financially vulnerable hospitals have reduced services and staff, gone through bankruptcy or closed, undergone mergers and consolidations, and been bought up by profit-driven, investor-owned companies.

Of the state's 72 acute-care hospitals, 67 percent (about 50 facilities) are now part of a multi-hospital system[1], and 15% may soon be investor-owned. Since the late 1990s NJ residents dependent on community hospitals for care have seen:

- The closing or bankruptcy of 19 hospitals, and the sale of eight not-for-profit community hospitals to for-profit buyers, plus at least six more pending hospital conversions.
- The rise of the out-of-network business model resulting in: diminished access to healthcare for communities, higher prices to patients, and higher profits to hospital owners. For-profits Bayonne Medical Center and Meadowlands Hospital Medical Center, vying for the dubious distinction of being the most expensive hospital in the nation[2], are emblematic of this business model.
- Unregulated "sale-leaseback" arrangements in which hospital property is sold to private investors and leased back to hospital owners without any public scrutiny or protections.
- Closures or limits on services, as demonstrated by repeated efforts to close Memorial Hospital of Salem County's maternity service.

Years of mismanagement by hospital executives and anemic oversight by board members and government regulators have destabilized many NJ hospitals, some to the point of bankruptcy. The opportunity to purchase financially failing hospitals at "bargain" prices, along with the potential for high profits using an "out-of-network" business model, have drawn hospital investors into NJ. Since the for-profit Solomon Healthcare Services took over the management of Bergen Regional Medical Center, formerly Bergen Pines, in 1997, NJ regulators have approved the sale of eight not-for-profit hospitals to for-profit investors; another six such sales currently are in the works. (Hospital Conversions Table in Appendix 1)

These for-profit sales have illuminated many of the profound flaws and limitations in the NJ Department of Health's (DOH) regulation and oversight of our community hospitals. The business practices of the new owners have, in some cases, undermined the quality of patient care, reduced access to healthcare services, driven up healthcare costs, and denied nurses and healthcare workers rights on the job, including the right to speak out on behalf of their patients and their professions.

Although the DOH has a mandate to ensure compliance with safeguards and protections at NJ healthcare institutions, the DOH has adopted a laissez-faire approach to hospital oversight. At a time when more oversight and accountability is necessary to uphold licensure and patient care standards, New Jerseyans find themselves less protected. This lax oversight and enforcement have emboldened some hospitals to violate or skirt licensing regulations, Certificate of Need (CN) requirements, and sound financial and governance practices, placing patient and worker safety and access to quality care at risk.

The New Jersey Department of Health (NJ DOH) has:

- Failed to update hospital nurse staffing standards since 1987 to address increased patient acuity and need.
- Refused to appoint a monitor to oversee finances and/or quality of care and patient safety at hospitals in acute financial distress or with highly suspect financial practices.
- Conducted superficial reviews and analyses of the impact of a hospital license transfer on access to, and quality of care for, the community served.
- Refused to use its full authority to scrutinize the track record of potential hospital buyers.
- Failed to closely monitor compliance with Certificate of Need Conditions placed on the new owners of hospitals and to promptly and effectively address violations of these Conditions.
- Embraced a "hands off" approach to the scrutiny and oversight of secretive hospital sale-leaseback arrangements that could result in the loss of community hospitals.
- Stopped the practice of conducting license renewal inspections of hospitals, relying instead on accreditation inspections by private companies and hospital CEOs' self-reporting of compliance with federal and state laws.
- Stopped posting on its website any information on violations uncovered, penalties assessed, and Plans of Correction submitted as a result of complaint inspections of hospitals.
- Failed to implement many of the department's own enforcement powers on behalf of healthcare consumers, and hospital patients and employees.

To protect patient safety, community access to care, and the working conditions of hospital employees, HPAE calls for:

- Updating and strengthening of our state staffing regulations to assure the correct number of icensed professional nurses at all times in all hospitals;
- Increasing oversight and support for financially at-risk hospitals;
- Increasing financial and operational transparency at all hospitals;
- Reinstating the DOH's hospital license renewal inspections, and public disclosure of inspection reports;
- Strengthening DOH oversight and enforcement of hospitals' adherence to CN and other licensing requirements;
- Strengthening standards for hospital conversions to 'for-profit', including the appointment of a monitor to oversee quality of care, access to services, and financial management.

THE FAILURES OF OVERSIGHT

Failure to Update and Enforce Safe Staffing Standards

Frontline nurses and healthcare workers know that safe staffing is crucial to the health and well being of our patients and our ability to provide quality, professional care. Nevertheless, the NJ hospital licensing regulations prescribe specific staffing levels in only a few specialty units, and leave hospitals free to develop, implement and enforce their own 'acuity systems' when determining nurse staffing levels. Despite profound changes in medical treatments and technologies, and an increase in patient acuity in hospital settings, the DOH has failed to update these limited staffing requirements in the past 27 years.

Under the Affordable Care Act (ACA) and other reimbursement changes, Medicare will financially reward and penalize hospitals using indicators directly linked to adequate nurse staffing levels:

- 30-day readmission and mortality rates for acute myocardial infarction, heart failure and pneumonia;
- Hospital-acquired infection rates; and
- Patient satisfaction as measured by HCAHPS Patient Satisfaction Surveys.

These reimbursement changes make establishing safe nurse staffing levels a smart financial investment, as well as a requirement for patient safety.

"Nurses at the bedside are the best advocates for the needs of patients, and know how and when to adjust staffing to make sure patient needs are met.

Study after study supports what nurses have always known – proper staffing leads to better outcomes, and reduces mortality and errors.

For years, we have fought for proper staffing levels in our hospitals. But NJ has not updated its staffing guidelines since 1987 and we need a staffing law now."

– Stephanie Orrico, RN

Independent research studies continue to confirm what frontline nurses know from their daily experience on the job: patient safety and patient satisfaction require adequate staffing.

- In a study that looked at staffing levels and penalty data for nearly 3,000 adult acute care hospitals, hospitals with higher nurse staffing levels had a lower likelihood of receiving penalties for excess readmission rates. **Researchers found hospitals with higher nurse staffing levels had 25 percent lower odds of Medicare readmission penalties** compared to their lower-staffed, but otherwise similar counterparts. With each additional nurse hour per adjusted patient day, hospitals lowered their odds of being penalized by 10 percent. The study authors suggest that hospital administrators focus on the staffing levels and workload of nurses in order to reduce Medicare readmission penalties.[3]
- According to another recent study, hospital nurse staffing levels also directly correlate with pediatric readmissions. Researchers found that children with common medical and surgical conditions were significantly less likely to be readmitted within 15 to 30 days when treated in hospitals meeting a staffing benchmark of no more than four patients per nurse. **The study concluded that lower patient-to-nurse ratios hold promise for preventing unnecessary hospital readmissions for children.**[4]

"As an ER nurse there are no nurse to patient ratios. While an ICU nurse might have 2–3 patients who require critical care, my average assignment is 6–7 patients. Of those I can have multiple critical care patients. The ER never closes. If we don't have a room we find space in a hallway regardless of staffing levels. There have been times where I have 2–3 ICU patients and 3 other patients…. I do my best… but I know that I am not able to give the care a patient deserves. You never know what is going to roll through the door, and the one thing we all pray for is that we have the help we need. I don't need a raise… I haven't had a coffee or meal break in 4 years, all I want to do is be able to care for patients and ensure their safety and treat them… We need legislation."

– Registered Nurse responding to 2013 survey on staffing

- Another study found a significant association between patient-to-nurse ratios and urinary tract infection and surgical site infection. After controlling for patient severity and nurse and hospital characteristics, the study found only nurse burnout – due to inadequate staffing – remained significantly associated with urinary tract infection and surgical site infection. Hospitals in which burnout was reduced by 30% had a total of 6,239 fewer infections, for an annual cost saving of up to $68 million.[5]
- A study compared staffing levels and patient mortality in California, Pennsylvania, and New Jersey. California hospital nurses cared for one less patient on average than nurses in the other states and two fewer patients on medical and surgical units. Lower ratios were associated with significantly lower mortality. **The conclusion of the study: Hospital nurse-staffing ratios mandated in California are associated with significantly lower mortality. When nurses' workloads were in line with California-mandated ratios in all three states, nurses' burnout and job dissatisfaction were lower, and nurses reported consistently better quality of care.**[6]
- A recent study found that a **five-point increase in patients' rating of nursing care yielded a 27% increase in overall rating of the hospital.** "Hospital administrators wishing to maximize Medicare reimbursement will realize the greatest impact by improving patient satisfaction with nursing care."[7]

In surveys commissioned by HPAE, nurses report serious and chronic understaffing where they work and an overwhelming majority (77%) supports a law that would establish minimum safe staffing levels for all hospital units.

SOLUTION

To ensure safe patient care, we recommend:

- **Enacting safe nurse-to-patient ratios through regulation and law.**
- **Requiring hospitals to establish committees with front-line RNs to develop systems for increasing staff based on patient need and acuity.**

Union's Efforts to Improve Hospital Standards, Staffing Levels Gain Legislative Allies

Andrew Kitchenman | January 30, 2014

Key leaders in state Senate and Assembly sign Health Professionals and Allied Employees petition

Source: http://www.njspotlight.com/stories/14/01/29/labor-union-s-efforts-to-improve-hospital-standards-staffing-levels-gain-legislative-allies/

Failure to Monitor Financially At-Risk Hospitals

Recognizing that financial mismanagement was contributing to hospital bankruptcies and closures, in 2008, NJ enacted (P.L.2008, c.58) an "early warning system" or 'Monitor Law' to identify financially fragile hospitals. Based on recommendations made in the 2008 Final Report of the New Jersey Commission on Rationalizing Health Care Resources[8], (The Reinhardt Report, chaired by healthcare economist Uwe Reinhardt), the Monitor Law gives the Commissioner of Health the authority to appoint a monitor with wide-ranging powers when a hospital is found to be "in financial distress or at-risk of financial distress". (see Appendix 2).

In the ensuing six years, the Commissioner of Health has failed to exercise this authority beyond attending Board of Trustees meetings at some financially troubled hospitals. In fact, the DOH has never issued the required regulations to accomplish the purposes of this law.

With such lax intervention by the DOH, financially distressed hospitals have slashed staffing and services in order to cut costs and repair their profit margins. These desperate measures rarely, if ever succeed, and the depleted hospitals limp to bankruptcy, closure, sale, or some combination of these, while the community, patients, and hospital employees must contend with a loss of services, jobs, and access to care.

For example, in October 2008, shortly after the "Monitor Law" was enacted, representatives of HPAE met with the DOH to request the appointment of a monitor at Christ Hospital, where the union represents the Registered Nurses. At that time, the hospital met five of the six triggers for the appointment of a monitor, as set out in the newly enacted legislation. The union raised several other financial and governance concerns in support of the requested monitor, but to no avail.

Christ Hospital's finances continued to deteriorate, despite receiving funding from NJ's Health Care Stabilization Fund in 2010 and 2011. The hospital's audited financial statement for 2009, issued in September 2010, included a "going concern" letter from the auditor and reported that the hospital was out of compliance with various covenants of its $20M revolving line of credit with a key lender. Nevertheless, the DOH remained unwilling to appoint a monitor. Staffing cuts, a pension freeze, and service cuts could not stanch the flow of cash out of the hospital. By the summer of 2011,

Christ Hospital CEO Peter Kelly had signed a Letter of Intent to sell the hospital to the California-based for-profit chain Prime Healthcare Services, requesting an "expedited review" of the transaction by state regulators because of the hospital's desperate financial condition. When Prime backed out of the deal because of community and healthcare advocates' protests and regulatory scrutiny, the hospital filed for bankruptcy and ultimately was purchased by Hudson Hospital Holdco, now CarePoint Health.

SOLUTION

To improve oversight of financially troubled hospitals, the DOH should:

- **Enact regulations to implement the Monitor Law.**
- **Increase reporting and interventions at financially troubled hospitals.**

Failure to Require Hospital Financial Transparency

Although both for-profit and not-for-profit hospitals rely on taxpayer-financed funding sources, such as Medicare, Medicaid, and charity care, not-for-profits, unlike their for-profit counterparts, are required to make extensive financial and governance disclosures to regulators and the public.

This disparity in transparency, along with the fact that the boards of directors of for-profit hospitals are accountable first and foremost to their owners and investors, while not-for-profits are accountable to the communities they serve, creates an uneven playing field that disadvantages our not-for-profit hospitals.

Troubled by the disparate requirements, the legislature passed the "New Jersey Hospital Disclosure and Public Resource Protection Act" (P.L. 2013, c.195) in June 2012. The law leveled the playing field by requiring all hospitals that receive charity care funding to submit to the DOH the same financial and governance information that not-for-profit hospitals already make publicly available in their Return of Organization Exempt from Income Tax, commonly referred to as the IRS 990.

Calls for the legislation came from civic leaders, elected officials, healthcare advocates, and workers concerned over the lack of financial transparency required of for-profit companies running the state's community hospitals.

The lack of financial transparency also presents challenges for elected officials and state regulatory agencies when they are allocating scarce public resources to our hospitals and when they must evaluate a hospital's request to cut or add services and programs. Accurate and complete information on a hospital's expenditures, including board and CEO compensation; management, advertising and legal fees; transactions with affiliated entities; and business deals with board members or their families and business associates are very relevant to these decisions. If a hospital claims financial difficulties as the reason to cut services or staff, or close in-patient units, or seeks financial stabilization funds, our regulatory agencies and elected officials should be able to make these decisions with full knowledge of the hospital's actual financial standing.

For example, Memorial Hospital of Salem County (MHSC) is owned by Community Health Systems Inc (CHS), a publicly-traded, for-profit corporation based in Tennessee. CHS owned 135 hospitals in 29 states and had a net operating revenue in 2012 of over $13 billion.[9] As a result of its recent takeover of Health Management Associates,[10] CHS will now operate more than 206 hospitals.

MHSC provides no audited financial information to the public; rather, its finances are combined with the other 134 CHS hospitals. So when, in 2009, MHSC applied to the DOH to terminate inpatient obstetric and related HealthStart services, based in part on the alleged financial hardship of providing these services, there was no way for community advocates to find out how much of the hospital's revenues were being sent to corporate headquarters in Tennessee or distributed to CHS shareholders rather than used to provide essential services to the local community. Nearby not-for-profit hospitals, that would have had to provide care to Memorial Hospital's abandoned obstetric patients, are required to provide the financial and governance transparency and accountability that communities and elected officials need and deserve. Salem Memorial withdrew its request to close their OB service in July 2011 only to re-issue the request in November 2013.

CarePoint's Bayonne Medical Center provides another example. Since taking over the hospital in 2008, IJKG Opco, the entity that owns Bayonne Medical Center, has transferred over $96M to its parent company, IJKG LLC, for "general and administrative services to the Hospital, including finance, legal, regulatory and treasury. Also, certain other costs incurred by IJKG are allocated to the Hospital."[11] Without any further itemization of these expenses, we cannot know what portion of these financial transfers represent reasonable expenditures as opposed to pure profit to the owners. Meanwhile, services and staff have been cut, contracts with insurance companies cancelled, and the hospital buildings and property sold to a real estate investment trust in an opaque and unregulated sale-leaseback arrangement.

The DOH failed to speak out in support of the hospital financial transparency legislation, and despite strong bipartisan support, Governor Christie issued a Conditional Veto (CV) of the bill in August 2012, replacing the bill's transparency provisions with a call for the DOH to review existing financial reporting requirements and report back to the Governor by February 2013. In January 2014, the Legislature concurred with the Governor's CV, and a report from the Commissioner of DOH is due in July of 2014.

In a related issue, healthcare advocates, consumers, and regulators are paying increasing attention to how hospitals set their prices and to uncovering the reasons why charges vary so wildly between hospitals even within the same city. With two of the most expensive hospitals in the country, NJ should be at the forefront of efforts to provide patients with more price transparency. Six years ago, the

"It is troubling that Governor Christie struck down legislation that would have held for-profit hospitals accountable for millions in taxpayer-supported funds, from charity care to Medicaid. Governor Christie took a simple bill requiring transparency and accountability to taxpayers and turned it into a bureaucratic 6-month study. New Jersey doesn't need additional studies to learn that we need more oversight. We've already witnessed for-profit hospitals hand over millions of dollars in profits to their investors, while cutting services and staff – and even bouncing employee checks."

– Ann Twomey, President, HPAE
August, 2012

Reinhardt Report recommended requiring hospitals to post their 'charge masters' and action on this recommendation is long overdue.

SOLUTION

To provide the public and elected officials with the financial transparency needed to make sound decisions relating to our community hospitals, we propose that the DOH:

- **Promptly initiate an open and inclusive process for reviewing current hospital financial disclosure requirements and developing recommendations.**
- **Involve local communities served by our for-profit hospitals, as well as citizen groups, health care workers, and health care advocates in all aspects of the process.**
- **Implement transparency provisions for all for-profit hospitals equal to that of not-for-profit hospitals.**

Failure To Properly Review Hospital Sales

Not-for-profit hospital sales and their accompanying license transfer are governed by the NJ DOH's Certificate of Need (CN) regulations and the NJ Community Health Asset Protection Act (CHAPA), requiring oversight and approval by both the DOH and the Office of the Attorney General (OAG).

If vigorously enforced, these laws and regulations should provide strong protections for preserving the quality and accessibility of health care when a community hospital is sold. The DOH Commissioner and the Attorney General are given broad authority to place conditions on the sale in order to protect the public health. The public has the right to review all the documents, voice their concerns at public hearings, and suggest conditions to be placed on the sale. Conditions that the Commissioner places on the CN become part of the hospital's license and, if the new owner fails to comply with a Condition, the Commissioner can take licensure action against the facility.[12]

NJ's CN regulations require the DOH to scrutinize the proposed license transfer before granting its approval, including looking at:

- The financial viability of the hospital post-sale;
- The impact of the sale on the quality and accessibility of healthcare services in the community; and
- The buyer's 'character and competence', including its track record at other facilities.

The Department has adopted a very limited interpretation of the "character, competence and track record" review of the prospective buyer that the CN regulations require,[13] choosing to limit this track record review to consideration of "like to like"; that is, a prospective buyer of a hospital is judged on its track record at other hospitals only.

The sale of Meadowlands Hospital to MHA LLC in December 2010 was a case in point. Richard Lipsky, one of the principals of MHA LLC, and Mikhail Lipsky, are officers of MER Associates, LLC, which owns Xanadu Adult Medical Day Care Center (Xanadu AMDCC) in Passaic NJ. Xanadu AMDCC did not include the criminal record of two of its employees on its application to participate in NJ Medicaid and as a result, the NJ Department of Health followed the recommendation of the NJ Office of the Medicaid Inspector General (OMIG) and denied the application.[14] Six months later, on March 12, 2010, the DOH ordered Xanadu AMDCC to immediately curtail all admissions because of the seriousness of the deficiencies found during an inspection.[15]

During its review of the Meadowlands Hospital license transfer to MHA LLC, the DOH asked only one question regarding the violations at Xanadu AMDCC.[16] In a response dated April 14, 2010, MHA minimized the seriousness of the Xanadu violations and, as evidence of their "compliance and operational achievements," went on to cite the "unblemished" record of the MHA principals at the NJ ambulatory surgery centers they owned and operated at that time.[17] The DOH appears to have accepted this response, despite the fact that only a week earlier, the DOH had cited one of those facilities for 14 violations of state and federal regulations, including medication administration errors, having expired sterile supplies and failure to evaluate patients' anesthesia recovery prior to discharge.[18]

When faced with the sale of a hospital to a buyer with a questionable track record and/or business model, the DOH has failed to place the types of Conditions on the license that would better preserve access to care, protect patient safety and assure that the new owners adhere to financial and governance best practices.

The CHAPA requires the Attorney General to consult with the DOH to determine whether the sale of a not-for-profit hospital is in the public interest. Approval of the sale is contingent on the DOH determining that "the proposed transaction is not likely to result in the deterioration of the quality, availability or accessibility of health care services in the affected communities". The DOH consistently has chosen to satisfy this obligation under CHAPA by accepting, at face value, the claims of the prospective buyer that the sale will not have an adverse impact on the affected community. The DOH has never, to our knowledge, hired an independent consultant to scrutinize the sale to determine its impact on the community, and recommend the modifications or conditions to be placed on the license transfer in order to protect "the quality, availability or accessibility of health care services". This kind of careful, in-depth review is routinely undertaken by the California Attorney General's office during its review of hospital sales.

State regulations grant the DOH broad authority to place Conditions on hospital license transfers, which should serve to protect the safety of patients, the community's access to care, and the workplace rights of the hospital's employees.

CHAPA currently provides that the DOH can appoint a health care monitor for as long as three years, primarily to monitor whether the for-profit hospital satisfies its charity care obligations.[19] A monitor was appointed when Salem Memorial Hospital was sold in 2002 to Community Health Systems, the first not-for-profit to for-profit conversion after CHAPA was enacted.

Subsequently, when Merit Health Systems LLC purchased Mountainside Hospital in 2007, the DOH declined to appoint a monitor and instead imposed heightened reporting requirements to ensure financial transparency, oversight of money transferred into and out of the hospital, capital improvements and charity care obligations. The degree of enforcement of these obligations is unclear. Later, when Bayonne Medical Center (2008), Hoboken University Medical Center (2011), and Christ Hospital (2012) were purchased by the principal investors of what is now CarePoint Health, the DOH withdrew its initial demands for heightened oversight in the face of the investors' protests.

Most recently, in the pending sale of St. Mary's Hospital in Passaic to Prime Healthcare Services (Prime), the DOH staff, in their recommendations to the State Health Planning Board, roundly rejected calls for the appointment of an independent monitor to assure patient safety, access to care, and the working conditions of hospital employees. Despite several lawsuits and an ongoing federal investigation that raise serious concerns over Prime's billing, coding and patient care practices, DOH staff wrote: "the use of a general monitor is not recommended. In past instances where the Department has appointed an independent health care monitor, the cost of the monitor substantially outweighed the benefits derived from the monitor. A general monitor is typically not as effective as state oversight."[20]

The DOH staff however, provides no evidence to support its assertions that the cost of a monitor substantially outweighs the benefits and that state oversight is typically more effective than that of a monitor.

SOLUTION

To protect patient safety and to ensure continued access to care, we propose:

- **Amending CHAPA to permit the DOH to hire a consultant, at the applicant's expense, to undertake a serious analysis of whether the proposed transaction will have an adverse impact on the affected community, and if so, to recommend conditions that would offset such an impact.**
- **Strengthening the DOH's review of the track record of the potential buyer to disallow the transfer of a hospital license to any potential buyer that is currently under federal or state investigation; or has a pattern of violations in any state in which the potential buyer has held a license to operate any type of healthcare facility; or that employs business practices that are incompatible with state health policy.**
- **Amending CHAPA to require the DOH to appoint a monitor in a hospital conversion, and expanding the monitor's role to include oversight of hospital finances and quality of care.**

Failure to Address Secret Sale Leaseback Arrangements

Some of our community hospitals no longer own the land on which they sit or even the buildings in which their staff provides patient care. As for-profit investors have bought up struggling NJ community hospitals, they have turned hospital property into quick cash, selling the property to private investors and then leasing it back in unregulated and opaque sale-leaseback arrangements. Public officials, community members, and even regulators are unaware of the terms of these sale-leasebacks, beyond knowing the sale price and the length of the lease. There are no requirements that the seller disclose how the proceeds are spent or even that the seller uses any portion of the proceeds for the benefit of the hospital or the community.

> ***"Meadowlands went from being in the red to an operating profit of $11 million in 2011; in less than three years under for-profit ownership, investors got a return of more than $14 million. There are similar tales at other hospitals in the state, which means this story points to another one: What is it about New Jersey laws and regulations, or its medical market, that makes the state especially susceptible to price-gouging? State regulators are concerned about what's happening, and tried to prevent Meadowlands from doing exactly what it's doing, so why do the hospital's owners think they can get away with being so aggressive?"***
>
> ***– Columbia Journalism Review, March 4, 2014***

Source: www.cjr.org/the_second_opinion/the_casualties_of_healthcare_c.php

CarePoint Health, the Hudson County for-profit system that now includes Bayonne Medical Center, Hoboken University Medical Center and Christ Hospital, introduced sale-leaseback arrangements to NJ's hospital landscape. Having bought Bayonne Medical Center out of bankruptcy for $100,000 in cash and the assumption of approximately $32M of debt in November 2008, the owners of Bayonne Hospital, IJKG LLC, took less than two and half years to reap a nearly $26M profit when they sold the hospital's land and buildings for $58M in February 2011 to Medical Properties Trust (MPT), an Alabama-based real estate investment trust or REIT.[21]

Less than a year later, the IJKG principals, operating as Hoboken University Medical Center (HUMC) Holdco, purchased Hoboken University Medical Center (HUMC) out of bankruptcy, once again working with MPT in a complex and thoroughly opaque transaction that involved the REIT gaining an equity interest in the hospital's operations, as well as ownership of the real estate. These transactions are now the subject of a lawsuit between MPT and HUMC Holdco. One of the significant issues in dispute is how much control MPT has over the day-to-day operations of the hospital. The parties to the lawsuit explicitly omit the agreements that underlie the lawsuit "for confidentiality reasons" so that once again, the details of these deals with real estate investors remain hidden from public scrutiny.[22]

In Secaucus, the for-profit owners of Meadowlands Hospital Medical Center, MHA LLC, took in $18M on the December 2012 sale of the property on which the hospital sits.[23] A little more than two years before, Navigant Consulting, at the request of the NJ Office of the Attorney General, had determined that the Fair Market Value of the Meadowlands real estate was between $10.7 and $11.3M.[24] The buyer in the December 2012 sale-leaseback was MHR Investments LP, an entity related to the RosDev Group, a Montreal-based real estate company with a track-record in Canada and the US that raises serious questions about its suitability as a landlord with influence over a community hospital. Their record includes a 14-year dispute with the Canadian government over a sale-leaseback agreement;[25] and a criminal indictment for dumping raw sewage in the Hackensack River that ended in a plea deal.[26]

These sale-leaseback transactions raise a number of disturbing questions that potentially have profound implications for both quality of, and access to, care. For example, MPT, in its 10K filed with the Securities and Exchange Commission, lists the following as key factors it considers in underwriting prospective tenants and borrowers, and in monitoring the performance of existing tenants and borrowers: admission levels; surgery/procedure/diagnosis volumes by type; current, historical and prospective operating margins; ratio of operating earnings to rent and to rent plus other fixed costs; payer mix; local competition; and demographics.[27] This compels us to ask:

- How does a real estate owner's consideration of these key factors impact access to care; staffing levels; decisions to add or close services; patient safety, and working conditions?
- What happens to the hospital if the real estate owner decides the hospital operator is in default of a provision of the lease agreement, a question being played out in the lawsuit between MPT and HUMC Holdco?
- What happens to our hospitals if the REIT (or another new property-owner) goes out of business, is sold, taken over, or files for bankruptcy?

SOLUTION

To protect access to and quality of care, and to provide transparency, public and regulatory scrutiny, and state government oversight of these transactions, we propose that:

- **DOH review these transactions, including track record review of the real estate investor in all jurisdictions in which it has holdings, with public review and comment.**
- **DOH add a CN Condition to all hospital license transfers requiring that when a sale-leaseback occurs during the time period in which a new hospital owner is required to maintain the facility as an acute care hospital, the seller-hospital place all profits from the sale into a healthcare foundation for the benefit of the community the hospital serves. Said profits should be considered those above and beyond any documented improvements made since the facility was purchased.**

Failure to Uphold Certificate of Need Conditions

The DOH has taken a shockingly casual approach to enforcing the very Conditions they set when approving a hospital license transfer. State regulations provide that CN Conditions become part of the license requirements of the hospital, and authorize the DOH to take licensure enforcement action against a hospital that fails to comply with these Conditions.[28] The DOH has a broad array of licensure enforcement remedies at its disposal, including civil monetary penalties; curtailment of admissions; appointment of a receiver or temporary manager; and license suspension or revocation.[29]

Once again, Meadowlands Hospital provides a case-in-point of the DOH's unwillingness to exercise its authority. The CN license transfer of Meadowlands Hospital Medical Center to MHA LLC sets out 18 Conditions regarding maintenance of services and community health programs and charity care; governance; community input; financial reporting; and employee retention and health insurance coverage. Among the Conditions are several that require periodic reporting by MHMC to the DOH.[30]

By June 2011 MHMC had already failed to comply with the letter or the intent of seven of the 18 Conditions placed on their license. HPAE cited these failures and potential threats to patient safety in a meeting with, and a follow-up letter to, the DOH calling for either "close and frequent scrutiny of operations" at the hospital or the appointment of an independent monitor to oversee operations and report findings to the Department and the public.

Since that time, the hospital's owners have continued to violate CN and other licensing requirements. During this same period, additional concerns over patient care and working conditions at MHMC frequently have been raised, and evidence of problematic financial practices and improprieties, including two IRS tax liens totaling $4.5M, have emerged.

HPAE and health advocates have repeatedly called for the DOH to use its enforcement powers to appoint a health care quality and financial monitor at the Meadowlands Hospital Medical Center. As further evidence of apparent financial improprieties and violations of federal and state laws and regulations mounted, NJ Appleseed Public Interest Law Center, on behalf of HPAE, wrote to the DOH in December 2012 setting forth the basis for requesting the appointment of a temporary manager to oversee the operations of the hospital and assure compliance with licensing standards. State Senators Joseph Vitale and Loretta Weinberg each sent their own letters calling for a temporary manager to be installed at MHMC. These requests have gone unanswered.

On the rare occasions when the DOH has assessed penalties against MHMC for violating CN Conditions, the penalties have been a fraction of what DOH regulations allow. CN Condition 11(c) requires MHMC to submit its annual audited financial statement (AFS) to the DOH no later than June 30th of the year following. On December 21, 2012, the DOH fined MHMC $1000 a month for six months for failing to file its 2011 AFS which was due June 30, 2012. DOH regulations authorize a penalty of $1000 a day for failure to implement a CN condition of approval.[31] The regulations allow the DOH to decrease the penalty assessed when there are mitigating factors.[32] By December 2012, MHMC already had a track record of failing to submit required CN and license renewal documents in a timely fashion. Nevertheless, when MHMC failed to pay the penalty within the required 30 days, the DOH merely sent another letter, on January 29, 2013 reiterating the $6000 penalty. The DOH sent a 60-day past due penalty reminder on February 20, 2013. When yet another 30 days went by and MHMC still had not submitted the 2011 AFS, the DOH raised the penalty to $2000 a month for the months of January through March 2013.[33] The hospital finally submitted the 2011 AFS on July 18, 2013 – 383 days past due. The DOH could have fined the hospital $383,000; instead, the DOH assessed MHMC $12,000. The message this sent to the hospital's owners was that the DOH did not take this CN violation very seriously.

Once again, in 2013, the MHMC failed to file its 2012 AFS by June 30, 2013. In a November 27th letter, the DOH notified the hospital it was assessing a penalty of $3000 per month, for a total of $12,000. For the first time, the DOH noted in its letter that it had the authority to assess a penalty of $1000 per day, which would have totaled $150,000, but did not explain why it gave the hospital a reduction. When the hospital failed to pay the $12,000 fine within 30 days, the DOH sent a 30-day past due letter to the hospital on December 30th and then a 60-day past due letter on January 30, 2014.

Instead of appointing a monitor or a temporary manager as advocates and elected officials had been requesting, the DOH reached an agreement with Meadowlands Hospital that they would hire an independent consultant to examine its financial records and systems, report on any deficiencies and concerns, and assess the hospital's current financial condition and viability through October 31, 2017.[34] The letter also stated that the Consultant "shall be required to provide all of its reports, findings, projections, operational and strategic plans to the Department and Meadowlands Board."[35] Of the three separate reports the DOH required, the first was due on August 17, 2013 and the second on October 1, 2013. Meadowlands Hospital did not submit either report, and on December 19, 2013 the DOH assessed a penalty of $31,000 against the hospital, and wrote: "Given the circumstances, the Department hereby requests that MHMC outsource payroll and billing functions to a nationally recognized firm with experience in payroll and billing services."[36]

Meadowlands Hospital is not the only example of the DOH's failure to enforce CN Conditions. When the DOH approved the transfer of the license to operate Bayonne Medical Center (BMC) to IJKG Opco in January 2008, the hospital was no longer providing OB services, having suspended the service in 2006. As part of approving the license transfer to IJKG Opco, the DOH placed the following Condition on the new owner:

> "6. Opco shall submit to the Department a quarterly progress report on their efforts to reinstate inpatient Obstetric and OB/GYN services with the reporting period commencing on the date upon which the certificate of need is approved. Within one year of the date of this approval, Opco shall have either reinstated these services or filed appropriate applications to the Department for their permanent removal."[37]

Four years later, BMC wrote to the DOH requesting approval to permanently close the hospital's Obstetrical Unit and remove the OB bed designation from its license. The justifications for the request included:

> "4. The previously DHSS approved CN for Bayonne Medical Center included a provision for the elimination of this service *if it could not be made profitable*"[38] (italics added)

The CN Conditions the DOH placed on IJKG Opco **did not** contain any provision for eliminating Obstetrics or any other clinical service or program based on its profitability. Nevertheless, the DOH approved IJKG Opco's request.[39]

SOLUTION

To protect patient care and working conditions, access to care and the integrity of the DOH's license transfer process, we propose that the DOH:

- **Appoint an independent monitor to oversee and publicly report on a new license holder's adherence to all CN Conditions.**
- **Assess the maximum penalty when a license holder violates a CN condition, unless one of the specific justifications for reducing the penalty exists, in which case the DOH should specify the basis for the penalty reduction in the penalty letter.**

Failure to Uphold Licensing Requirements

In February 2011, the DOH amended its hospital licensing regulations to eliminate its longstanding practice of conducting biennial licensing survey inspections, during which a trained, multidisciplinary DOH inspection team spent several days at a hospital assessing compliance with state licensing standards. Instead, the DOH now only requires hospitals submit a "regulatory compliance statement" (RCS) with their license renewal application. DOH regulations define the RCS as:

> "…a submission to the Licensing Office consisting of:
>
> 1. A written attestation on facility letterhead, signed by a facility's chief executive officer, stating that the facility is in compliance with the requirements of this chapter and that the facility will continue to remain in compliance during the term of the license;
> 2. A copy of documentation of a facility's certification by, or accreditation from, an accrediting body recognized by the Centers for Medicare and Medicaid Services (CMS); and
> 3. Upon request of the Licensing Office, a copy of the accrediting body's most recent report of its survey of the facility and recommendations for corrective actions, and a progress report of all corrective actions the facility has taken in response to the accreditation body's report."
>
> Source: N.J.A.C. 8:43G-1.2

To comply with CMS requirements hospitals can select which company they wish to be inspected and accredited by. Two of the accreditation companies are not-for-profit and two are for-profit. In all cases, the hospital is paying the accrediting organization for the inspection. A hospital unhappy with one of the accrediting companies can always switch to another of the four CMS-approved companies. And while healthcare consumers, elected officials, and hospital employees previously had ready access to the results of DOH survey inspections, the results of current accreditation surveys are considered proprietary and are not made available to the public.

Up until several years ago, complaint inspections and any related penalty and enforcement letters were readily available on the DOH website. Now, an interested person has to file an Open Public Records Act request to review the results of complaint inspections. In addition, before the DOH will publicly share inspection results, the DOH has repeatedly changed its policy as to whether the requestor first must wait for the hospital to file its Plan of Correction and have the DOH approve that Plan.

The CMS-approved accrediting companies are assessing compliance with Medicare Conditions of Participation, however not all NJ hospital licensing standards, including those related to safe patient handling and workplace violence prevention, are covered by the CMS Conditions of Participation. The DOH pretends to address this gap with the first RCS requirement – an attestation by the hospital CEO that the facility is, and will remain, in compliance with NJ licensing standards.

Meadowlands Hospital Medical Center (MHMC) provides a disturbing example of the problem with relying on CEO attestation of compliance rather than DOH inspection.

The hospital's 2013 RCS, signed by CEO Lynn McVey on Feb 7, 2013, attests to the hospital's adherence to all state and federal laws, rules and regulations despite overdue financial statements and DOH citations. Nevertheless, The DOH renewed MHMC's license on March 18, 2013.

SOLUTION

To assure meaningful oversight and enforcement of hospital compliance with licensing laws and regulations, we propose the DOH:

- **Resume conducting its own biennial licensing survey inspections;**
- **Restore its former practice of posting survey and complaint inspection findings and enforcement letters on the DOH website;**
- **Include workers and advocates during all inspections.**
- **Require hospitals to routinely submit the reports from their accreditation surveys and make these reports publicly available.**

Failure to Enforce Healthcare Worker Safety and Health Protections

Injuries caused by patient lifting and transferring tasks and by patient-on-staff violence are among the leading causes of occupational injury and workers' compensation and related costs in New Jersey healthcare facilities.

In 2007, New Jersey enacted two strong laws protecting healthcare workers and their patients from the hazards of workplace violence: the "Violence Prevention in Health Care Facilities Act" (P.L. 2007, c. 236), and unsafe patient lifts and transfers, the "Safe Patient Handling Act" (P.L. 2007, c. 225), covering hospitals, nursing homes, state and county psychiatric hospitals and developmental centers.

The laws and their implementing regulations, adopted in 2011, include elements health and safety experts have identified as being essential for the success of ergonomic and violence prevention programs, notably:

- Frontline worker participation in a joint worker-management committee that oversees all aspects of the program;
- Policies and procedures to minimize risk;
- Periodic risk assessments;
- Worker education and training;
- Reporting and recordkeeping provisions; and
- Protection from retaliation for workers exercising their rights under the law.

Reports from NJ healthcare unions and informal surveys of both Registered Nurses in NJ and HPAE leaders reveal compliance with these laws and regulations is extremely uneven.

In contrast to their counterparts at other facilities, nearly 40% of local union leaders at HPAE represented facilities reported they have a joint worker-management safe patient handling committee and over half reported a joint violence prevention committee. Training on the use of safe patient handling equipment is taking place during paid work time at over 90% of HPAE-represented facilities, and more than three-quarters of these facilities are providing annual violence prevention training as required under the law.

The DOH has not conducted any outreach to either covered facilities or facility employees to inform them of their rights and responsibilities under these laws.[40] The DOH no longer conducts routine licensing survey inspections and, to our knowledge, none of the accrediting companies whose inspections the DOH relies upon, requires hospitals to have joint worker-management committees to oversee their safe patient handling and violence prevention programs, the core mandate of both laws.

Fewer than one-quarter of NJ nurses responding to an online survey commissioned by HPAE in 2013 reported that their facility had the required safe patient handling and workplace violence prevention committees. Less than half reported receiving the requisite training under either law.

SOLUTION

To protect both healthcare workers and the patients they care for, we propose the DOH:

- **Undertake an outreach initiative to covered employers and employees, including providing educational materials and programs detailing the provisions of the Safe Patient Handling and Violence Prevention in Health Care Facilities regulations, as well as employer penalties for non-compliance.**

IN CONCLUSION

Caregivers, patients and our communities deserve a state government that protects their rights and safety. The failures of the NJ Department of Health to uphold and enforce standards for accessible, affordable and quality health care are having a substantial impact on our lives and our health, as well as on the high costs of health care. It is time for our State's elected officials to act, to restore transparency and accountability to government, as well as to the healthcare system New Jersey's residents depend upon.

APPENDIX

1. NJ Hospital Conversions

Hospital	City/County	Date	Buyer/Pending buyer
Bergen Pines (now Bergen Regional Medical Center)	Paramus/Bergen	1997	Solomon Healthcare Services (Manager)
Memorial Hospital of Salem County	Mannington/Salem	2002	Community Health Systems (CHS)
Mountainside Hospital	Montclair/Essex	2007	Merit Health System
Bayonne Medical Center	Bayonne/Hudson	2008	IJKG LLC (now part of CarePoint Health)
Meadowlands Hospital Medical Center	Secaucus/Hudson	2010	MHA LLC
Hoboken University Medical Center	Hoboken/Hudson	2011	HUMC Opco (part of CarePoint Health)
Pascack Valley Hospital	Westwood/Bergen	2012	LHP Hospital Group (with Hackensack U Med Ctr)
Mountainside Hospital (part of Merit Health System)	Montclair/Essex	2012	LHP Hospital Group (with Hackensack U Med Ctr)
Christ Hospital	Jersey City/Hudson	2012	Hudson Hospital Holdco (now CarePoint)
St. Mary's Medical Center	Passaic	Pending	Prime Healthcare
St. Michael's Medical Center	Newark/Essex	Pending	Prime Healthcare
St. Clare's Health System (3 hospitals)	Morris County	Pending	Prime Healthcare
Raritan Bay Medical Center	Middlesex	Pending	Prospect Medical Holdings

2. Provisions of Monitor Law

"Early Warning System/Monitor Law" Provisions

The law gives the DOH the authority to:

- Inquire about a hospital's financial resources and sources of future revenues;
- Provide hospitals with consultation and assistance;
- Appoint a monitor "for a hospital that is in financial distress or at risk of being in financial distress";
- Participate in the development and oversight of corrective measures for hospitals with financial or potential financial difficulties.

The law requires the DOH to issue regulations, guided by the Reinhardt Report, that specify:

- Indicators of financial health and the threshold levels that trigger DOH intervention; and
- The progressive levels of monitoring and DOH intervention to resolve financial or potential financial distress, including the levels of involvement by a monitor.

The DOH has failed to issue regulations implementing the Monitor Law. The Reinhardt Report recommended three progressive levels of monitoring and intervention:

Level One Monitoring:

- Monitor attends meetings of board of trustees and key board committees;
- Monitor can meet with key employees or board members;
- Within 30 days of monitor's arrival, management and board must prepare a Management Action Plan (MAP);
- Monitor meets monthly with management and key board members to review MAP implementation and results; and
- If no "material improvement" in is reached key indicators within 3 months, Level 2 imposed.

Level Two Monitoring:

- Monitor has full voting power at board and committee meetings;
- Monitor holds bi-weekly meetings with management and key board members to discuss progress and results of MAP; and
- If 6 months have passed since MAP was adopted and key indicators have not "materially improved," Level 3 imposed.

Level Three Monitoring:

- Monitor has full veto power over actions at board and committee meetings;
- Monitor has weekly meetings with management and key board members to discuss MAP; and
- If 9 months have passed since MAP was adopted and key indicators have not materially improved, Intervention is imposed.

Intervention: Includes Level 3 Monitor, plus Level One Intervention

- Hospital is required to hire independent consultant to prepare report with recommendations addressing operations, management and governance;
- Hospital required to implement recommendations or hire consultant to implement recommendations; and
- Weekly or biweekly meetings of monitor, consultant, management and key board.

Level Two Intervention

- If key indicators have not "significantly improved" after 6 months, or if the Monitor believes management or its board is interfering with the implementation of the consultant's recommendations, State may ask hospital to replace members of management team or governing body.

Level Three Intervention

- If hospital is not "well on its way to financial recovery" in 12 months, State may replace entire management team or entire board, or direct the hospital to find a strategic partner, be sold, or close.

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AFTERWORD

"The state of New Jersey is failing in its duty of protecting vulnerable citizens from poor service and taxpayers from wasted funds. At the core of the problem is a complete lack of priority given to oversight.

The findings of this report that the Department of Health failed to conduct license renewal inspections of state hospitals or to ensure that hospitals complied with standards set as a condition of their purchase or conversion to for-profit status, further demonstrate that we have an oversight crisis in the state of New Jersey. New Jersey's failure to use its own monitoring and enforcement powers has placed healthcare consumers, hospital patients, employees and the institutions themselves at risk. As taxpayers of New Jersey we should all be concerned about how our tax dollars are being spent – lack of oversight over healthcare expenditures could leave us all poorer and sicker.

Quality oversight should be seen not as a luxury to be dispensed with in the face of austerity but as an inseparable element of good government. We must drastically improve the quality of the state's oversight of its programs and services in order to make it a better steward of the public interest."

– Janice Fine, Associate Professor, Labor Studies and Employment Relations, Rutgers University

– Patrice Mareschal, Associate Professor,
Department of Public Policy and Administration, Rutgers University
Co-authors of "Overlooking Oversight: A Lack of Oversight in the Garden State is Placing New Jersey Residents and Assets at Risk"

"This report accurately captures the frustration of health care advocates with respect to the Department's seemingly truncated view of their statutory and moral obligations to regulate, plan, and ensure access to quality, safe and affordable health care services to residents of New Jersey, especially at the juncture where the Legislature has given it the authority to grant or deny a for-profit entity the privilege of owning and operating a charitable community hospital."

– Renee Steinhagen, Director, New Jersey Appleseed

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