
Public Hearing

before

SENATE LEGISLATIVE OVERSIGHT COMMITTEE

SENATE HEALTH, HUMAN SERVICES, AND SENIOR CITIZENS
COMMITTEE

“The Committees will meet jointly to receive testimony from invited guests concerning the recent trend in which not-for-profit hospitals are converted to for-profit entities in the State, and whether the need for oversight of such conversions by independent monitors is warranted”

LOCATION: Committee Room 1
State House Annex
Trenton, New Jersey

DATE: May 20, 2013
1:00 p.m.

MEMBERS OF COMMITTEES PRESENT:

Senator Robert M. Gordon, Chair
Senator Joseph F. Vitale, Chair
Senator Barbara Buono, Vice Chair
Senator Fred H. Madden Jr., Vice Chair
Senator Ronald L. Rice
Senator M. Teresa Ruiz
Senator Jim Whelan
Senator Dawn Marie Addiego
Senator Diane B. Allen
Senator Thomas H. Kean Jr.
Senator Robert W. Singer
Senator Samuel D. Thompson



ALSO PRESENT:

Elizabeth Boyd
*Office of Legislative Services
Committee Aide*

Eugene Lepore
Francisco Maldonado
*Senate Majority
Committee Aides*

Christine Shipley
*Senate Republican
Committee Aide*

***Hearing Recorded and Transcribed by
The Office of Legislative Services, Public Information Office,
Hearing Unit, State House Annex, PO 068, Trenton, New Jersey***



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Chairman

BARBARA BUONO
Vice-Chair

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PAUL A. SARLO
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New Jersey State Legislature

SENATE LEGISLATIVE OVERSIGHT COMMITTEE
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PUBLIC HEARING NOTICE

The Senate Legislative Oversight Committee will hold a public hearing on Monday, May 20, 2013 at 1:00 PM in Committee Room 1, 1st Floor, State House Annex, Trenton, New Jersey.

The public may address comments and questions to Michael R. Molimock, Committee Aide, or make bill status and scheduling inquiries to Sherri M. Hanlon, Secretary, at (609)847-3855, fax (609)292-0561, or e-mail: OLSAideSLO@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

The committee will meet jointly with the Senate Health, Human Services and Senior Citizens Committee to receive testimony from invited guests concerning the recent trend in which not-for-profit hospitals are converted to for-profit entities in the State, and whether the need for oversight of such conversions by independent monitors is warranted.

Issued 5/13/13

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PUBLIC HEARING NOTICE

The Senate Health, Human Services and Senior Citizens Committee will hold a public hearing on Monday, May 20, 2013 at 1:00 PM in Committee Room 1, 1st Floor, State House Annex, Trenton, New Jersey.

The public may address comments and questions to Elizabeth Boyd, Committee Aide, or make bill status and scheduling inquiries to Alice Murphy, Secretary, at (609)847-3860, fax (609)943-5996, or e-mail: OLSAideSHH@njleg.org. Written and electronic comments, questions and testimony submitted to the committee by the public, as well as recordings and transcripts, if any, of oral testimony, are government records and will be available to the public upon request.

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SENATOR ROBERT M. GORDON (Chair): Good afternoon, everyone.

Welcome to a joint meeting of the Senate Health Committee and the Senate Legislative Oversight Committee.

May I have a roll call, please?

MS. BOYD (Committee Aide): Yes. Since many of the members are on both Committees, I will just run through each person one time.

Senator Thompson.

SENATOR THOMPSON: Here.

MS. BOYD: Senator Addiego.

SENATOR ADDIEGO: Here.

MS. BOYD: Senator Singer is here.

SENATOR SINGER: Here.

MS. BOYD: Senator Madden.

SENATOR MADDEN: Here.

MS. BOYD: Senator Vitale.

SENATOR JOSEPH F. VITALE (Chair): Here.

MS. BOYD: Senator Gordon.

SENATOR GORDON: Here.

MS. BOYD: Senator Whelan.

SENATOR WHELAN: Here.

SENATOR VITALE: Senator Rice is in the building.

SENATOR GORDON: Well, good afternoon everyone, and welcome to this joint hearing of the Senate Legislative Oversight Committee and the Senate Health Committee.

We are meeting today on an issue of tremendous importance to communities throughout the state -- namely, the growing trend towards the privatization of hospital facilities in New Jersey. The timeliness of this hearing, I think, is indicated by today's *Bergen Record*, whose lead story refers to for-profits cashing in on hospital land.

According to the American Hospital Association, approximately 20 percent of community hospitals in the United States are for-profit entities. In New Jersey, the number of for-profit hospitals has increased from zero in 2002 to six at present -- and more conversions are on the horizon. In a few days, Pascack Hospital in Westwood will reopen as a joint venture between Hackensack University Medical Center and a private investment group. Prime Healthcare of California, we are told, will acquire five hospitals in North Jersey, including Saint Mary's in Passaic, Saint Michael's in Newark, and Saint Clare's in Morris County.

These developments raise important concerns in public policy issues. For example: How can we ensure that return on investment does not eclipse community mission? Second, do State regulators have adequate tools and resources to monitor the growing number of for-profit hospitals? Three, are new laws and regulations needed to protect consumers and payers from excessive charges and to ensure adequate reinvestment in facilities? And finally -- and certainly not lastly -- is more transparency needed in financial reporting? These are some of the issues we want to address today.

First and foremost, on behalf of Senator Vitale and members of both Committees, I want to stress that we are here in an information-gathering capacity. We have convened this meeting to hear from witnesses

representing many of the stakeholders -- as many stakeholders as possible to get a full picture of this important topic.

We have representatives from a number of groups today. And I should say at the outset that we had extended invitations to a number of persons representing both for-profit and not-for-profit hospitals, and a number of those people were not able to attend today. But we will certainly give them an opportunity to have input in the process.

With that, Senator Vitale, would you care to say something?

SENATOR VITALE: Thank you.

Good afternoon, everyone.

I should first start out by picking up where Senator Gordon left off -- which is my frustration with a few of the entities who provide care in the state. We invited -- and we expected to come -- someone from the Hospital Association. They called today and, at the last minute, could not be here. We invited a representative from the New Jersey Hospital Alliance, an organization that represents mostly (indiscernible) hospitals, and we expected them to come, or their representatives; they are not here today. We also invited CarePoint -- formerly known as Hudson Holdco -- the company that owns Bayonne, Hoboken, and Christ hospitals. They declined to come. The others were invited, and we expected them to be here and, at the last minute, said they couldn't be here -- or wouldn't be here. We do have written testimony, though, from the Hospital Association.

With respect to Hudson Holdco -- now CarePoint -- who owns three for-profit hospitals in New Jersey, their unwillingness to be here is disturbing.

I want to thank those from Prime who are here today -- who are really not yet in New Jersey. They are hoping to be here with the acquisition of several hospitals. But for those hospitals that are owned by a for-profit -- they are not here.

And Senator Gordon raises some good issues about today's press. Last week's press -- *New York Times* -- with respect to the charges at Bayonne -- being, in some ways, the most expensive hospital in the country. And that's what we have questions about. We won't pass judgment until we hear what the answers are. We don't have the opportunity to ask those questions publicly or to have them answered publicly. But both Prime and Holdco, as well as the company that now owns Mountainside, have had plenty of discussions in New Jersey -- both with the Administration and with other administrative entities; not with the Legislature publicly. And that's part and purpose of today's joint hearing.

Every member of this Committee -- on the Health Committee and Legislative Oversight, many of them overlap as well; and welcome, Senator Kean, for being here--

SENATOR KEAN: Welcome back, right, to the Health Committee room.

SENATOR VITALE: Welcome back to the Health Committee room. You care deeply about the issues in New Jersey -- healthcare issues; Senator Rice, one of the deans on this Committee who has his own issues in the City of Newark that he represents. He has questions that he needs to have answered as well. And we don't have those entities here today. This won't be the last time we'll have a hearing now; and we'll make sure that they come -- even if it is kicking and screaming. They should be here to

publicly explain what they're doing in New Jersey. Their lack of attendance today, from my perspective, speaks volumes.

We have several, though, individuals who represent a variety of organizations from around the state who have agreed to come. And we're going to try to keep this to five minutes per presentation, if that's possible, so we can have follow-up questions from the members. But as time permits, we may provide you with more of an opportunity.

First up would be Joe Scott from Jersey City Medical Center.

Joe, do you have anyone with you, or just you?

J O S E P H F. S C O T T: (off mike) Just me.

SENATOR VITALE: Thank you.

MR. SCOTT: Although maybe I should have brought somebody from Barnabas Health.

On Thursday, Jersey City Medical Center--

SENATOR VITALE: Hold on one second. Let's just get you on so you can be recorded. Thank you.

MR. SCOTT: Okay.

Good afternoon, everybody. Thank you for inviting me to be here today.

I don't think anybody's dealt with the for-profit issue more than I have in the last five years. If you had asked me five years ago, would Hudson County have a majority of the hospitals be for-profit, I would have thought there was no way that could possibly happen. On Thursday-- The good news is -- for Hudson County -- on Thursday we made an announcement that we would be merging with Barnabas Health and we will

remain a not-for-profit healthcare institution, continuing to serve all the residents of Hudson County.

But I came here today to really talk about what I think are some real issues around -- especially around out-of-network and transparency. The out-of-network issue, I think, ends up costing everyone more for health care. As you all-- I hope you all had a chance to read the *New York Times* article where they talked about Bayonne having the highest charges. Finally, someone got the reason why they have the highest charges -- and that's because, in New Jersey, the patient comes to the emergency department; the hospital does not have a managed care contract -- then that hospital can turn around and charge the managed care company their charges. And that's essentially what Bayonne has done. I think that's a significant issue for everyone to be concerned about. And I come here not to just discuss that issue, but to also offer a solution.

In the future we should be looking at that legislation to really look at how hospitals negotiate with managed care contracts and, if they're out-of-network with more than half of the managed care contracts in the area -- and 80 to 90 percent of their patients come through the emergency department -- then the amount of money that they can charge that managed care company should be capped.

Now, the two things we have to be very careful about here are, one, preserving the ability for hospitals to negotiate fairly with managed care companies. For example, we are out-of-network right now with Aetna; we've been trying to get them back to the table for two years. They were paying us less than what it cost us to take care of their patients. I think they finally-- It's interesting. After we made the Barnabas announcement, I

think they're coming back to the table. So I think that's key -- that you preserve the ability of a hospital to continue to have negotiating power.

And the other thing is you have to be very careful about what the impact of these kinds of charges and payments from managed care contracts are to the consumer. Healthcare costs and healthcare insurance in Jersey City and Hudson County has risen significantly, and we believe it's because of the direct impact of this out-of-network strategy employed by some for-profit hospitals.

The other issue that I think is really important is to talk about transparency. I actually gave you a handout that lists the reporting requirements for not-for-profit hospitals, publicly traded for-profits, and privately held for-profits.

So Hudson Holdco's privately held for-profit is owned by three gentlemen; Meadowlands Hospital is a privately held for-profit. Publicly traded for-profits have SEC reporting requirements -- and I actually gave you all a copy of what the different reporting requirements are. I think what you'll see, very clearly, is there is certainly a higher burden of reporting and transparency -- first for for-profits (*sic*); the second for publicly traded for-profits; and the least amount of transparency in reporting is around privately held for-profits. So I think that's a key issue, as we move forward. I know there was legislation last year that talked about having more transparency in public reporting of information. But that was not passed by the Governor -- or signed by the Governor.

So those are the two issues that I think are important as you think about what those issues are surrounding for-profits coming into New Jersey.

I will make one other comment. In Florida-- I came from Florida five years ago, and I was the CEO of a large, public hospital in Fort Lauderdale. And we competed against publicly traded for-profits like HCA and Tenet. I learned more about the business of health care by competing against those hospitals. And those hospitals really do serve their community. And so I think there are legitimate for-profits that can come into New Jersey and serve the community well, and do it ethically and at the highest level. I think the concern that you begin to have, and where I think the most scrutiny needs to be, is around these individually owned investor hospitals -- where we're not sure where that money is going.

The other key issue is they also receive charity care. For them to be able to receive charity care and have no public reporting requirements I think is frightening, and I think they should be held accountable just like every other hospital in New Jersey is -- where we have to account for the monies that we receive especially when it's public monies.

SENATOR GORDON: Thank you very much.

Any members of the Committee--

Senator Singer.

SENATOR SINGER: First of all, I want to make just one disclosure so there is no misunderstanding. My wife is the Senior Vice President of Saint Barnabas.

MR. SCOTT: Oh; oh, great. Thank you.

SENATOR SINGER: So congratulations. But I didn't want you to think I'm in a conflict by saying that.

That being said, you know, my concern -- like many other member's -- that we're seeing that hospitals that are in financial straights

are being picked up by for-profits; and, all of a sudden, miraculously are turned around. And that's a question I don't have an answer to -- that I think we have to know why. I mean, here are these hospitals that were not-for-profits for years -- struggling, providing service to people, doing the best they could. And, in many cases, suddenly they were faced with either closing the hospital or being bought and taken over.

You know, I understand that we're going to see, down the road, probably four, or five, or six large hospital systems in the whole State of New Jersey -- and that might be the future of where we see because you mentioned something about managed care. Why did managed care come back to the table? Because now you have a network of hospitals throughout the state, and that is, kind of, how you fight them. If you have a network of hospitals, they can't say no when you're that big because then it cuts out how they can serve their patients. So that's one tool that's being used to offset the managed care dollars.

But I think, more so, where I think we all have concern -- at least I do -- are they making money by sacrificing patients' care? And that's something we have never gotten a clear answer about. I mean, how do you suddenly turn a hospital around -- not just with out-of-network -- but how do you turn a hospital around to make money where not-for-profits couldn't that weren't paying taxes on the properties, weren't paying profit taxes -- all the other expenses that go along with being a for-profit to a nonprofit -- yet miraculously, in the same neighborhood, they're making money. And there are one or two things: either they're not giving the service and the patient is not getting what they should be getting, or they're

not serving all the patients or doing it properly, or they're shortchanging the employees, or some miraculous thing that we should all want to learn from.

So I agree with you about one thing -- we have to be open minded in wanting to learn, as you said -- and so well put -- that competition is good, and you meet the challenge and you find new ways to do things. I don't think anybody is against that. I think the concern that I have is I don't want to see that patients and then employees are the brunt of what is happening.

MR. SCOTT: I think if there was transparency around this issue you would be able -- I would be able to answer those questions for you. But we don't know how much they're getting paid. I've heard different numbers -- for example, they get \$30,000 an admission; I get \$3,000 an admission. Well, for \$30,000 an admission, I could walk away with a \$20 million, \$30 million bottom line very, very easily.

The other thing is I also think it's about good management. I came to Jersey City Medical Center five years ago. The hospital was ready to close. And nobody would've looked at us. We tried finding partners. But we put a good management team in place and really focused on what's important from a safety, quality engagement; from our patients, our employees, and our physicians -- and really turned the hospital around, economically, to the point where everyone said to me, "You should keep asking for stabilization dollars." And this year we finally said we didn't need stabilization dollars, moving forward. But that's about good management and about making sure of taking care of the community in the long run. And I think if there was transparency around this issue, you would have the answer to your question about where is the money coming

from. I think there are a couple of things: one, there's a real estate deal; and two, there's the out-of-network. And it's significant -- there are significant dollars there. And the dollars are going to individual investors.

SENATOR SINGER: Just one follow-up.

You know, somebody said this, and it's very true. We have to be fair about it. Senator Vitale was very involved in that -- years ago -- in this, too, as he headed the Health Committee. We could never allow Jersey City Medical Center to fail. It is too vital to that community, and that's a safety-net hospital. So the answer is, I think the State recognized that also and helped out financially. I know Joe was a leader in that, and I appreciate that. Because you can't have that happen. And we realize there are safety-net hospitals throughout (indiscernible). The problem you had, like many hospitals, is that you're payer-mixed.

MR. SCOTT: Yes.

SENATOR SINGER: It wasn't quality of care, it wasn't not-- It was just payer mix. And we have to realize that Jersey City is turning around and you're going to have a better payer mix. But through those hard times, it just wasn't there.

MR. SCOTT: Well, 49 percent of our patients are still charity and Medicaid -- and we did it. And we attract a lot more patients with insurance, though, also.

SENATOR GORDON: Anyone else on the Committee?

SENATOR KEAN: Yes.

SENATOR VITALE: Senator Kean. Oh, I'm sorry -- does someone else--

SENATOR GORDON: Just a follow-up question -- you mentioned that patients being admitted through the ER--

MR. SCOTT: Correct.

SENATOR GORDON: --if they're out-of-network the payer has to pay the charge.

MR. SCOTT: Right.

SENATOR GORDON: I have heard that there has been a conscious effort to, really, channel patients through the ER. Can you comment on that?

MR. SCOTT: Well, and again, I think if this were a transparent issue, we wouldn't be guessing about what that number looks like. But, anecdotally -- and it's only anecdotally -- I can tell you that pregnant women get admitted through the emergency department, according to some physicians -- and they're deemed emergency admissions because they're bleeding or they have pain. Well, of course they have pain; they're going into labor. But they go through the ER, and then they get the out-of-network rate. So there's a lot of, I think, those kinds of anecdotal stories that people will tell you.

I will tell you if we did have an opportunity to look at some other statistics -- rate statistics for any for-profit coming into the area -- it would be data that all hospitals collect on, and that is patients who are left without being seen in the emergency department. The national standard is -- it should be less than 2.5 percent for every hospital. So it would be interesting to look at that by payer mix; but again, we don't really have that transparency.

SENATOR VITALE: Mr. Scott, I think that part of the reason that we're here today, too, is because we don't have-- We haven't had the public discussion about for-profits, but we do have some experience -- which is one of the reasons why it is we're here as well. And Meadowlands Hospital in Secaucus is a for-profit.

MR. SCOTT: Yes.

SENATOR VITALE: We had no experience with that ownership group prior to their acquisition of what was formerly Liberty Hospital in Secaucus.

MR. SCOTT: Yes.

SENATOR VITALE: And since that time -- at least in my experience -- that they have not acted in the best interests of those who pay premiums, those who receive care. They are important to the community as an emergency room, but it doesn't seem to me a place where people schedule their surgeries as much as some of the surrounding hospitals. They have been found in violation by the Department of Health on several occasions; have failed to cure those issues. They have liens from the Federal government and others for not paying their taxes. And recently they entered into a land -- lease swap with a company from Canada -- those in the business of doing this kind of work -- those kinds of transactions. And so while the dollar amount escapes me, it's many millions of dollars for the--

MR. SCOTT: I thought it was \$18 million.

SENATOR VITALE: Eighteen million for the property. Does that include the building, or just the land under the building?

MR. SCOTT: It's the land.

SENATOR VITALE: The land under the building. So the purchaser of that property is the same company that owns what's formerly the Crown Hotel--

MR. SCOTT: Next door.

SENATOR VITALE: --next door.

MR. SCOTT: Yes.

SENATOR GORDON: Which dumped the sewage.

SENATOR VITALE: Which dumped the sewage in the river -- right; for which they were fined.

So being cynical, a little bit, I wonder in the future what that means to that land and what that means to that hospital if it is that hospital ultimately fails. The company that owns that land, acquires the property, it's probably not out of the question that they would expand their hotel chain. Or with the Mall of America (*sic*) coming nearby, maybe it's an opportunity for them. And I don't know what their motive was, but it is that the money that they received from that lease -- or from the sale in a lease-back -- we don't know where that money went. And Senator Weinberg is here, and this afternoon I'm going to ask her, after you speak, to explain her transparency bill. But some of the information that would be provided, if they follow the same rules as not-for-profits, we might learn not just-- We know how much it was; but who received the money, how it's going to be spent by the hospital -- will they be paying off the debt? Will it be improving the infrastructure of the facility? Will it be paying back their investors? And what does it mean to the community? Will they be using some of that money to invest in services and infrastructure to better serve

that area of the state? We don't know -- and no one is saying. We can only wonder what the answer is.

MR. SCOTT: Again, I think you go back to, "Where's the transparency? What happens to that money?" We're apparently suing Meadowlands Hospital for monies that they owe us also, as part of the transaction. So, you know, I agree with you -- I don't know where that \$18 million went. I don't-- It sounds like they've had a whole host of issues around everything from IRS liens to not paying their bills. And we're--

SENATOR VITALE: Alleged fraud.

MR. SCOTT: Yes.

SENATOR VITALE: So they're -- a lot of that.

MR. SCOTT: Yes.

And so when you ask, "Is there a need for oversight?" Well, certainly it looks that way.

SENATOR VITALE: Well, it seems to me -- and just to take a little bit more of your time -- when you think about a for-profit entity, for example -- and the Meadowlands as an example -- it seems to me, at least, while it is that they have to have a functioning hospital that serves the community in order to maintain their license and to get patients to come to their facility, the money that they receive in terms of investment-- So the investor group that purchases the hospital, made some improvements to the facility. But when it is that the money -- when revenue came into the hospital, whether from a land swap -- land deal -- but before that other ways in which they made their profits -- the money immediately went back to the investors and very little went back to the facility. Some checks were bounced to their employees -- they couldn't get paid on time -- checks they

did receive bounced. And so my perception is that they have a for-profit motive first, which is we make our money first, we make it back first, we take care of our debt first. And that always seems to be first in line before it is patient care and the well being of the hospital as a long-term investment so that they can maintain their standing in the community. And that's what matters most. It's not an opportunity for someone to come in, buy a hospital, improve it, flip it, make a profit, pay themselves back -- with interest, by the way -- and then flip the hospital, or get rid of it or something else. So that's-- One of our concerns of that for-profit model -- that's our experience with for-profit models in New Jersey, except for Salem and Mountainside. But that seems to be what could be the worst of it, where that's -- their first priorities are paying themselves back with interest and then seeing what happens. That doesn't happen, generally, in the not-for-profit world because their mission is different.

MR. SCOTT: I think what you have to be concerned about, and I think if you're looking for a priority list of oversight, it was to be based on what the model of ownership is. I think when you have these single investor-owned, non-publicly traded companies coming into New Jersey, where the profits go to the shareholders before they end up going back to the hospital, making sure that what needs to be taken care of gets taken care of -- I think that's key, as you move forward. And so I think you have to be careful about looking at who's coming in, what their model is, how they operate, and, really, where the source of revenue is coming from to purchase the facility and how that-- You know, what's the motivation for buying the hospital? Is it to serve the community or is to serve individual investors? I think that's key.

SENATOR GORDON: Just a follow-up question.

In the *Record* story today, I seem to recall there was a suggestion that there be a requirement that a certain percentage of the assets that are removed from the entity be reinvested in the facility or care. What do you think of that idea?

MR. SCOTT: Oh, well, absolutely. These were all not-for-profit hospitals serving a sometimes very poor patient population. And so there should be absolutely a mandate on how much of that money actually goes to the investors, and what gets turned back into the facility. I mean, every year we spend about \$10 million in capital. Now, some of those-- I've looked at both Christ Hospital and Hoboken as we actively bid to try to take those over as part of Jersey City Medical Center. And, let me tell you, the infrastructure for both of those hospitals needs a lot of work. So when you sell the real estate, you need to reinvest. And I don't know what that number is, again because we don't have that transparency and, obviously, they're not here today to talk about that.

SENATOR GORDON: Does anyone else on the Committee--
Senator Kean.

SENATOR KEAN: Thank you.

Thank you, Mr. Chairman, Mr. Chairman.

Sir, it's good to see you; congratulations on the good news that you announced last week. It's an extraordinary partnership that will better serve all the citizens of New Jersey. So I guess-- I think you should be congratulated on your leadership.

You said earlier that you came from a situation in Florida where there was a great deal of private sector hospitals, a great deal of competition.

MR. SCOTT: Yes.

SENATOR KEAN: You came to your current post five years ago, and turned it from a \$40-some-odd-million annual loss to, this year, a tens of millions of dollars -- I won't say profit -- but, over a five-year-period; -- and you said there was some management issues--

MR. SCOTT: Our revenues exceeded our expenses.

SENATOR KEAN: Yes, your revenues exceeded-- (laughter) You went from one direction -- through the Chair -- through to the other; now it's five years.

MR. SCOTT: That's right.

SENATOR KEAN: And I think that's an extraordinary testament, again, to your leadership skills and how, over the last five years, the residents of the region have been very, very well served. And maybe one of the Chairmen took part of the question, but what is it that we need to look out for? You're saying that you had a robust, competitive system in Florida that in some instances it worked to add more competition in the end to serve the patients in a very significant way. We had a mixture of for-profit, nonprofit, governmental hospitals, community hospitals to experience here in New Jersey. What do we need to look out for, what do we need to-- What are our next steps?

MR. SCOTT: You know, when there are public reporting requirements, I think that in an organization--

SENATOR KEAN: And if I may -- through the Chair -- can you answer if Florida has some of those standards? After you look at the comparison, does Florida have those types of transparency issues, those types of--

MR. SCOTT: Well, the hospital that I was employed by was actually a tax-supported facility. So we were actually a public hospital. Everything we did was in the sunshine. So that has a whole other dimension to it.

But I think the real question becomes, if there are no reporting requirements, if there's no reason for a hospital to be transparent, then they can do the things that we're concerned about here. You know, they can sell the property and turn around and take that money and do whatever they want with it because there's nobody looking at where that money is going. So I think that's the key. I think, as we move forward, there needs to be some oversight when there's no public reporting requirement -- or that there's very little public reporting requirements.

And once there is some scrutiny, then I think things start to change. And I think that's a key issue, as we move forward. Those transparency issues are vital to-- I understand the community's concern when you're talking about closing a hospital. Every community -- every time there's a hospital closing -- stands up and says, "You can't close my hospital." And you know, I understand the emotion around that. At the same time, is it better to--

SENATOR KEAN: I mean, Muhlenberg is in my backyard.

MR. SCOTT: Yes, yes. And nobody wanted that hospital closed.

SENATOR KEAN: And that, as well as the portion of -- in Union -- when Overlook came in there as part of the (indiscernible) chain. I mean, that whole-- The dynamic there was-- I mean, both as patient care but also from an employer's perspective.

MR. SCOTT: Right. But the question becomes, "At what cost?" And at what benefit to a couple of individuals to save a hospital that ends up costing everyone more money? And I think that's key; I think that's the argument.

SENATOR KEAN: Right. That's the application process. So part of that analysis -- you wouldn't want to (indiscernible). It has to be that.

MR. SCOTT: Sure. I think-- And we've learned. This is all new to New Jersey, obviously, you know? Before this happened, with Bayonne Hospital, no one ever thought about buying a hospital, turning around a real estate deal, and then taking the money and doing whatever they do with it.

SENATOR KEAN: Are there other states, do you know, that have done it right, in your opinion -- that you know of?

MR. SCOTT: In terms of transparency?

SENATOR KEAN: Transparency, oversight, the application process?

MR. SCOTT: I don't know, but I'll be happy to look into it for you.

SENATOR KEAN: If you can -- through the Chair -- if there are other state models, that would be helpful.

SENATOR SINGER: Senator Gordon, just one other thing which you might just want to think about.

SENATOR GORDON: Senator Singer.

SENATOR SINGER: You know, we do farmland assessment in the State, and if you sell that property you built on, you have to pay back the taxes that you didn't pay for -- it's either three or five years. Maybe we have to take a look and say, "If you go from a nonprofit hospital to a for-profit, there might be a payback of taxes that would be held in account for the hospital betterment or to the township or something. Just a thought. We do it with farmland assessment, realizing a person got the benefit. Here you've gotten the benefit of nonprofit for all these years. You're going to profit. And yet the taxpayers really subsidize that hospital getting those taxes. Just a thought.

SENATOR GORDON: Interesting idea.

Anyone else on the Committee with a question? (no response)

Seeing none -- thank you very much, Mr. Scott.

MR. SCOTT: Thank you, thank you, all. I appreciate your time.

SENATOR GORDON: It was very helpful.

I see the Senate Majority Leader here, who is the prime sponsor of a bill that would have provided some transparency. I think we all would benefit if you would describe the goal of that legislation and some details of your bill -- what you think it would have accomplished.

SENATOR LORETTA WEINBERG: Thank you to both Chairmen and members of the joint Committee.

I did not come prepared. We only took a break from the Budget Committee for 20 minutes, which enabled me to walk over and see what was happening here.

I first became involved with the idea of for-profit hospitals some 20-some-odd years ago -- give or take -- when the biggest county hospital in the state, then known as Bergen Pines, was leased for 19 years to a for-profit management company. They signed a 19-year lease, because a 20-year lease would have constituted a sale and required much more oversight. So we already had a problem by the way the contract was structured.

And it has created problems that have lasted through a good portion of that contract that is coming down to the last four years or so.

The hospital transparency bill that the Governor really gutted in his conditional veto -- in his veto -- would have just put some very basic requirements for for-profit hospitals, making it very similar for the kinds of transparency that we require today of the not-for-profits. And it would seem to me with the large investment of public funds -- third-party payers, through the kinds of taxes that Senator Singer talked about -- that that should be a basic requirement. And why this was fought in the manner it was fought -- mostly by lobbyists representing the for-profit hospitals. And I was told, "If you pass this kind of transparency bill we won't want to come in to New Jersey." Which raises another question: why not? Why -- because we're asking for transparency, and that leads to accountability, and accountability leads to the public knowing how their health care is going to be provided; is it going to be provided by healthcare folks or by real estate folks? And we have put in a new bill, and I am hoping that, particularly

given the oversight that this joint Committee is providing, as well as the latest press reports -- and I commend to you, any of you who haven't had a chance to read the front page story in the *Bergen Record* this morning that you do so -- I hope that that will help this Legislature again pass a hospital transparency bill, which they did. And above all, I would hope that it will help the Governor to see the reason why we need transparency and accountability, and that the new bill we put in he will see fit to sign.

So I thank you for the extra spotlight you're putting on this issue, and I thank the press for following it as closely as they have. I read-- I'm not sure if it was a statement from Bayonne Hospital, which I just had an opportunity to read, in terms of their explanation about they being one of the highest-cost hospitals in the nation -- was also mentioned -- for-profit, out-of-network. This whole new model that has come into New Jersey bears watching. Out-of-network real estate.

And I thank you for the work that you're doing here. Thanks.

SENATOR GORDON: Thank you very much, Senator Weinberg.

Any questions for Senator Weinberg? (no response)

Senator, you're free to go back to the Budget Committee. Thank you. (laughter)

As our next witness, we'd like to hear from Travis Stein, representing the Committee of Interns and Residents of the SEIU.

Mr. Stein, thank you.

TRAVIS STEIN: Good afternoon. Can you hear me?

SENATOR GORDON: yes.

MR. STEIN: Thanks for having me. My name is Travis Stein. I'm speaking today on behalf of SEIU United Healthcare Workers West, with a healthcare worker union in California. And we're here in solidarity with SEIU's Committee of Interns and Residents. Both our unions strongly support effective laws to protect charitable assets, and to ensure that community hospitals remain assets and services to our communities.

Our experiences -- both here and in California -- suggests that very careful scrutiny of hospital conversions is critical to protecting high quality care and responsible corporate behavior. One California company -- Prime Healthcare -- inspired this out-of-network business model that we've been talking so much about, and is being emulated by Hudson Holdco here in New Jersey. And Prime now seeks to acquire at least four other New Jersey hospitals of its own.

Prime Healthcare's business model typically leads to excessive healthcare costs and, as was vividly demonstrated in a pair of recent *New York Times*' articles, the story is based on 2011 Medicare data. And it brought national focus on inflated hospital prices, and spoke directly to how the out-of-network model Hudson Holdco adopted for Prime Healthcare has led to excessively high prices for out-of-network, emergency room patients, including those at Bayonne Medical Center, Hudson County.

Even beyond Prime and Hudson Holdco's emergency room business model, Prime Healthcare provides an especially poignant example of why scrutiny in hospital acquisitions by regulators is so important. Nonprofit officials, eager to unload unprofitable facilities, have reasons not to scrutinize well-appointed buyers like Prime and Hudson Holdco, and may look for fig leaves to cover up the most conspicuous offensive behavior.

In Prime's case, fig leaves are dubious quality awards issued by hospital ratings companies that rely on hospitals' Medicare bills. The awards cannot be trusted if medical diagnoses on a hospital's Medicare bills are inflated because analysts use the same diagnoses to figure out whether patients are likely to survive.

Prime's quality scores are inflated because the company tells Medicare that an impossibly high number of patients are extremely ill. Many of these diagnoses are questionable, which is why Prime faces Federal investigation for alleged Medicare fraud.

Although nonprofits seeking to sell their hospitals to a well-funded purchaser have proven all too willing to turn a blind eye. It is not hard for regulators to judge whether the problems at Prime are real. For example: At one of Prime's hospitals in California, 32 percent of the seniors there were diagnosed with severe forms of malnutrition, including 1 in 5 who were billed for kwashiorkor, an extremely rare form of severe malnutrition, typically found among starving children in impoverished, famine-stricken regions.

Of course, these thousands of seniors right in California didn't really have kwashiorkor, so patient outcomes were far better than you would expect for these severely ill patients. And so after all, if you're not really sick, you're going to get better really fast.

But such outlier rates for serious conditions don't just lead to exaggerated quality scores -- they also mean higher costs to the healthcare system as a whole, and strain the trust between hospitals and patients.

The impossibly high rates of serious conditions at Prime's hospitals -- conditions like severe malnutrition, acute heart failure,

autonomic nerve disorder, septicemia, and encephalopathy -- have led to award-winning journalism and to State and Federal investigations. Nonprofit hospitals, eager to sell to company's like Prime, are incentivized to overlook the warnings and point to that fig leave on those quality awards.

Because of these incentives and just how important our community hospitals are to us in our most vulnerable days, we strongly commend you guys for your continued work towards improved scrutiny of hospital conversions by regulators like you who serve no interest beyond that of our communities.

Thanks for letting me speak.

SENATOR GORDON: Thank you very much.

Any members of the Committee with questions?

Senator Rice.

SENATOR RICE: Yes.

Since the conversation is about for-profit hospitals and, in this case, it's Prime -- and I guess Prime is here -- let me just say some concerns that I have. And Prime represents a good example of all the for-profits and why we should be very careful.

Number one, let me go on record by saying that I sent a letter on behalf of our constituents, as well as some members of our delegation, requesting that the State Attorney General get in touch with California and perform an independent investigation of the issues out there. Those issues are not new to those of us in the Legislature; it was the same request that was made, when Prime went to purchase Christ Hospital, by Assemblyman Conaway. And everybody throws the *done deal*, but subsequent to all of this

taking place, the events that are happening now in Newark (indiscernible), in particular with Saint Michael's, we in the delegation -- the Essex delegation -- pretty much most of our members collectively met at Saint Michaels' to try to figure out what was going on. We weren't satisfied with the answers -- all we knew was that they had to get out of there; they couldn't handle Saint Michael's. We asked to meet with Prime, and Prime was kind enough to send some representatives from out-of-state.

There were some interesting things that took place at those meetings that really disturbed those of us who were legislators. But I appreciate the speaker they sent in, because at least he was honest. And I told him I could deal with him because he's straightforward. Number one is that we raised questions about how -- and I think this goes back to the question you were raising, Senator -- or someone raised -- about how do you make a profit? If you can make a profit, then why can't the institutions we already have make a profit? And they made it very clear that 10 percent, they told us, of the emergency room patients -- they can be admitted. And we asked about the others, and they just kind of just -- I'm not sure what they were saying. But 10 percent they look for, and that turn some profit. And then they started talking about dollars, and we said, "We may not be the brightest people in the world, but your numbers don't work. They don't work because of what we're doing with budgets with UMDNJ and other institutions. We don't have enough money to deal with those."

And then we asked them, "Well, have you really had any conversations with Saint Barnabas, with Clara Maass, with East Orange General Hospital, with Beth Israel to determine the impact of what you're trying to do here with all these institutions?" Because we just went through

a closing with Saint James, Saint Michael's, and Columbus Hospital. Catholic East did not want to take over Saint Michael's. They told the Governor that. We told them it wouldn't work, but the Governor kind of insisted that -- I mean the former Governor -- and all of a sudden, the place just didn't work. And they told us -- and this is why I said I liked the guy, because he was straightforward -- he said, "Well, we haven't talked to anyone; there is no need for us to collaborate or speak or meet with anyone because we are a for-profit hospital and we're in the business of making money." And I said, "Well, I like you. Now, let me ask you a question. Have you considered the impact on institutions and ancillary groups that we're trying to get into place to make better, such as the Federal Qualify Health Care Centers? Have you taken a look at what you want to do, based on the recent reorganization, restructuring plan; that the Legislature went through a fight; (indiscernible) division had a lot of concerns, and there are still a lot of concerns? And the Governor signed as related to UMDNJ and some of your other institutions?" They said, "No." And I said, "So what you're really saying is that you haven't looked at anything. Have you taken a look at what happens to medical transportation, or at least what role it plays, if any of the audits are going to be impacted?" "No. We're in the business of making money." And I said, "So what you're telling me -- because we asked the question about health care and patients, too, and charity care -- "So what you're telling me is that you're in the business of making money by any means necessary" -- that's what Malcolm said: by any means necessary. I said, "I appreciate that, but I will fight." And I will say it again, I will fight it until somebody gives us some answers.

Now, if that's the mentality of profits -- and Speaker Oliver was at that meeting and we spoke -- when the numbers kept coming up, we kept explaining to them that we're doing budgets and those numbers just don't work -- at least the way they were being articulated.

And so I do believe that transparency becomes important. But I also believe that beyond transparency, when for-profits are coming into our states, is that we not only need to look at what they're doing if they get approved; we need to look at, when they get here, who they are before they get here. There's a lot of relationships in California that many of us have; we can call out there and find out what's going on. I'm not even certain-- I know that all the investigations are still -- allegedly -- are still ongoing, even though they keep denying that things are happening. I believe that one of their facilities may have even closed recently, or maybe getting ready to close.

We don't want to be left in the Essex County area, or any place in the state, with the profits coming in, and then down the line it becomes another Catholic East situation. Because that's what it looks like is going to take place.

Then when this whole scenario coming up-- And I suspect the same thing probably happened with Christ. We raised the question, "We thought Christ was a done deal; what happened with Christ? You didn't do it." Well, the public didn't support it. Well, it was interesting that the public didn't support it. At the same timeframe the Assemblyman, our colleague, had asked Paula Dow, the Attorney General, to look into those allegations. They backed off that.

In the interim, up in the Essex side of it, when we start to ask questions, we can't seem to find out what is going on. So besides the transparency, there needs to be a stronger look at the history of these institutions -- who are they? And we were told they were funded by a guy who with a few more people wanted to buy up everything in the world; and they are doing all these wonderful things. Well, that medical care piece is a very serious interest to all of us in New Jersey, and there are real questions about the people who became ill in those institutions, and some of the impact that the lack of treatment had.

And so we have to be very careful of any approvals, of any of these for-profits in the state right now. And there needs to be a lot more hearings than just this one, and some kind of way we need to get these other institutions, and agencies, and people that you said, Mr. Chairman, who didn't come here today. They need to understand the rules of the Legislature, of this State -- whether they like it or not; and we work with them very closely. But they can't avoid coming in and answering hard questions. They need to be here because apparently when you don't show it means that you have more knowledge or you have concerns about what you need to say. And no wants to come in and perjure themselves, or say the wrong things, or get caught in that. So I'm a little concerned why you don't come and tell your side of it, or your side, or what you think about it. And so I just want to lay that out there.

The final thing is that, on this whole piece -- at Saint Michael's, for example, there is bond debt, okay? And when this stuff started to go out there, and all the scenarios surrounding Saint Michael's, it really went out indicating that the bond is going to be picked up by the not-for-profit.

Then all of a sudden that changed. But that change-- Some of the respondents to the request to try to work with Saint Michael's backed off or responded that they couldn't really be helpful because of the debt. But the debt is not going to be picked up by Prime. We're going to pay that debt.

And so there are some real serious things going on here. And I think we should remove the politics from it. I think we should remove the relationships as they relate to folks who represent these people in this state, and be legislators on both sides and do the right thing for health care. We cannot fast track the takeover of these institutions without knowing more.

So I want to be on record of saying that, and it's not to offend anybody. But I didn't like the conversation that our delegation had; and what's become very clear to me is that it's not about patient care, it's about money. And I was glad the gentleman was honest about that, because I know how to deal with that.

SENATOR GORDON: Thank you, Senator Rice.

Senator Kean -- you had a question?

SENATOR KEAN: Thank you; thank you, Mr. Chair.

Through the Chairs -- some of the purchases that have happened in the State of New Jersey happened because there was no other buyer. The circumstances that existed created the unique circumstance where only one offer was acceptable. Is that an accurate assessment in one or two or three of these instances? That there was only buyer that met all--

MR. STEIN: In New Jersey?

SENATOR KEAN: Yes -- in New Jersey.

MR. STEIN: I can't speak to the other buyers in New Jersey, specifically.

SENATOR KEAN: But in this instance there was an acute circumstance where a number of hospitals had declared bankruptcy; there were management companies that were doing -- making decisions in a very short period of time, right?

MR. STEIN: I'll defer to you on that.

SENATOR VITALE: Senator, maybe he can answer-- Yes, your light's off.

There were-- We can find this out later on in Committee, but there were a number of -- I shouldn't say a number of -- there were several suitors for, I think, most of the hospitals that have been sold or are considering a sale. So it seems that the hospital -- the selling hospital has entertained a few bids from different entities. In the case of -- I don't know about Hoboken, for example -- but for Hoboken and Christ and some of the others, there were other bidders -- willing buyers -- and it wasn't just the one entity coming in and offering the final deal -- take it or leave it -- or whatever. It was a good deal. In my experience it didn't seem that there was just one. In the case of Saint Mike's, there may have been more than one; but at the end of the day it seems like there was just one.

SENATOR KEAN: I mean, I understand -- through the Chair -- if you're coming from California, I--

MR. STEIN: Sorry.

SENATOR KEAN: No, maybe I am focusing on too specific of an example.

MR. STEIN: I could say specifically to Saint Mary's, there have been numerous, I think, interested parties -- not just one.

SENATOR KEAN: But I guess the question-- And I think everybody on the Committee has fought, one time or the other, on the issue of transparency and openness -- whether it's in this area or in a number of other areas of public import; sometimes successfully, sometimes not.

But I guess the question I have is -- (indiscernible) to the Chair in response to that -- that, generically, is there -- somebody can be a willing suitor but have an offer that's not practical or respondent to the needs. So I think we need to be very clear -- and maybe this will come through later -- is when compared to *what* is the question. I guess, Chair, there may have been three or four or five people potentially interested. That's a different standard than *a)* who made offers; *b)* who made responsible offers; *c)* who made offers that could be sustained for both the patients within the service area as well as the purchasing entity to create jobs. And so I think that's what we're looking, and we come from a spot where there are some for-profit hospitals throughout the country that are-- I mean, we've got just as strong a network of nonprofits and others in the State of New Jersey; we just need to figure out the right way to balance that, going forward. And maybe that's a conversation we can have with a future participant.

Welcome east, by the way. I know that's a long flight.

MR. STEIN: Thank you.

It's an issue that's very important -- that we have specific experience with. It's an issue that we know about and an employer that we know about specifically, and a business model that's been very concerning for us in California.

I thank you for the opportunity to share our experience.

SENATOR SINGER: And I think that Senator Rice kind of alluded to the fact--

One of the issues that was of concern was that the forgiveness of debt was talked about -- the bonding debt. And the question was if you're going to give that debt to the State to pick up, other hospitals might be bidders if they knew about that. And some of the questions were that was not known to everybody. So if you're going to say to a nonprofit, "There will be a forgiveness of debt. Would you consider taking over?" When it comes out later that, well, they had no other bidders, and if you forgive the debt we'll keep the hospital open -- it changes the whole outlook of what is happening. And I think that's a real question we have to understand. If at some point the State is going to say, "To keep this hospital open, we're going to forgive State indebtedness, bonded indebtedness -- that we're backing those bonds -- then everyone should know about that before you say, "This is the final offer." And I think that was the question with Saint Michael's; there was really a question about it. I understood that there was talk about forgiveness of debt -- of bond indebtedness -- and other facilities didn't know about that. No one had said to them, "Well, by the way, if you take this over you may not have to pay back that debt." And that changes the bottom line for everyone.

So I think that we all have to be -- when we're talking about a hospital takeover -- everyone has to be -- when it comes to the State -- playing on the same page.

SENATOR GORDON: Any other questions for this witness?
(no response)

Thank you, Mr. Stein.

We will next hear from Virginia Treacy, JNESO

Virginia, are you here?

VIRGINIA TREACY: Good afternoon.

Thank you for the opportunity to address you. I was hoping I could get to go last so I could hear what everybody else had to say first.

I do want to discuss for a moment the letter that was referred to by Senator Rice to the AG about stopping the process. We don't disagree; in fact we strongly support Senator Weinberg's bill for more disclosure. I should, with full disclosure, tell you that we do represent all the registered nurses and technicians at Saint Mary's, at Saint Michael's, and the registered nurses at Hoboken University Medical Center. So we have our shareholders in the situation.

And we have done so, at Saint Mary's, through three bankruptcies, four ownership changes; at Hoboken, through three ownership changes; and at Saint Michael's, only through three ownership changes. I might point out that at Saint Michael's, which maintains its not-for-profit status -- that the conditions that were placed on their transfer of ownership, their certificate of need, and the sale -- most of which were not met over the last five years -- no one, either at the State Department of Health or at any other legislative level, including local legislators, was successful in holding their feet to the fire, such as community needs assessment. I think Senator Rice is correct when he says there has been a really bad situation, but it's not anything new at Saint Michael's. We represented those people since 1980, and I can tell you that the problems that he refers to have been in place through that entire situation and

through all ownership changes. And they have been not-for-profit the entire time. Conditions such as the community needs assessment were never done even though two hospitals were closed. The adult day-care center that was supposed to materialize at the Saint James Center was never provided. The Columbus Pavilion somehow came and went without any serious investment. And all of those things occurred even though the process provided for those conditions to be met. But no enforcement was provided for. If you're going to give the State tools for reporting requirements, you need to also give them teeth to enforce them. There's nothing wrong with disclosure, there's nothing wrong with conditions.

But the letter that Senator Rice refers to asks for the process to be halted. That seems to deny exactly why the Department of Health Certificate of Need and the CHAPA Review were established -- so that there could be public oversight of these sales. So we're not in favor of anybody stopping the process anywhere; besides, what criteria do you use to determine when you'll stop the process and when you'll allow it to go forward? That's the purpose of that legislation and that oversight.

So we want to make certain that there is disclosure in public oversight, but that it be provided for. You need to strengthen CHAPA, you need to strength full disclosure. You also need to allow that process to continue.

The second thing, of course, would be the for-profit versus the not-for-profit. Both need to be required to protect community assets and community services. I don't think there's any real attempt or real enforcement made -- Saint Michael's is a good example. Services were discontinued at two existing acute-care service hospitals within a geographic

location. And there was no oversight to make certain that the communities' needs were even assessed, let alone met. So if we're talking about for-profits versus not-for-profits, I can tell you from personal experience that hospitals such -- I won't name any today just in case -- not-for-profit hospitals in this state have very checkered records, as well as for-profits. One of the hospital systems-- I mean, one of things that's been bandied about, about Prime is that they're engaged in Medicare fraud. May I remind you that in 2006, Saint Barnabas was required to pay back \$650 million to the Federal government. I think they've done a fine job in redeeming themselves since then, but certainly not an unheard of problem in New Jersey. Many of our hospitals have been forced to repay under those conditions. You'd have to do a lot more in this State to show that you weren't acting in good faith than engaging in Medicare fraud. And I think as the Obamacare -- or the new healthcare initiatives move forward, you're going to see more and more facilities take a lesson from labor unions. And that is there is strength in unity and you need to get your acts together and bargain, as Mr. Scott indicated earlier. That's how you keep healthcare costs down, and that's how you preserve services -- when you have that disclosure, that process, and you have accountability to the public.

I'm getting there. I wasn't quite ready for you today, but I'm trying.

In any event, we're extremely concerned. I believe Senator Singer referred to employees and terms and conditions of employment. That is my responsibility for the members at those facilities -- at Saint Mary's and at Saint Michael's. There are 2,600 jobs that are involved in just those two facilities. And to be perfectly candid, since we live in a

capitalistic society where making money is usually rewarded, if you have somebody who can do that while you and the rest of the agencies that are charged with protecting the public interest make certain that that happens, then we should all be very happy -- and I keep my members, hospitals stay open, communities keep the services that their entitled to.

And that's all that I wanted to say today, is that we do hope that you have more disclosure and more public oversight, and that you don't stop the process. The other thing I probably should add is that we have reached a collective bargaining agreement with Prime at Saint Mary's that is effective the day of the sale being completed. And we were satisfied with that -- our membership ratified it recently.

We hope to do the same thing at Saint Michael's, and we hope that other facilities in the state remember that employees are also members of the community who are entitled to utilize the services they help provide.

Thank you.

SENATOR GORDON: Questions from any members?

I have a question. One of my main concerns is that the State of New Jersey fulfill its mission of monitoring the quality of care and staffing, and establish the standards that are necessary for quality of care. You're suggesting that in the current situation we're not-- We're dropping the ball now. Can you specifically suggest things that the Department should be doing, or the tools and resources that it should have to achieve -- to do the job that it needs to do?

MS. TREACY: Like every other State agency, the Department of Health probably needs more money and more staff. I don't know where

to get that; maybe we could ask the for-profits how to do that. They seem to have a better handle on it than the rest of us. (laughter)

But there are-- We have great standards in this State. We have great staffing regulations; now we need to improve those. But who enforces them when you try and find a situation, such as staffing ratios in New Jersey? You're told by the Department of Health that that's a matter of the hospitals' policy -- that they can't interfere with that unless we can show them there is cross-patient harm. Well, that seems kind of backwards. You don't wait until the patients suffer before you step in and enforce the existing regs.

I don't know what to tell you as far as-- I know the budgets are tight everywhere and maybe-- But maybe providing them with an enforcement mechanism. I believe Certificate of Need applications contain conditions. There should be a way. The courts, perhaps -- not that I think the courts are more efficient than State agencies. Maybe they're-- But there must be a mechanism, whether it's fining them or in some way making certain that they do it.

I hate to keep harping on the community assessment, but I don't know how you close two hospitals, operate a third, and never ask the people who are served what it is they need from you as an institution. That, to me, is essential. That doesn't take a lot of money. That just takes -- I mean, we would have been glad to pay for part of it. I don't know how you do that -- I'm not suggesting I have all the answers -- but I don't think by stopping financial deals from occurring.

By the way, we do represent Hoboken, which is owned by Holdco. And we have not been terribly disappointed thus far. We did,

however, lose our defined benefit pension plan in that takeover -- and that was very hurtful to the people who work there -- as did other people, who were almost all the employees who were unionized in that institution -- lost their pensions. And that's inappropriate.

SENATOR VITALE: Ginny, may I ask about that?

MS. TREACY: Yes.

SENATOR VITALE: About the pension plan and what exactly happened there at Hoboken?

MS. TREACY: Well, it's--

SENATOR VITALE: And how that came to pass?

MS. TREACY: How that came to pass is called *hard bargaining*. And when your employees are in a 90-day probationary period, to ask them to go out on strike over a pension plan is suicidal. It's not-- I generally don't try to hurt my members or myself. And so when the hospital told us -- the new owners told us that the pension was off the table, it was a matter that we would have had to take the entire facility out on strike over that issue; and we probably would have been readily replaced since there are -- I think it's 2,800 registered nurses collecting unemployment in the state right now.

SENATOR VITALE: Well, Ginny, was that a conversation that you had before the acquisition of the hospital, or during the process? I know that--

MS. TREACY: No--

SENATOR VITALE: --Hoboken didn't go through the traditional CHAPA hearings, and the Attorney General and their attorneys for Holdco citing some--

MS. TREACY: No, and the asset purchase agreements in both facilities were very different. I think in Hoboken the conditions placed on the new owners were not as stringent as they were in Saint Mary's asset purchase agreement. I have not yet read the one for Saint Michael's, because it's God knows where. But at Saint Mary's the asset purchase agreement provided for the acquisition of existing contracts. And then our bargaining with Prime yielded that they were continuing our existing agreement including our pension plans.

SENATOR VITALE: If my memory serves me correctly, going back to the time before the deal was consummated at Hoboken, that there were-- There was an attempt to -- at least a discussion -- to have a CHAPA hearing; that didn't happen.

MS. TREACY: Right.

SENATOR VITALE: The law that I think we all voted for, and I think I sponsored, required a CHAPA hearing. The Attorney General and the attorney for Holdco at the time -- the former Attorney General -- had a brief correspondence and they decided that the law would, essentially, forgive them from having a CHAPA hearing, citing that it was municipal authority; while the law said that it was a county authority would be excused from a CHAPA and not municipal -- but it happened.

But during that process, I recollect that there were a number of restrictions or requirements placed on the potential sale -- at least discussed -- which was to honor the existing contracts of insurance companies, the pension issue, and some others. And when that was forced or discussed, essentially the perspective buyer said, "We're not going to do that. If you require us to do that, we're out of here." And so, basically, they held a gun

to the head of the State, and to the authority, and it didn't happen -- it didn't come to pass. And so your pensions are gone and some other things didn't happen either.

So that's part of the problem with the whole process. Even if it's a not-for-profit acquisition, there's going to be a CHAPA hearing and we know that. But it's to the community is benefit. And the other issues that were not resolved-- In Newark, for example, the Saint Mike's deal, what happens to the pensions there for the unions and for the non-union members? So there could be protection for the union members, but no protection for the non-union members. It means that the existing owners haven't accounted for all the pension money for their non-union members. You should care about them as much.

MS. TREACY: Well, yes. And I mean, that is a problem when you don't have regulations. If I'm not required -- church plans are not required under ERISA to do anything because they're not covered by ERISA. So they have-- They're not required to do something, and times are tight, and money's tight. It makes perfect sense from a business perspective -- whether you're for-profit or not-for-profit -- to not fund the pension. That was not a new issue when Saint Mary's in Pennington bought Saint Mary's -- the old PBI -- in bankruptcy. That pension was horribly underfunded at that time, and since that's escalated since, the non-union people, as I understand it, have kind of been left holding the bag. The union people have not and, fortunately, at Saint Michael's most of the employees are covered by a union pension. So that should not happen to them.

But again, there had been a church pension plan that was not fully funded at Saint Michael's prior to them engaging in union pensions also. But it's an example of what happens when you don't require things. And if you do require them you must include enforcement mechanisms; otherwise, it doesn't work.

And your recollection, by the way, Senator, is very on point. At the State Planning Board hearing -- that's exactly what happened. The potential owners said they wouldn't agree to the conditions and they would let the hospital close. So the State removed the conditions.

SENATOR GORDON: Senator Thompson.

SENATOR THOMPSON: So in essence had there not been a change of ownership taking place here, there would come a point in time that they would face the situation about the pension system anyhow, right? Because it was underfunded and it went broke?

MS. TREACY: The one-- The church plan? Yes. Our union -- Thank God our union plan is funded to the 90-- We're in the green zone.

SENATOR THOMPSON: Kind of like the problem we have with State pension plans and so on, too, right?

You point out in your testimony that there are bad actors, there are good actors with your not-for-profits or your for-profits. I mean, of course, the emphasis here is on the for-profits today. But as you say, when you speak of Medicare fraud, Medicaid fraud, you find out it's occurring in not-for-profits as well as in for-profits, as well as numerous other problems. But I think maybe the situation we're speaking of here isn't necessarily for-profits versus nonprofits, but just what you need to do to see that if it's going to take place, it's done right. Because there are circumstances where

it may be going the direction of for-profits, is the best thing to be done. Without it, you may just lose the hospital totally. So what we're looking at here is how to see the process takes place in the proper circumstances, in the proper order. Not necessarily all for-profits are evil and all nonprofits are great.

MS. TREACY: I think that's a very good summary of what I was trying to say. It's not the designation of for-profit-- Look at some of the for-profit systems in California that have been very successful and treat people properly and maintain community services. And that has to be the bottom line.

I think at Saint Mary's it's a good example. Passaic General got sold to Beth Israel Passaic, which consolidated and closed Beth Israel Passaic, got State bond money then. Then went into bankruptcy; and then sold to Saint Mary's which itself was on the verge of bankruptcy when they purchased the facility. I mean, you can't make money in a place that's not properly organized. It makes no sense -- and maybe because I don't have to do this -- if you close two hospitals and leave the third one open, and you all used to serve the same patient care area, it seems absolutely incredible to me that you can't make a go of it. Something else is wrong, and I think part of it is the managed care contracts. If you're a freestanding hospital in this state you cannot survive the negotiations with insurers for managed care (indiscernible). It just doesn't work.

And so I think that's part of the equation. Everybody who has spoken so far has addressed one part of the problem. But if what you're looking for is oversight, you have to incorporate all those things.

SENATOR GORDON: Senator Kean.

SENATOR KEAN: Through the Chair-- Part of that is also-- I mean, it's negotiation -- is one aspect. There's also the affordable care component, isn't there -- in terms of stand-alone hospitals -- having an impact on stand-alone hospitals?

MS. TREACY: I believe you're right, yes.

SENATOR KEAN: In terms of-- Continuum of care patient -- all those areas from just paperwork and other aspects, right?

MS. TREACY: Well, it's also hard to provide the latest equipment, to have neurologists-- I mean, it's impossible for a small community hospital, in most cases, to maintain 24/7 services that you might find in a larger teaching institution. It's just-- It doesn't exist. So patients-- And I think Saint James is a good example. Saint James-- Part of the condition of sale and the closure of Saint James was to maintain a (indiscernible) or an emergency room. It didn't take patients in the community very long to figure out that they weren't going to get treated if they were really sick at Saint James. So they stopped going there because they-- Why go through that rigmarole of going to Saint James, being stabilized, and then transferred to Saint Mike's if you needed care? So eventually it came to the point where Saint Michael's (*sic*) said, "Well, we don't have enough patients to justify keeping this open." But it's almost like a self-fulfilling prophecy.

SENATOR KEAN: This may be an apples-to-oranges comparison, so please correct me if I'm inaccurate in the analogy.

The vast majority of New Jersey's nursing homes are for-profit, right? I mean, it's 258 for-profit, 17 government owned, 96 nonprofit. And there is no, from all the reports and everything else, there's no

discernable difference between quality of care, patient experience, is there? I'm asking, through this-- Can you get to me about what the experience from your perspective is?

MS. TREACY: Fortunately I don't represent too many nursing homes, because there are very few nurses who work in nursing homes -- which is one of the ways they keep costs down. They utilize other personnel to provide hands-on direct care, reach is why their costs are a little lower, and probably why for-profits are more attracted to nursing home environments. Because you can operate with more caregivers who are less -- I shouldn't say less-- I don't mean to impugn their care -- but are not as highly licensed or as highly educated, perhaps. They obviously do a good enough job -- or a fine job providing care to the residents with some oversight from registered nurses. But I think you're right, I don't think that there has been-- Again, there are good operators and bad ones, and I don't believe that for-profit versus the not-for-profit has negatively impacted that industry.

SENATOR KEAN: Thank you, thank you.

SENATOR GORDON: Any other questions for these witnesses?

Mr. Willard (phonetic spelling), do you have any comments to make? (no response)

Okay. Thank you very much.

MS. TREACY: Thank you.

SENATOR GORDON: We will next hear from Jeanne Otersen and Ann Twomey of the HPAE.

A N N T W O M E Y: Good afternoon.

My name is Ann Twomey. I'm President of Health Professionals and Allied Employees, which is a healthcare union representing nurses and healthcare workers throughout the state.

You have a packet that we've passed out -- actually, my testimony in your packet is missing a page so you're going to be getting another copy. However, I just want to make sure that you -- explain what's in here because there's a lot of information. In addition to my testimony we have some background information, we have correspondence with the Department of Health, correspondence with the Governor. A lot of this is concerning Meadowlands Hospital. We've done some background papers research so that you have -- you'll get a real sense of the impact of for-profit hospitals in the state, particularly through Meadowlands.

Now I'm not actually going to go through my entire testimony and read it to you, but there are a couple of points I'd like to make, though. And one has to do with a point that Senator Singer raised -- and that was he asked the question, "When the individual hospitals are struggling financially, how do the for-profits make money?" And there's probably a more defined answer, but what we see in New Jersey is that they buy these institutions for pennies on the dollar; they get debt forgiveness; then when they come in they generally cut staff -- and they can do that in several ways, and they do it in probably all ways, including cutting full time to per diem, there are layoffs; they cut pensions -- as the prior speaker mentioned -- that's pretty clear cut; they cut benefits -- they cut benefit time, they cut health insurance coverage.

Then they go out-of-network. And I just want to mention that I think there was another comment about going out-of-network. Well,

there are other hospitals that are out-of-network, and there needs to be some system of balance, because if small community hospitals can't survive on the arrangement it has with an insurance company, and they're not powerful enough to negotiate a better arrangement, then something has to be done to create a balance so they're getting enough. We get that. But what we're seeing is that these particular hospitals -- they go out-of-network and patients then come into the hospital through the emergency room, the most expensive way to get care; it kind of turns the whole system on its head. Then, of course, they sell the land -- or sell the building. And they make millions on this -- after paying virtually little for the institution -- a struggling institution. In the case of Meadowlands, they paid \$15 million for the hospital when Liberty sold it. And they just sold the land -- not the building -- for \$18 million, but they didn't turn the money into fixing up the hospital structure. As was mentioned earlier, they gave their creditors -- investors -- their money.

And then we are seeing-- We have seen, and I think, that the concern about Prime Healthcare from California is a real concern if the Department of Public Health in California has stopped allowing Prime Health to acquire any more hospitals because there is a question of upcoding -- which the speaker from California mentioned -- where if you describe things in a very particular way it could mean that a higher level of diagnosis could be their reward -- and therefore, more money will come into the hospital -- but it might not be the most accurate. And so if there is that question, we're saying to the Department of Health, "Take a look at that. Why are we exposing New Jersey to possible wrong practices?"

The other situation that we've seen is that with this process -- or sometimes lack of process -- the suitability of those who are buying these institutions is either not sought after or, even if they have bad track records, it doesn't seem to count. And, in some cases, the buyers of our hospitals have no track record in health care -- none whatsoever. And that has to be looked at, and that has to be looked at carefully.

Obviously, we have to hold the buyers accountable -- not only to the commitments that they make under the CHAPA process or the Certificate of Need process, but also for reporting. I believe Senator Vitale mentioned the case where the audited financial statements from one hospital was due June 2012 for June 2011. This hospital has been fined twice and the next financial statement is due this June, yet we don't even have the one from 2011 yet. So we don't have 2011; 2012 is going to be due. And they get to get away with it.

So where does the money go? It's public monies that go to these hospitals and no one has the ability to track it.

I also just want to make a comment. Everyone wants to keep their hospital in their community, and that's exactly the right posture to take. And nobody wants to lose their jobs. Obviously, as a union, we fully agree with that. But the process that's happened in the case of Saint Mary's -- it was our understanding that there were probably five or six or seven other potential bidders. But it wasn't clear at that time that the forgiveness of the debt was going to be available. And so-- And in the case of Christ Hospital, it was announced -- we never got notice of this -- that they had picked Prime Healthcare, and that if we don't go along with it this hospital was going to close. And they scare people, they scare the

community, and yet it's not based, necessarily, on any facts. It's just the scare tactic. We were successful at Christ Hospital, working with the community, demanding to open the process -- and the process was opened. And in this case, when questions were asked of Prime, they withdrew their bid. And another-- Actually, Hudson Holdco took over. But there was bidding, and there was a willingness for others to come into the situation.

So we have in our testimony several recommendations, and it includes the failure -- or trying to correct the failure of the Department of Health from monitoring -- in doing their job. Since February 2011, the Department of Health doesn't do any annual inspections of hospitals anymore. What they do is they rely upon the Joint Commission and the other private companies who do inspections, which are much different than what the Department of Health used to do. They come in and they do their type of inspection -- and this is not public knowledge. Reports are not available. You can't get them. They call them proprietary.

But each hospital in New Jersey is supposed to sign a regulatory compliance statement saying that they have complied with all the rules and regulations and the State laws. And that is a requirement for them to get their license renewed year after year. And yet, there are some hospitals, including Meadowlands Hospital, that never sent that compliance form -- or signed that compliance form -- and they were issued another license renewal. So the Department of Health is not even enforcing the rules that they have, and their rules are too bare-boned to begin with.

I just mentioned about the fining of that particular hospital; they've been fined for not producing their financial reports -- but still no reports. They still-- I have to tell you, the fines amounted to about-- I

think it was like \$16,000 in total. And that's nothing for some of these organizations, you know? And they don't have to produce a report.

We also had-- There have been Department of Health surveys. We've called the Department of Health in to look at some of the conditions in the hospitals -- they're in your packet. Some of the conditions that have taken place particularly in Meadowlands Hospital are extremely serious and we believe put the community at risk. It certainly puts the healthcare providers at risk. And we've asked the hospital to come in and appoint a monitor because, when this particular hospital took over, they said all the right things up to the day they took over. They renegotiated a contract; they said they were going to do all of these wonderful things. The day they took over they stopped honoring the contract. They've been committing violations. And they, by the way-- I know Hudson Holdco has been cited. Well, Bayonne Hospital has been cited as having the highest charges. Well, Meadowlands is number two. So don't let the highest be the only one that you're looking at, because in the case of Meadowlands Hospital, some of the charges have been horrific, to say the least.

So I have put in my testimony things that we are recommending -- very specific things we're recommending to be done with respect to accountability, enforcement by the Department of Health -- including that every time there is a sale to a for-profit there should be a monitor.

SENATOR GORDON: Ms. Twomey, could you just-- Could you briefly summarize those recommendations? Because I know I am particularly interested in what we can do to try to improve the enforcement

mechanism. And if the tools are not there for the Department of Health, we want to give them to them.

MS. TWOMEY: Okay.

J E A N N E O T E R S E N: My name is Jeanne Otersen. I'm also with HPAAE.

The recommendations we put together have come out of, as Ann has already said, a lot of our real-life experiences on the front lines. And we do believe ownership matters. But whether it's a for-profit or a nonprofit, we do need, as I think Senator Thompson said, to have the process protected.

Among our recommendations -- I think you'll also hear from Citizen Action and a number of other groups that share these -- is that we have to start much earlier. What we've seen over and over is that the board often doesn't have the full information to do the right -- the correct due diligence, to really look at all the potential bidders; and there's not really a requirement that they do an open bid. So people find out way too late.

So we believe the transparency should start way at the beginning -- not just over the finances, but over the entire process of opening a hospital up to another buyer. We believe the track record should be strengthened right now; it really is what they call *like-to-like*, so that when the Meadowlands owners came in they had a troubled track record -- an adult day care and surgery centers -- but we were told, "Well, it's not a hospital, so we don't look at it."

We need to make sure we broaden what the standards are for having any violations of our State or other state violations of patient safety laws. We also should be looking clearly -- and that's concerning the Federal

investigation into Prime: Do we want to know the outcome of that before we move ahead? So we think the track record should be strengthened, the transparencies, as I said, of the process, as well as Senator Weinberg's bill is very important.

I think we need to strengthen the standards. In each of our transfers we've had a Certificate of Need and we've had CHAPA regulations, and it's a good, strong legislation. But each time the Department weighs different things and sets different standards -- is it 7 years or is it 10 that we want them to maintain an acute care hospital? When we say they have to hire all the substantially -- all the employees, which is generally put into language, three months later they're laid off. You know, how do we strengthen those standards? What is it we really want to protect?

As Ann already said -- oversight and monitor. Unless we have a monitor or invoke what already is in law to allow them to actually put a manager in place where there are consistent patterns of violations, all we do is fine in very small amounts and cite. And I think the fundamental problem is that we have a Department of Health that's doing business as usual because, in the good old days, a nonprofit would violate something; there would be a problem, you'd go in and you'd tell them -- and I'm looking at Senator Thompson who knows this, from the Department of Health -- you say, "Fix this," and they probably do, right? And then that's the end of the story. That's not happening. These are companies that, too often, think they can violate the law and just pay a small fine, and it's worth the cost of doing business.

There's a reason we don't have that audited financial statement in our hands from Meadowlands Hospital. I don't know what it is, but we could all guess.

We need to -- as I said already -- I think open the bidding process. I know others, like Renée Steinhagen, will talk to the need -- and so did Ginny Treacy -- for community a needs assessment, that we take seriously, at the very beginning of the process.

The last thing I would say is these real estate investment trusts should be very troubling, based on just reading that article today. The lawsuit between Prime and Holdco is about getting some 25 percent -- as I understand it -- operational control. So no longer even a passive real estate investor who owns the property, but someone who will, in fact, want some control over our hospitals. These are not making widgets, these are hospitals. These are community assets. We need to do a better job of protecting them.

MS. TWOMEY: And make them public.

MS. OTERSEN: And make them public -- right. So we need to regulate those real estate trust transfer lease-back arrangements.

MS. TWOMEY: They sell the land, they sell the property -- but we don't see the terms of that sale.

SENATOR VITALE: *We*, meaning the State. *We*, meaning everyone except for-- Do they have to report to the State?

MS. TWOMEY: No.

MS. OTERSEN: No, they do not. And I'm sure Renée can speak to this in broader terms. But at this point when we've asked the State, what they've told us is that unless it's disclosed within the CN

application, they don't have any obligation or right, as they see it, to ask for copies of the contract between -- what happens if you go into default, etc. So those are completely opaque to us at this point.

SENATOR GORDON: Senator Thompson.

SENATOR THOMPSON: I do find it somewhat distressing that you indicate that the Health Department is not doing adequate follow-up when they find that there are significant deficiencies out there.

As you may know, of course, I did head up the Health Department's Clinical Lab Improvement Service for years, in which I was responsible for licensing and regulating the clinical labs, which included hospitals and blood banks. And I took it very seriously when I found somebody who wasn't doing it appropriately and saw to it that it was rectified in very short order. And perhaps that is something we should take a look at, if the Department is not adequately doing follow-ups on that kind of stuff.

One other question I had. I am curious why you gave us the results of the inspections that were conducted at Meadowlands and you told us what deficiencies were found there. A question I'd ask you about these deficiencies: Did these appear to be policy problems or personnel problems? For example, you might cite that there were certain forms or reports that they were supposed to complete, and they were not there. I would consider it a policy problem if they never did it; I would consider it a personnel problem if you looked through a thousand and there are 10 or 15 missing. That's a personnel problem. Which would you say most of these problems were, then? Policy -- i.e. they just weren't doing what they were supposed to be doing; or, okay, sometimes employees were remiss and

didn't do it and, therefore, did not have adequate supervision to see that it was done. Which of the two cases-- I guess the first is more serious -- policy; second, then you have to see that the employees do it right.

MS. TWOMEY: It was policy, for the most part.

SENATOR THOMPSON: I'm sorry?

MS. TWOMEY: It is policy failures for the most part.

SENATOR THOMPSON: In other words, they didn't do any of the reports -- not just several missing.

MS. TWOMEY: No, no. Some of the deficiencies that you're talking -- that the Department of Health came in and did surveys--

SENATOR THOMPSON: Well, you mentioned, for example, not cleaning operating rooms, or so on. So was a policy in place that these things are supposed to be done, but it wasn't done, or--

MS. TWOMEY: There were policies in place, of course, that they were supposed to be done -- even taking histories on patients. But the process that has been put through by management didn't allow the cleaning of the rooms to take place in between cases, it didn't allow the proper histories to be taken on patients. And I have to also mention to you that when one of the nurses who reported this to the Department of Health so that they came in to do an inspection -- within a week she was fired.

SENATOR THOMPSON: I saw that in the material.

MS. TWOMEY: She was reinstated because--

SENATOR THOMPSON: The pressure you put in, and from legislators and others -- right.

MS. TWOMEY: Yes. But that's significant in terms of -- and particularly this place and how they operate; it's a fear thing. So it's not a

question that the employees don't make mistakes, but it wasn't their mistakes in these particular incidents.

SENATOR THOMPSON: Okay, that was my question.

MS. TWOMEY: It was not their mistakes. And so it was a question that they didn't have time to do it; people were being pushed through to do multiple procedures in the shortest period of time without taking the proper -- getting the proper treatment in between.

SENATOR GORDON: Any other questions for this witness?

SENATOR RICE: Yes.

SENATOR GORDON: Senator Rice.

SENATOR RICE: Could you repeat what you said about the contracts, and the Attorney General, and the CN?

MS. OETRSEN: Are you talking about the real estate contracts? Is that what you're asking?

SENATOR RICE: Yes. You said that the State said they could not -- unless it's in the CN.

MS. OTERSEN: Yes, it's actually a quote from the Department of Health in this story in the *Record* that you have in your packet, I believe, right? And we've been told that in the past at some point-- Actually, way back during one of the Bayonne situations where they were selling the property, and we asked the State to look into the real estate investment trusts and what the sale lease-back -- and we were essentially told that that's not something that the State had authority to look at. They said if it was in the CN with a plan to flip the property they would look at it. But if it was not in the CN, if it was done after-the-fact, and unless it rose above 10 percent ownership, that it fell out of their jurisdiction. And I

would ask Renée to clarify that, if I'm wrong. But that's my recollection of the conversation on Bayonne, and then we went and looked at the *Record* story this morning; it's somewhat repeated. And as I understand the threshold -- it's, like, 10 percent -- that it would trigger some kind of CN and there was a lawsuit over that. But that's what we were told -- is that it's proprietary and you don't have -- we don't have a right to the information. Even if the Department looked at it, it's not a public document. But my understanding is that they have looked at it.

SENATOR RICE: All right, so through the Chair and my colleagues, the problem I'm having is that I'm not an attorney but I disagree. Maybe we don't have the right to look at it, but the request I'm making to the Attorney General -- look at everything. Find out who we're dealing with. And the reality is very simple. You take Saint Michael's, for example. We have tax dollars tied up into that whole proposition -- with Catholic East here. And unless you have all the information from some entity -- whether it's Prime or someone else -- then you really can't protect the taxpayers and the voters, the patients, the workers or anyone else.

And so maybe it's something you can't get, but we should have the answers as legislators. We're still oversight, you know? We're still focused, we're supposed to get information on behalf of the taxpayers. It doesn't mean we can give it to you; like they said, "we're going to operate without that transparency," as you talked about before -- doesn't make any sense. In fact, I think we have a legal obligation -- meaning the State government; maybe not the (indiscernible) citizen -- to have that information. You review it, you analyze it, critique it, and tell us exactly

what it means in terms of impact -- positive and negative -- on not just the entity but on people and quality of health care, etc.

So I would hope that the Chairs-- One thing to come out of this is that we take a look at legislation to make sure that there aren't going to be any Certificate of Needs given to anybody if they don't want to share information with the right people. That bothers me because I'm concerned there's going to be a cop-out by the State, given the fact that in this country -- you have heard me say this before -- there's a privatization movement taking place, whether it's good or bad. We're privatizing health care, education, corrections, public housing; eliminating affirmative action. And so I've always viewed the Administration -- not the Attorney General, I think we have a good Attorney General -- as one that is more into the privatization of these entities. And so it's easy to say, "Well, we can't look at it, we can't factor in all we need to know to determine whether this thing is good or bad." That bothers me, because I can smell some excuses coming or approving something that is not ready to be approved right now. And that's why I asked, in writing, on behalf of some members of my delegation, who are also members of the Legislature Black Caucus, that the State Attorney General do an independent investigation, talking to the people to find out in California exactly what's going on and let us know. To me, that's important. I can't emphasize that -- in this record, and I hope we're being recorded -- enough. I'm asking that. So if we fail to do that as a government -- not individually, but as a government -- and something goes wrong in the future, then this State needs to be held accountable.

This is serious stuff we're talking about and huge money -- it's huge money.

SENATOR GORDON: Thank you, Senator Rice.

Anyone else on the Committee with a question for these witnesses?

MS. TWOMEY: May I just make a comment?

SENATOR GORDON: Yes.

MS. TWOMEY: You know, we've worked many years with many of you, and so I know that we have the right people here -- who we're speaking to. There is a great urgency to address this. It's clear that many-- Like 10 years ago we didn't have all these for-profits. Something exists in New Jersey that is attracting people to come and buy up the hospitals and I don't think it's altruism. I believe that it's -- there are conditions that exist that allow for a lot of money to be taken out of the healthcare system and going to places and to people, and it's not benefiting the hospitals, the communities, or the people who work in them. So we're asking you to do what you-- You clearly get the message, and I know that you're also committed to protecting our hospitals.

And I want to thank you for this hearing, for that reason.

SENATOR GORDON: Thank you. And I can assure you that, speaking for both Committees, this is a priority item for us that is not going to be dropped. There will be considerable follow-up and hopefully some legislation developed in an effort to address these problems.

MS. TWOMEY: Good. Thank you.

MS. OTERSEN: Thank you.

SENATOR RICE: Mr. Chairman, while they are leaving -- just for the record, because I heard some things mentioned -- in the meetings that we had with some of our delegation members -- they are right. Prime

did indicate that they are going to sell us the building, or a building, or some building. That's a concern -- number one. And number two, once again I want to emphasize that they said they were in the business of making money and this other communication stuff doesn't mean anything to them -- at least not at this point.

There was another question raised; the questions was, "Okay, are you going to be going to the State for some money?" They said, "At this time, no, but more than likely we would. We don't expect the State to give it to us, but we're going to sure ask."

And so all these things kind of raised questions in the minds of some of us sitting there, and then it was this whole talk about the amount of money they were going to put into Saint Michael's, and the numbers didn't work; they didn't work. And I want to emphasize the 10 percent; and I think you need to circle that 10 percent and have someone look in as to what 10 percent of the emergency room population will be admitted -- can be admitted. And that's how they make their profits. And someone needs to (indiscernible) some formulas into that, okay? And you're going to find out that there is something else there. It doesn't work that way. Because if that was the case, then we could do that. Then why don't we spend it on the institutions we have and that we have already closed? These are the concerns that some of us have, who really have been paying attention to this more so than some of my other colleagues because the impact is not directly on their districts or their institutions right now.

SENATOR GORDON: Thank you, Senator Rice.

We're going to hear next from Jeff Brown, representing Health Care Quality Institute.

J E F F R E Y A . B R O W N: Thank you. I have copies--

Thank you, Chairman Vitale, and Chairman Gordon, and members of the Committee for holding this hearing.

I think health care in New Jersey is changing, and we need laws and regulations that will really keep up with the changing times.

The trend in conversions of nonprofit hospitals to for-profit entities is a complex and multifaceted issue. At the Quality Institute we're sort of agnostic when it comes to the actual for-profit versus nonprofit status. But we do recognize that each type of entity has slightly different motivations. Furthermore we recognize that, regardless of corporate structure, hospitals provide a vital benefit to the communities in which they reside. And a lot of these hospitals that are converting to for-profit reside in communities where -- the safety-net communities where that hospital is really vital care for the people it serves.

The bottom line is that for-profit health care is not necessarily a negative thing, but every hospital must be held to similar standards of financial transparency, quality, safety, and should provide a notable community benefit. When we look at hospitals we generally ask a series of questions: number one, does the hospital deliver quality care and does it deliver that care cost effectively? Number two, is it safe? Number three, is the hospital transparent -- financially and otherwise -- to the community it serves? And finally, does it provide a notable community benefit?

When it comes to quality of care and cost-effectiveness, I was actually looking back at some research that's been done looking at nonprofits versus for-profits. And I came across an article in *Health Affairs* from 2005. And one of the things that it found -- it's sort of a no-brainer

statement -- but that they found that the corporate structure of hospitals, while it doesn't predict behavior, he can predict motivations a little bit. And the for-profit entities are more likely to be motivated, above all else, by profitability. I mean, it makes sense -- if you're for-profit, you're for profits. I think where the-- We don't have a problem with making money; I think making money is a good thing. But when you look at our healthcare system and some of the misaligned incentives we have, that's where some of the problems arise. In a recent *Journal of the American Medical Association* article that looked at hospital charges when it comes to surgeries, they found that hospitals were actually able to make more money on surgical errors and inefficient care.

In New Jersey -- it was mentioned before -- we have some New Jersey-specific issues when it comes to out-of-network and the fact that some hospitals are able to game the system a little bit and admit people through the emergency room and charge them an exorbitant costs. And some of that was borne out in the Medicare cost data that was recently released.

I think that one of the things that could be a huge help to all of us in this regard is for publicly held data, much like the hospital charge data that CMS released; for more of it to become public, for more of it to be able to be translated into ways the public can understand. The more data we have, the more transparency we have, then we will be able to really assess these different hospital models.

When it comes to transparency, Uwe Reinhardt, who is the famous Professor of Political Economy and healthcare expert at Princeton University, has expressed on multiple occasions that the only way health

care can function in a free market is that its operations, prices, quality, and products are completely transparent to the public. So thus it's important that any hospital, regardless of corporate structure, is transparent with its prices, investments, and plans for the future. I think this includes the lease deals that were noted in the article this morning; it includes their investors; and it includes, really, how they plan to spend their money.

Furthermore, as entities that take in public dollars -- be it Medicare, Medicaid, or charity care -- I think there's an extra layer of transparency that should be there. The taxpayers deserve to know if a hospital is making money off of taxpayer dollars; then they deserve to know how those dollars are being invested, and if they're being invested in a way that's really helps out the community.

At the very least, that transparency -- if it's not looked at on a continual basis -- at the very least it should be looked at during the conversion process.

Finally -- and I mentioned this some -- in addition to transparency, any hospital that receives public funds should provide community benefits regardless of corporate structure. In New Jersey we passed a law to ensure community benefits and community needs were taken into consideration in hospital sales and conversions -- that's CHAPA; it's been mentioned previously in this hearing. I think the State has, unfortunately, been a little lax in regards to those requirements and we need to see some teeth to that process. We need to really see some teeth when it comes to the community health needs assessments. Many of the hospitals in New Jersey that are converting from not-for-profits into for-profit, as I mentioned, are safety-net hospitals -- hospitals that are much needed by

their communities and they're often the only health care for many of the citizens in those communities. While we should be looking at other ways to address that disparity, we should also ensure that when the hospital converts, that a rigorous review occurs and then its effect upon the community is taken into strong consideration. We need our regulatory process to keep up with the changing delivery system.

Last, but not least -- the bottom line is that, as I mentioned at the outset, the business of health care is changing and we need a regulatory process that will keep up with that. Many of our safety-net hospitals are experiencing a shrinking payer mix; there are government cuts at the Federal level; and for-profit companies are, unfortunately, sometimes a last resort for many of these hospitals. In many cases, the for-profit takeover can protect vital jobs and services; in others, it can turn a needed community hospital into a profit machine that isn't beholden to any of the community members. In either case, what doesn't change is that our patients need health care that is of high quality, cost-effective, and safe. And our communities need trustworthy and transparent institutions to deliver that care. Thus, we need our laws to keep up with the changing times. We need a regulatory framework in place and a rigorous review process that ensures all of those needs are met.

Thank you.

SENATOR VITALE: Questions?

Senator Ruiz.

SENATOR RUIZ: Thank you, Chairman.

First, I want to apologize to the Committee members, but I also serve on Budget. So while I try to be at every place at the same time, it is virtually impossible.

I want to thank you for your comments today -- I think they're global and probably just segued from something that my colleague stated. While this Committee is, right now, focused on hospitals transitioning from nonprofit to private, I think that we should be focused on transitions of hospital conversions overall.

When I first took office, two days -- shortly after winning the election -- there were two hospitals that were slated for closure. And it was really a not-for-profit converting to a for-profit; and I will say that transition was disastrous in my mind. It ended up in the closure of two emergency rooms, two hospitals -- and it was very, to me, staged out and disingenuous to the elected officials and, most importantly, to the community at large. That when we are focused, in transitions, for the betterment of the health care, we really have to engage in a conversation -- that healthcare facilities within that region are talking to each other so no one is fighting. We kept talking about this regionalization of services so that everybody can thrive in their own capacities and have room for everyone; and that the core mission would remain access to community health care and institutions in those same neighborhoods.

Now, while we do focus on this, we need to focus on the global hospital transition whenever it happens, because oftentimes it is the New Jersey resident who loses. I've seen it firsthand. And when there is infrastructure that is in place or forgiveness of loans that is in place, we kind of get impacted twice. The community accesses those quarters for

emergency health care and for services of need, and then the State of New Jersey taxpayers as a whole. We have significant concerns with some of the upcoming ventures that may happen, and hopefully they'll-- You know, I'm open to anything that will work on behalf of New Jersey residents: employability, economic development, and, most importantly, having safe access to community health care for my residents in the City of Newark and all those throughout the State of New Jersey. But when, in fact, things go in a different direction, do we have measures or avenues so that people just don't come in for a temporary amount of time and then have access to prime real estate to turn it over?

That's not necessarily directed at you or anyone. (laughter)

MR. BROWN: No, but I would agree with that.

SENATOR VITALE: It's directed at all of us. Good point, Senator; good questions.

Thank you, Jeff.

SENATOR RICE: Mr. Chairman.

SENATOR VITALE: I'm sorry -- Senator Rice.

SENATOR RICE: I was looking at the lists of people from the New Jersey Health Care Quality Institute -- you know, your representatives. You know, when you come before a hearing -- I know you don't have a lot of time to talk -- but when I hear people talk about data and how we should get data and pay attention-- And when we talk about safety, you had mentioned -- you gave an example of Bayonne, for-profit hospital is having (indiscernible) exorbitant charges, receiving an A rating on this year's hospital. And UMDNJ got a C on safety. And then you indicated, more or less, that this data is important for the public. Well, it is, but you can't give

public data without talking about why the C versus the A -- you understand what I'm saying? Because if you look at the history of UMDNJ, and the funding patterns and things like that, then it doesn't mean that it's not an A hospital; it means that it's not performing the part because of what we're not doing collectively. And so all you healthcare people are supposed to be the gurus and policy people to help us set policy; you need to be a little bit more holistic or objective about -- when you lay stuff out. And that's the problem with the public now -- we're giving them a piece of information of what to look for, and not everything they should look for. And so we have to share that -- that this would be an A institution, whether it's for-profit or not-for-profit, if these things were to occur. And the reason they didn't occur is because State government or Joe Schmuck or somebody became a barrier to it. That's the piece you leave out and that's the most important piece. And what that does is allow other folks to come in and say, "Well, you know what? It's like the public school system; we'll just close the building down." No, you don't close the building down. You look at causation and fix that if it makes sense to you.

And so I just want to be on record saying that, because I always love when intellectuals come in here. But I look at the more germane things, to real people, and what I know. So I just want to say that to the Institute, because I respect the people on here. Some of them get contracts and some of them close hospitals because they couldn't afford to keep them open. And some of them used to be (indiscernible). So I just want to be clear that there's another thought out here as to what kind of information we should have as a consumer.

MR. BROWN: Thank you, Senator, for the comments.

And I would say the issue with safety that I included in the written testimony was really just to illustrate that we didn't see a trend when it comes to safety scores in the not-for-profit versus for-profit question. I think it comes down to individual hospital leadership.

And UMDNJ got a--

SENATOR RICE: And resources.

MR. BROWN: Yes, oh, and resources, certainly. UMDNJ got a B on that safety score last year, so it fluctuates from year to year. It was just--

SENATOR RICE: Because of resources.

MR. BROWN: Yes, yes they do -- yes, absolutely.

SENATOR RICE: Just like Rutgers getting beat up because of resources. They want to take all of ours.

MR. BROWN: Yes. And more data-- We believe more data is better, and the more we can really get that data into a form that average consumers can digest and use to help them make better decisions.

SENATOR RICE: But the right data is important, too.

MR. BROWN: Yes, the right data. Yes, yes.

SENATOR RICE: More than anything else.

SENATOR VITALE: Thank you. Thank you, Jeff.

Note to self: Next time, say nice things about University Hospital when you come. (laughter)

SENATOR GORDON: We're next going to hear from Ward Sanders, New Jersey Association of Health Plans.

WARD ELL SANDERS: Thank you, Chairman Gordon, and Chairman Vitale, and members of the Committee for the opportunity to testify on this important matter.

My name is Ward Sanders and I represent the New Jersey Association of Health Plans, which has a number of health plans -- the major health plans -- as members of the organization.

I've provided written testimony, but I would like to summarize a couple of key elements here.

The first is -- and a number of folks have mentioned this -- is that CMS recently came out with information about hospital pricing across the country. There is a lot of reporting as a result of that release. The *New York Times* noted that Bayonne Medical Center has charged the highest amounts in the country for nearly one-quarter of the most common hospital treatments, noting as an example that they charge, on average, \$120,040 to treat transient ischemia, a type of small stroke that has no lasting effect. It was 5.6 times the national average and 23.6 times what Medicare had paid.

The response to that CMS release, from a lot of folks and from the press reporting, was that that's just the sticker price. The sticker price doesn't really matter. And one of the things that I wanted to try to do today -- because I think it plays into today's hearing -- is to explain very briefly why the sticker price really does matter, and it matters a lot. It matters to consumers, and it matters to payers whether the payer is an insurance company, the State through the State health benefits programs, or Medicaid, or a union, or other large employer.

First, for consumers, the price that is charged-- There is a price protection in New Jersey law that New Jersey passed, I think, in 2008, to

limit to a certain percentage of Medicare for folks under, I think, 500 percent of the Federal poverty limit. Anybody above that, however, is going to get hit with that sticker price -- and it's not an insignificant number of folks. To get hit with a tens of thousands of dollars bill for a family of four or somebody who is earning just over \$100,000 a year -- they're probably not going to think of themselves as rich and they're not going to -- those prices are going to be very difficult to pay, in many cases. So it matters to consumers because a certain segment of consumers actually pay that price if they don't have insurance.

Secondly, if you have -- or are lucky enough to have coverage, and you could have out-of-network coverage, that coverage is going to be linked to the charges. So while you have in-network benefits and you have out-of-network benefits, if you choose to go out-of-network the benefit and the cost-sharing deductibles and co-insurance are going to be linked to those charges. So again, the consumer is out-of-pocket significantly for a lot of money based on these astronomical charges.

And there are two other reasons I wanted to mention as well. Normally when you go out-of-network on a voluntary basis the insurance contract will -- and the State health benefits program does this -- almost all payers have usual and customary amount or an allowed amount; an amount that's provided to pay for services. The challenge here is that these astronomical charges feed the profiles that pay that. So the higher and higher the charges are the more disconnected from reality that these fee profiles go to. So when the State Health Benefits Program pays 90 percent of what's called PHCS fee profile, and the fee profile is based upon those astronomical charges amounts, taxpayers are funding that. They're paying

those enormous amounts because the fee profiles for allowed amounts are based on these sticker prices.

And lastly -- and this has been discussed, Joe Scott and others talked about this earlier today -- is that if you go to an emergency room, New Jersey law does a very good thing and protects consumers, and says if you went to an emergency, you didn't necessarily choose that you were going to go there. You are protected and treated as if you're in-network. Cost sharing is what you are going to have to pay. But there is no contracted amount on the backend that the plan and the hospital have. And as a result, hospitals can command very, very high payment levels. And so sometimes folks will say, "Well, let market forces take force, or come into play." They can't there. There's, in effect, a guarantee of payment that's not based in reality. So one of my recommendations that we have is to try to address that. But it is a key reason why these charges matter, and matter a lot.

So as Senator Thompson and others have said on this issue of for-profit versus not-for-profit, we also share this notion that we-- It doesn't really-- The tax status is largely irrelevant to us. We do care about the business model. And the business model that offends us is one -- and should offend taxpayers and consumers and others -- is that it's based on a model where they go out-of-network with a number of health plans; sometimes they will waive cost sharing. There will be an increase or a large usage of driving folks through the emergency room, where they can command payments above what's really an appropriate level. And sometimes you'll see advertising for this. You'll see billboards that say, "Come to our hospital; the wait time is 2 minutes." There are electronic

billboards in New Jersey that do that to drive New Jersey residents to these emergency rooms. That's the model that offends and we think has a really bad effect on the New Jersey healthcare system.

So as folks transition from nonprofit entities to for-profit entities, one of the things that we've observed, too, is that in the CN agreements it will often say that you have to have -- the hospital, as a condition of the new owners, will have to look at the existing contracts; they have a good-faith negotiation with payers. It has been the experience of a number of payers -- if not all the payers -- that that good-faith negotiation has not happened. You can argue about what good faith is and where the appropriate level of rate setting is, but to terminate a contract on the day the deal is done and to have very little conversation or non-productive conversation is what a number of plans have faced. So we do believe that the CN condition regarding good faith negotiation of contracts was not met in a number of circumstances.

So I know Senator Gordon and Senator Vitale are always interested in solutions. We looked at some recommendations and, quickly, in my testimony there are seven items that we'd like to lay out.

Number six and seven really reflect what Mr. Scott -- the CEO from Jersey City Medical Center -- said. We echo and support the direction he was headed in. The first being -- this is number six on the list -- to have some level of disclosure regarding for-profit hospitals. Not-for-profit hospitals have to file IRS 990s; entities that are publicly traded have SEC filings; entities that are closely held have fewer filings that they have to make. As a very regulated entity, health plans don't make these decisions lightly, and I don't want to have a knee-jerk reaction to say, "Make them do

more regulatory filings.” But I do think that this is an avenue that needs to be pursued to look at what information regulators and other public officials and other public interested parties should have access to, reasonably, as these transactions go through. Maybe it’s not everything that’s in the 990; but we do think that there is room for an expansion of the reporting requirements for these entities.

And again -- also as Mr. Scott had noted -- if there was some trigger mechanism-- I mean, the Health Plans would like some fee profile on the backend in these emergency situations so you don’t have these excessive charges. And not all states require what New Jersey does and they leave consumers on the hook for emergency room cost sharing. We would ask that if you could identify our outlier entities -- maybe it’s based on the number of emergency room admits that they have that have gone up dramatically, or maybe it’s the number of out-of-network if they have a predominance of out-of-network patients coming into the facility. Some sort of triggering mechanism that says, “This is an outlier hospital and we need to make sure that we’re not just paying astronomical amounts.” And again, the State is a payer through the State Health Benefits program. Some people try to make this about insurance companies, but most large employers self-fund their benefits. That’s employer money that they could use in employing folks. And in the small employer market, while that’s an insured business, it just gets reflected in the premiums. We think it’s important that there be a backend cost containment feature where you have that consumer protection and there is no market force at work.

And just briefly, the other things that we had noted were that we are supportive of the notion of an independent monitor in certain cases

to oversee the transition in compliance with these CN conditions. As we've noted, compliance with the CN conditions has not always occurred -- in our view. That, as part of a CN approval, the new owner promises not to engage in routine waiver of cost sharing. Medicare treats that as fraud. Many states treat that as fraud. Certain case law in New Jersey treats that as fraud. I think that a clear statement to require that hospital not to engage in that kind of conduct would be an important part -- or should be an important of the CN approval.

And also, as part of the CN approval, to not increase the hospitals charge master, or without at least some good cause to increase that charge master. What we've seen is that their rates go up from that charge master dramatically in certain cases when for-profits or perhaps others take over hospitals. In these transition times there should be some mechanism to rein in -- just a switch to a different model that helps this out-of-network model.

And then with respect to CHAPA, we had two suggestions as well. There are cases where a hospital is sold by a public entity to a for-profit that may escape CHAPA review. And we would suggest that CHAPA -- at least consider expanding CHAPA to apply to those cases.

And then also when there is a hospital sale emerging out of bankruptcy, to get the Attorney General's Office -- to allow them to intervene at an earlier stage and not necessarily provide deference to the courts' approval of the new buyer, and undertake that CHAPA-type review.

So on sort of a quick basis, those were some ideas that we had that we thought would really laser in and target outlier conduct, and help

address New Jersey becoming a very fertile ground for this out-of-network model that has a bad impact on our affordability of coverage.

I'd be happy to take any questions.

SENATOR GORDON: I don't have a question, but I really do appreciate your specificity in making those recommendations. Again, I'm hoping that we're going to have some legislation emerge from this process.

SENATOR VITALE: Ward, you and I have talked about -- thank you for your testimony -- you and I have had plenty of discussions about the out-of-network issue. And it goes back, I think -- the genesis of that was the Bayonne model, when we first got talking about that -- when Bayonne -- Hudson Holdco at the time, now CarePoint -- purchased Bayonne. They immediately went out-of-network with all of the plans that proved they had contracts with that hospital. And while it is that they would argue that, "Well, reimbursement wasn't enough," which is part of the reason why Bayonne closed in the first place, how can we adopt the same model -- same payer mix, same model -- whatever -- and expect a different result? While we didn't talk about or get into the issue of the management of that hospital and some of the others that may have caused its demise, they chose to go out-of-network entirely. Now they're in for most of the plans, but not all. But for quite a bit of time they were doing what you said they were doing earlier -- they were advertising for out-of-network services to anyone who-- The example is, "You used to have United; you already have United as your plan," or Horizon, or another, "and now Hoboken is out-of-network, or Bayonne is out-of-network." And they answered, "Don't worry about it. You can still come here. We won't charge you any more, but with cost share, than we have charged you if we

were in network with your plan.” And they may have waived cost share altogether just to get them in the door. And when they got them in the door, because you are now out-of-network, they got to charge their health plan -- the hospital got to charge their health plan out-of-network rates, which were astronomical compared to what it would have been if they were in network.

And so what happens is that that affects rates, of course, because you are now paying millions of dollars more, over time, and rates are impacted. And those of us who pay premiums feel that pinch. And so they eventually came in network. As you rightly point out, this would have been-- It is considered fraud in Medicare; you can't waive cost share in Medicare. It is what it is. But you can, for now, in New Jersey -- with private plans you can waive cost share and get away with it. And we have legislation pending, and Chairman Schaer in the Assembly and I have been working together on a compromise to move this issue along. But it's frustrating that this continues to happen.

Now it's not just happening in for-profits; it happened, most recently, at Saint Joe's in Paterson. And they canceled their contract -- or didn't re-up their contract -- with United and they put a full-page ad in the *Star-Ledger* a month or so ago that said. “Don't worry if you're a United plan member. Still come to our hospital even though we're not in network. We will only charge you the cost share you would have paid if we had still been in network with your plan.” And they mentioned the emergency room part -- that's a no-brainer; in an emergency you can go there. But for a “planned service or a scheduled procedures, still come to our hospital.”

So what does that do? Certainly it's great for the patient, potentially, or the plan member because they get to go to their local hospital if they live in town or in the area. But if their charges are -- and what you wind up paying even through negotiations -- much higher than you would've paid in network, it's going to have a downstream effect on rates. And that's a big part of the problem. They will argue that, "Well, that's the only way that we could *a*) force the plans to the tables, and *b*) make a go of it."

No one knows what the right number is. They do; maybe you do as well. And I don't know what the negotiation looks like with United. But it's not something that-- It's isolated for this particular not-for-profit hospital; but it was a model for the for-profits. It was a model for Holdco when they even purchased Hoboken a couple of years later -- most recently -- and then Christ as well. So I don't know--

MR. SANDERS: And to your point, Senator, if you look at the healthcare dollar -- like a premium dollar -- New Jersey law requires and Federal law now requires at least 80 or 85 cents of that dollar to pay for care -- payments to doctors, or hospitals, or pharmaceuticals, and so forth. If you look at the claim portion of the dollar, almost close to half goes to hospitals. So writ large, this model, where there are so many plans out-of-network -- it's just a couple in Hudson County right now and some other places where you have this challenge, but if this expands I think you're going to look at, it's already enormously expensive for the State Health Benefits Program, for Medicaid for the State, for employers and their self-funding, unions that are self-funding -- it's enormously expensive. If the

largest piece of your healthcare dollar is the hospital, and this model propagates further, you'll really have an affordability crisis.

So I know that there's a lot of concern about keeping hospitals open. And we should fight to keep hospitals open. But there are circumstances where we have to look also at the larger picture and weigh and balance the interests of everyone. Access has to be-- Geographic access has to be essential, and we need to support essential hospitals. But we also have to look to this larger picture as well, as to what's going to happen to our healthcare system if the predominant model becomes a model that is out-of-network with most plans.

SENATOR VITALE: Could you just briefly -- and then I have to go -- you explained to me earlier the out-of-pocket costs related to charges. Could you go through that again?

MR. SANDERS: Sure. Again, we heard sometimes it's folks who say, "Sticker price was irrelevant. It was just a bargaining tool in negotiations with health plans." But it's a lot more than that, and it matters. If you are uninsured, obviously the price is the price. And hospitals can and do go after folks for that full price. So if something that's-- Medicare would pay \$1,000 for it, and a health plan might pay \$3,000 for it, but the hospital charges \$20,000 for it; and if this person is uninsured and not protected otherwise by New Jersey law, they're going to be out-of-pocket for it, and they're going to go after them for that amount. So it really adversely affects consumers.

Also, if you have an out-of-network benefit, your deductible and co-insurance are driven off of the bill of charges for out-of-network services. So the more and more you pay out-of-network, you're going to

pay for out-of-network services, you're going to pay a greater portion of that care. And if it's a larger number, you're going to pay a portion of a much larger amount. So it affects consumers in that way as well. They're just out-of-pocket for a lot more money.

SENATOR VITALE: Right. Thank you. Thank you for your suggestions as well, Ward. We appreciate it very much.

MR. SANDERS: Thank you.

SENATOR VITALE: Thank you.

SENATOR GORDON: Our next witnesses-- I should tell you, we are getting close to the end.

We're going to hear from Renée Steinhagen, and I'd like to bring up Phyllis Salowe-Kaye as well. Given the hour, to the extent that you can be brief, we'd appreciate it.

RENÉE STEINHAGEN, Esq.: Chairman Gordon, Chairman Vitale, and members of the Committee who are still here, I want to thank you for this invitation to testify before this Joint Committee hearing to discuss the trend of conversions in nonprofit, for-profit entities; and to suggest changes to the Community Healthcare Assets Protection Act that would provide improved protection to the public as a result of conversions.

New Jersey Appleseed Public Interest Law Center is a lead advocacy agency and a member of the New Jersey Health Care Coalition, and we're a founding member of the relatively new Labor Community Business Coalition that has emerged to address the escalating entry of the for-profit investors and corporations in New Jersey -- which Ms. Salowe-Kaye will discuss.

I have a quite extensive testimony, and I think I'm going to take the 14 pages and put it aside.

SENATOR GORDON: Bless you. (laughter)

MS. STEINHAGEN: And why I say that is people who know me -- and I'll be self-critical here -- the intensity of my experience with these conversions is enormous and very factually driven. And I think it's best if I remove myself from that.

I have detailed testimony of justifying these changes, based on the law and the experience and the gaps that have emerged from one transaction to the next.

So I'm just going to head it, and I'm going to go through it quickly without going through the case law or the statutory provisions; and even my remarks about what were the individual factual circumstances that generated my feelings of inadequacy in the law, and my remarks that the bottom line is that the regulators -- both the Attorney General and the Department of Health -- I think have failed.

The law was a great step forward; we were one of the first states to actually get a law passed. To address Senator Ruiz' comment, it is not just nonprofit to for-profit; the law covers all mergers.

The key of the law was an enhanced participation. That means people like myself representing the community could actually see the decision making going on by the boards, and there was criteria by which transactions were supposed to be judged by. And there was hope that this would provide the protection to the public -- that was fearful when there's a transformation of health care and new-- You know, like education, health care has become now intruded by the for-profits.

And I would say nonprofit organization made itself vulnerable -
- and I'll say it only by saying gross mismanagement in some cases; but a
general lack of transparency and accountability to the community that
opened themselves up to this.

But from one transaction to the next-- And I will say the first
conversion in New Jersey happened in Salem Memorial Hospital, and it was
a system that bought the hospital. But I wouldn't be as quick as Joe Scott
here to say that the systems are not the problem and it's just private
investors. In that case, CHS was coming in and it already had Medicaid
fraud and Connecticut's Attorney General had denied them the right to
purchase Sharon Hospital. So there were some issues about some of these
systems as well that are still confronting us. But track record is important.

And I would like to say that in Salem, I believe that the
attorneys that helped the board go through that process really fulfilled the
spirit and the letter of the law. And we ended up with a fair market value
of \$34.5 million for Salem Memorial Hospital with a full-fledged conversion
foundation, with CN protections that we had since used when the hospital
was trying to close its gynecological and obstetrics. And I would venture to
say because of the high non-documented immigrant population down there
that was using those services, the Department, with the community,
actually stopped it because of some CN requirements, okay?

But since then, there has been a real dilution of CHAPA, and
possibly due to inadequacies. One thing that became clear -- and I will just
tell you this -- the original statute requires the Attorney General and his
common-law enforcer, charitable trust, to issue regulations. Those

regulations have never been issued despite numerous requests to one Administration after another. Therefore, they should become mandatory.

We became clear very early on that CHAPA does not cover -- at least the Attorney General interprets CHAPA not to cover; and I might differ with Senator Vitale on it. I think rightfully, the way the language of the statute is, it does not cover closings of hospitals. CHAPA merely covers the sale of a licensed, nonprofit facility, okay? So the Attorney General, let's say, in the Columbus situation, once the Department issued the CN closure, the AG lifted their fingers and no longer continued CHAPA.

What did that mean? That meant a lack of public participation and oversight, and conspiracy theories in the community as to why the hospital was closing. It's also clear that it doesn't cover public assets. And that will mean not only Bergen Regional; there's Roosevelt Hospital in Middlesex, and UMDNJ in its reorganized state.

So the issue of closure and the issue of public hospitals is an extremely important issue.

Bankruptcy, as Ward Sanders mentioned, is another issue. The bankruptcy court does not preempt State regulations, but it's clear that the Attorney General has played a minimal role in the fate of nonprofit hospitals that have filed for bankruptcy. And I go on to explain what that means -- also lack of participation of the community, decisions made by the bankruptcy judge that have nothing to do with health care. And also think about, you have assets being sold in bankruptcy -- you need creditors to be paid off. And other nonprofit systems don't usually have that money. Historically, nonprofits purchase other nonprofits by assuming debt -- meaning bond debt -- not actually outlaying money. So the nonprofit--

The whole way nonprofits even developed is not typical for them to go out and acquire new hospitals. So this whole bankruptcy issue is a very skewed one. And the protections that CHAPA bring are usually lost in the expedited process that happens very quickly after that.

The role of the Department of Health -- and I've testified before the Senate Health Committee before about this issue. But CHAPA, though it contains the Attorney General's common law authority, the law allows the Attorney General to consult with the Department of Health to determine if the transaction is not likely to have an adverse impact on the health services in the affected community. And I go through the statute, and I myself go through the difficulties I've had with the Department -- that this standard is different than their track record standard. And, in fact, we've had discussions before how other states' attorney generals have done actual health fairness impacts at the time. And some of these concerns that people are talking about -- the business model of the new purchaser -- could actually be analyzed at this point, and should be analyzed at this point. And so I think the law needs to be changed to make it clear to the Department what this standard that is in the law means, and that they should be given the authority to hire consultants to actually undertake such fairness impact studies -- which the California Attorney General has done.

Coming to the healthcare monitor, I have a little history there. CHAPA authorizes the Department of Health to appoint a healthcare monitor for a period of three years, and it was primarily to monitor charity care. And the first Salem, the Commissioner did hire such a monitor. And then the next transition, former Commissioner of Health, Dr. Fred Jacobs -- who's currently on Appleseed's board, and who I talk a lot about this with --

he subsequently decided-- He declined to appoint a monitor when Merit Investors purchased Mountainside. But he instead imposed heightened reporting requirements to ensure the financial transparency, oversight over money in and out of the hospital, capital improvements, and charity care obligations. It's really unclear whether the Department has actually enforced these commitments. But it's clear that in the case of the conversions of Bayonne, Hoboken, and Christ, the buyers-- And I have to add this here -- they've been referred to in a recent CHAPA filing concerning the Saint Mary's deal in Passaic as the *Bayonne Threesome*, and so that's how I'm referring to them from now on. (laughter) They refused such reporting requirements. And I will say, inexplicably the Department relented. And starting with Bayonne -- which was the third conversion -- those very reporting requirements to get at the transparency, to ensure that monies, commitments of capital improvements go into the hospital -- all these things have gone by the wayside.

And then as Jeanne Otersen talked about, the experiences at Meadowlands Hospital with the transfer of the license to an investor operator who had no hospital track record and whose track record operating ambulatory care centers was seriously compromised, indicates that the scope of the monitor must be broader than charity care. So I make recommendations regarding that.

This is a big issue for me -- I call it the continuity of mission. CHAPA, as I've indicated, codifies the Attorney General's supervisory role over charitable corporations. But it also codifies the Superior Courts supervisory role over *cy pres* proceedings, which in turn require the court to first determine that the maintenance of the charitable mission is impossible

or impractical before the conversion of the assets is permitted. And I say CHAPA has adherence to the common law on this point, in a certain provision where it says the Attorney General must consider whether the nonprofit hospital considered the proposed conversion as the only alternative or the best alternative.

Now, in the initial transactions under CHAPA, the applications filed with the Superior Court acknowledged this common law principle inherent in *cy pres*. But later pleadings have omitted these allegations of impossibility and impracticality. And in the case of the sale of Christ Hospital, when there was a viable nonprofit option where the license remained in the hands of a nonprofit corporation, the Board of Trustees, the Attorney General, and the Court actually acted as if it didn't exist. And for this reason we really think that CHAPA must be amended to make this principle explicit.

Trustees have to understand that the duty of obedience is essential to understanding how to proceed when considering a significant change of control. Otherwise, common misconceptions as to the nature and extent of the board of trustees' fiduciary duty to the corporation reign. It's fundamentally misleading to tell the public that once a transaction is approved the hospital will continue to function in the same way that it has as a nonprofit hospital for years to come, and that the sale will continue the hospital's mission of providing essential health services.

Now, charity care in New Jersey is a function of licensure. It's not corporate status. And no matter what the spin is attached, the provision of hospital services by a for-profit entity does not, as a legal matter, constitute a charitable purpose.

The last provision is the provision of community assets -- and I'm calling that the *claw back*, which you have alluded to in conversations -- coming around with the Real Estate Trust -- Investment Trust funds. Now, CHAPA is supposed to make sure that the proceeds -- the full fair market value of the proceeds -- remain in the nonprofit sector for the same purposes that they originally existed. And as a preliminary matter, I have to say, since the sale of Salem Memorial, no new conversion foundation has come into existence. And at Mountainside Hospital, the former foundation was well funded and it has continued in existence.

Over the years we believe this seminal requirement has been diluted, primarily because the Attorney General and the courts have failed to restrict the future sale of the real estate asset -- the land and facility, or just the land as we did in Meadowlands -- held by the converting nonprofit hospital. And this has especially been the case when the hospital was purchased out of bankruptcy, pursuant to an expedited sale process. And the purchasing entity has turned around and sold the facility to the REIT, as we saw in Bayonne.

I go through the law-- I do think the Attorney General and the Court do have powers over this. CHAPA reads as a single transaction or a series of transactions. But the Attorney General has taken the position that the intent to sell the real estate property-- He allowed this to go through even though in these cases we were able to point out that the transaction was permitted under the asset purchase agreement, and where the principles or the purchaser had already done that before.

And you've talked a lot about-- And so what we're proposing is an ability for what we're calling really a claw back. And we can go through the details of that.

I think these real estate trusts-- As the financiers have sometimes said to me, "Well, this is just another way of financing the hospital, you know? We're taking out the value of the hospital and then we're going to use it to improve the hospital." But there are some really interesting things about these REITs. One, as has been mentioned before, if in fact the REIT was part of the transaction to begin with, on the CN application the Department does say, "If you're not going to own the facility please tell us and give us the lease terms." Now, that's the real issue here -- the lease terms. They're obscure; no one knows about them. I would venture to say that -- like in Meadowlands and, again I'm saying this just thinking in my mind -- why do you just sell the land when no one knows the terms of the lease? That's a good way to launder money out of the hospital.

On the more formalized level, the difference between a loan-- Basically, where it's a secured loan, you're selling the hospital, you're getting money, you're saying you're going to use that for operations, allegedly-- And it's not a fixed-rate loan. My understanding is that there's escalating clauses to that lease. Again, at the end of the lease, you don't own the facility. So it's another way of getting -- taking the community healthcare asset. When you think about it, you take a hospital -- I'm going to Christ, because the number was in my head -- it was 140 years old. And you're taking a community asset, and because it was mismanaged or operated, or maybe not even mismanaged -- it just had a hard time going --

its fair market value is, I've been told, almost nothing. And then you're taking it, giving it to a for-profit entity that then sells the building off and makes an instantaneous -- when I say profit, it gets money. What it does with that money-- Does it reinvest it in that asset? Does it reinvest it in the operation? I do not know. All I know is that at the end of the lease term, the hospital doesn't own the asset. You're continually paying rent or lease. This is not like a fixed-rate loan. So this is not just a substitute for another way of financing the transaction.

And on that, I'll end with any further questions that you may have.

SENATOR GORDON: I don't have any. I just want to compliment you on providing that level of detail. I, for one, promise you I will read the 14 pages. And I'm hoping we can continue working to make the modifications of all that are required.

SENATOR VITALE: Thank you, Renée. There were a number of points that you raised today. Of course, Renée, we've had a dozen conversations about these issues, and the issues that Ward raised and Joe Scott, and some others. So I think we're going to take from today-- And we'll meet again privately as a Committee or just together to talk about some ideas for a change in CHAPA, the in-network, and some of the other issues that we're concerned about. But have that conversation in a more detailed manner.

MS. STEINHAGEN: I just want to-- Listening to people, and talking about the out-of-network and from being involved in policy -- that just shows you where people think the profit is. If we're talking about out-of-network, and we're talking about safety-net hospitals-- I thought the

issue-- We're talking about competing for the very same insured patients and not improving access to the very people who are in need in these communities.

But it's very interesting-- Both Saint Michael's and Saint Mary's -- now that are on the block -- when looking at the statistics, they're actually not the major Medicaid and charity care providers in their respective communities. They're high Medicare providers, and they provide to insured patients. That might be that they have dwindling numbers of insured patients and that's why they haven't been financially viable. And so there are some real questions about what these safety-net hospitals -- who they're going to serve, and what they're going to serve. And not that we're just handing over hospitals to people who are just going to compete for doctors and compete for that small group of insured patients.

SENATOR VITALE: Thank you.

SENATOR RICE: Mr. Chair.

SENATOR GORDON: Senator Rice.

SENATOR RICE: Some of the issues you raised concern me, because what I heard you say is that reasonable people can agree and disagree. And there needs to be a different interpretation on the part of the Administrations -- maybe not just this one, maybe the ones in the past, too -- regarding the common law and what it really means in terms of interpretation and what the intent is, and then CHAPA and everything else.

But it also appears that it has never been challenged in court. Is that what I hear you saying in some of your testimony?

MS. STEINHAGEN: How does one say this as someone practicing before the bar? I think the courts have been reluctant to look at

this from an intellectual point of view, and rely heavily upon the recommendation of the Attorney General; and that the courts are reluctant, especially when the transaction gets to them at that stage and they're told that it's either this transaction or the hospital is going to close, to actually deny an application. Do you understand? So there has-- You know, I'll tell you my experience with Christ--

SENATOR RICE: I guess what-- Let me just cut you.

I guess what I'm getting at -- maybe I wasn't clear -- sometimes the courts go beyond the issues that's brought there and they create them. I guess my question is whether the interpretation is ever challenged? Because if you go in to the court this way, they are never going to rule on what you're bringing. Sometimes you may get minorities saying, "Well, we think that this should have been discussed," or what have you.

MS. STEINHAGEN: It has been challenged. I, myself, have challenged it most recently in the situation of the Christ Hospital deal, over the claw back regarding the lack of a conversion foundation. There were some other issues: the alternative purchasers, the notion that the entity -- they did make the choice based on first finding that it was impossible to maintain as a nonprofit. And the judge said he wasn't going to sign the order that day because some of the concerns that I had raised were concerns that he had, and then he signed it the next day.

So there hasn't been a written opinion by a lower court. And as I'm saying, my sense is that there is quite a bit of deference to the Attorney General's recommendation in all these transactions. And the court does not want to be seen as interfering with a transaction that was negotiated and consummated by some private parties.

SENATOR RICE: Well, that's always the first argument -- deference to the entities. And usually a judge might do that. So I guess what I'm getting at is that maybe -- and I thought I heard Chairman Gordon indicate that he's going to take a look at some of the things that should be codified. Because I think that's important, because the one thing -- I'm not a lawyer, but I do know that when you go to court, the first thing you are going to argue -- particularly when it comes to entities versus government -- is you give deference. And judges are going to really need to (indiscernible) that. And you gave good indications that you and he (indiscernible) the same mindset and, late in the day, deference was given.

So I think that's important, Mr. Chair, that we really look at all-- There is a lot of information out in the ratings, and a lot of questions. There are a lot of things that the speakers are indicating should be looked at -- if they have to become a part of legislation. I think staff should extract all of those things and give us a bullet list so we can see just what those things are -- clearly without reading the other stuff between. And this way, when we do legislation, all of us can maybe have some input as to what that legislation should look like. And maybe, by the same token, we can take that bullet list and talk to some of our independent healthcare and legal people -- because one issue may raise another that needs to be looked at -- and turn it into something comprehensive.

SENATOR VITALE: Any other questions? (no response)

Phyllis.

PHYLLIS SALOWE - KAYE: Hi. I'm Phyllis Salowe-Kaye, the Executive Director of New Jersey Citizen Action.

As one of the founders of the campaign to protect community health care -- which is a coalition of broad-based and diverse organizations and individuals representing New Jersey residents, healthcare advocates, community leaders, elected officials, healthcare and insurance providers, healthcare unions, and policy experts who have come together to protect and advance access to quality and affordable health care for all New Jerseyans -- I urge you to broaden the scope of the Community Health Care Assets Protection Act.

It seems like there's a clearance sale going on right now of hospitals in New Jersey, where for-profit companies are coming in and they're buying low and then they're turning around and selling pieces at a very high rate of money. And where that money is going -- Renée indicated we don't know if it's going back into the hospital or if it's going into somebody's pockets.

What we do know is that the residents of the community -- the people, the people who use the hospitals, the small businesses that are near the hospitals -- are all being scared and told that unless this particular buyer -- one particular buyer -- purchases a hospital, that that hospital is going to close. And folks in the community are scared about losing their community hospitals. And so we've come together to urge you around -- I guess there are four general principles that we would like you to consider.

The first is that this coalition opposes healthcare business models that limit or reduce access through practices that eliminate insurance contracts; reduce services, quality, staffing, or affordability of care to residents; or that rely on cost shifting to consumers and other healthcare facilities and taxpayers.

Number two is to improve and strengthen New Jersey standards for approval and enforcement of hospital and healthcare conversions under the existing laws -- such as CHAPA and the CN licensing laws and regulations.

Three, require strong standards, and the enforcement of existing standards for access and quality of care. Protection of employees' rights and safe working conditions are important; financial transparency and accountability to our communities; and we need to look at the track record of the entities purchasing our community hospitals or healthcare facilities.

And finally, to promote policies that protect the community mission, financial sustainability, and accountability of our State's not-for-profit and public hospitals.

And here I have a thousand new signatures from folks in the Meadowlands and Secaucus who are added to the already-existing, I guess, 1,700 signatures, which brings 2,800 people in Secaucus are calling upon the Attorney General to appoint a monitor to deal with the hospital there. At Saint Michael's in Jersey City we reached out to 6,000 people and had hundreds of people come into community meetings. And we had multiple bidders on that hospital. The initial bidder left because they didn't want to become transparent and provide the information. So there were 6,000 people there. Meetings are currently happening in Newark and-- Well, we had a community meeting facilitated by Councilwoman Mildred Crump in Newark. There's a meeting this Thursday night in Paterson; faith-based organizations are coming together about Saint Mary's Hospital; and we're going into Denville in two weeks.

It is really important that this process be opened up -- that the community be permitted to come in early in the process; that they not have to hear about their hospital either being sold or closed.

Finally, I could not be here today if I didn't talk about Prime Healthcare, that we heard about earlier. Thirty-five organizations came together recently -- statewide organizations and local organizations -- asking that the Attorney General and the Department of Health stop the sale of Saint Michael's Hospital in Newark and Saint Mary's Hospital in Passaic. There are huge concerns about the fact that-- My colleague from California -- and he might have flown out, but Prime is not allowed to operate in California anymore; they can't buy any new hospitals. Rhode Island has called for them to stop any purchases until this investigation at the Department of Justice is finished about Prime Healthcare. We think that needs to be done in New Jersey. We think that the bidding process needs to be opened and other people, who have all the information in front of them, like forgiving the bond -- everybody needs to come in with all the information and be permitted to come in and make their bids for these two hospitals -- and now Denville.

So you're going to hear from us; we really need to have the community involved. And they can't be called in at this late date.

So thank you.

SENATOR VITALE: Thank you.

SENATOR GORDON: Thank you.

SENATOR VITALE: Thank you, Renée; thank you, Phyllis.

SENATOR GORDON: Our final witness is a representative from Prime Healthcare.

There have been a number of statements made today about Prime. They asked to go last so they would have an opportunity to answer some of these. And we're going to give them that opportunity right now.

DALE J. FLORIO, Esq.: (off mike) Good afternoon. Thank you for letting us appear today.

With me, to my left, is Arnie Kimmel, Senior Vice President for Development, Prime Healthcare. And also we're please to have the CEO of Saint Mary's Hospital, Ed Condit. So we thought this would give you a broad view of what they're doing, and also a chance to respond to some of the inaccuracies that were mentioned today.

So Chairmen, thank you.

ARNIE KIMMEL: I'll be as brief as I possibly can.

First of all, we're glad to be here and we're glad to be near being here in New Jersey. We believe we have a lot to offer to the state and we're looking forward to the relationship.

We are, as has been said, a California-based, for-profit hospital company. We're privately held. There should be a distinction made between investor-owned and not-investor-owned and privately held companies. There are advantages to both models, certainly. But as a privately held company, we're able to act quickly. We're also able to avoid the kind of quarter-to-quarter pressure that investor-owned companies have to perform, so that we can concentrate on what's best for the long-term for our hospitals and for the communities we serve.

We own and operate 23 hospitals in 5 states now -- 14 of them in California. I've said to a number of you, and I've said to quite a number of other stakeholders, that we're proud of our record. It's a perfect track

record in terms of turning around and operating and keeping struggling community hospitals. We have kept every commitment that we've made, and in every sale -- whether it is the purchase and acquisition of a for-profit, or the conversion of a not-for-profit -- we've made a number of commitments having to do with keeping the hospital open, having to do with keeping the hospitals full service, having to do with capital investment, and having to do with charity care. In every instance, the Attorney General and some of your colleagues have checked with the Attorney General's Office in California to find out if we kept the commitments that we made. The answer that they got from her -- and I will add parenthetically that she is no political friend of ours -- but the answer was, "They kept every promise they made."

The statement that was made just recently about our inability to acquire hospitals in California is simply not true. The Attorney General did turn down one deal. She's approved -- and Attorneys General before her have approved -- the other 14. We're very much alive and well in California, as well as growing around the country.

I think that it's also important to point out that those hospitals that were financially distressed were largely clinically distressed as well -- not performing, not performing for their communities. Today, every single one of them on is, and every single one of them is profitable -- referring to the 14 hospitals in California. The others are newer to us -- acquired in the last two to two-and-a-half years. I can assure you they will be performing clinically, if they have not, and performing financially as well.

It's important to link those two, and that, I think, is not very well understood largely. And what I mean by that is that the way to make

money in a hospital is to take good care of people, to be efficient, to do the right thing the first time, the right thing the right way the first time. Those quality measures that we're so proud of -- that some others denigrate for some reason -- are meaningful to us. They measure things that are about as objective as can be -- the kinds of things that everyone is starting to care about, if they hadn't before: readmission rates, patient satisfaction, mortality, morbidity, and compliance with protocols. There are hundreds of universally agreed to protocols; the question is, how often do we -- hospitals and doctors -- do it right? And the answer varies from 50 percent to 100 percent of the time. We win awards and we make money because we do it right the first time. We're good at that. Our length of stay is half-a-day less than the Medicare mean. When hospitals are paid a fixed amount, if we can do it a half-a-day shorter on average it means that every other patient stays a day less. Bad things happen to you when you're in a hospital longer than you need to be, and it costs money to be in a hospital longer than you need to be. The fact that our length of stay is a half-a-day shorter, in total and on average, suggests directly that we are efficient from the time they're in the emergency room on.

I want to speak to a handful -- quick handful -- of significant issues, most of which have come up today.

First of all, with regard to being out-of-network: There was a time 12 years ago when, for about 6 months, several Prime hospitals went out-of-network. We haven't done that since; virtually every one of our hospitals has virtually every third party contract available to it. That's true in our California hospitals, it's true in Texas, it's true in Kansas, it's true in Nevada, and it's true in Pennsylvania. And it will be true in New Jersey

where we have three acquisitions pending, and Rhode Island where we have one. I've said that to the Health Plan Alliance, and I'm saying it in public here, and I've said it any number of times. So the notion that we make our money by going out-of-network is simply 180 degrees from the truth. And it's not something we do, and it's not something that we will do.

We will negotiate tough contracts. We were without an Aetna contract in California for, I believe, a year. We've signed one in the last few months. But when I met-- In fact, the first time I met with Ward Sanders, he brought his Aetna board member who said, "Gee, you're talking a good game, but you don't have contracts with us in California. You must be out-of-network." And my response was, "We're out-of-network with you, but we're not out-of-network with Blue Cross, we're not out-of-network with United, we're not out-of-network with any other in California. Maybe you're the issue." That's what negotiation is about. And so it's hardly our model -- that's an important distinction to make, and apparently not widely understood.

The second issue that has been addressed satisfactorily, to my way of thinking, is our position regarding unions. We have union contracts wherever we have union employees. We negotiate in good faith as we've evidenced in Saint Mary's so far. We've negotiated a collective bargaining agreement before we even took over because we told the unions in both Saint Mary's and Saint Michael's that we needed them -- that we needed the labor piece and we needed the support. And we've negotiated a yes, and I'm confident that we'll negotiate to yes with the rest.

With regard to the investigations that are alluded to, we acknowledge that there is a Federal investigation. We were subpoenaed for

records. That doesn't make us different from a whole lot of other systems, by the way -- but those are the facts. Those allegations appear to have had everything to do with allegations that were made by the SEIU several years ago. Those allegations, since they were public, needed to be and were investigated by the California Department of Health, the Joint Commission, and HFAP -- which is the other major accrediting body. They found nothing wrong with our documentation, nothing wrong with our care, and completely negated the allegations that we were over-diagnosing malnutrition, over-diagnosing septicemia, and the other kinds of allegations that came from the SEIU.

With regard to two other issues, quickly: transparency. I've met with Senator Weinberg twice; I've told her that we will support legislation that requires the same thing of us that it requires of not-for-profits. I don't know how to be better citizens than that. And you can believe us or not, but again I would ask that if our credibility is in doubt, check with where we've been. The sellers have done that -- not just in New Jersey, of course, but everywhere. And they've had multiple options; they picked us for any number of reasons -- part of which was our ability to act quickly, part of which was our ability to pay a fair market price, and part of which was our ability to point them to a track record of high-quality, low-cost hospitals serving their communities -- the FQHCs, the health departments, the churches, the schools, and the rest.

The last issue that I'll address is the REIT. We have in almost every instance used the REIT as a financing mechanism. It is where the cash comes from to invest in hospitals -- and you can believe that or not. But again, in Saint Mary's case we've made a commitment of \$44 million

already. We've started to know Saint Mary's really well and we've developed -- Ed, and his team, and we have developed a needs list that is \$44 million long. We've made that commitment and we haven't taken over yet.

We've made similar commitments -- identical commitments -- similar commitments in the case of Saint Michael's.

But the REIT is simply a financing mechanism. And I understand the long-term concerns. We want to be a tenant. We don't want to be in the property business. That's not how we chose to tie up our capital, and we chose to invest our capital in our facilities. Again -- ask them if they're up-to-date; ask them how they perform.

I'll give a quick anecdote and then I'll stop. In the case of Saint Michael's -- and I think every is aware -- there's a big, beautiful, really well designed emergency room that opened, I think, about a month ago. The CT scanner that serves the emergency room is two floors away -- big mistake. The first thing we will do when we take over is move the CT scanner either inside of or next to the emergency room in order for us to take good care of patients in the emergency room. And I should say on the subject of emergency rooms -- and I talked about our charity care commitments in every instance -- these happen to be three Catholic hospitals that we will have acquired in New Jersey. Their ministry, their mission was an important part of their reason for being. They insisted -- and we quickly agreed -- to maintain their charity care policies. And I will say that, on average around the country, people spend four to six hours total in emergency rooms. In every Prime hospital, they don't spend more than two hours. And no one -- no one walks away without being seen -- no

one. Not two-and-a-half percent, not one-and-a-half percent, not a half-a-percent. So our doors are open. And we make money by taking good care of people.

That's it. With that I'd like to try to respond to any questions you might have.

SENATOR GORDON: Any members of the Committee have questions?

SENATOR VITALE: I do.

Thank you for coming, Arnie. I appreciate it.

Again, we've had conversations about the acquisitions. And I want to follow up with you on a few of the things that you just testified to.

On your REIT, what is the length of the REIT, anyway? I forgot.

MR. KIMMEL: They vary.

SENATOR VITALE: The one for Saint Mike's. No, I'm sorry, for Saint Mary's.

MR. KIMMEL: There is-- We don't have a relationship with a REIT for either Saint Mary's or Saint Michael's, or Saint Clare's for that matter. In our Asset Purchase Agreement we have the right to do that. We have not made a commitment to do that; it's not clear that we would.

SENATOR VITALE: Right. Because you said in your testimony that that's where the cash comes from -- so if you don't do a REIT, then where does the cash come from?

MR. KIMMEL: Well, we have-- We're a nearly \$3 billion company -- \$3 billion in revenue. We have cash at all times sufficient to more than live up to the obligation we've made at Saint Mary's. It may be

that we need to sell the property; if we do, we'll lease it back. Part of your question was for how long. The shortest term is 30 years, and the longest is 99.

SENATOR VITALE: So you don't know whether or not-- I mean, are you seriously considering a REIT in one of those hospitals?

MR. KIMMEL: We're seriously considering them. No decision has been made.

SENATOR VITALE: So how does that process unfold then? So you decide that that's something that you want to do after you've acquired the hospital? It's not something that you have to do before you acquire the hospital -- is that right?

MR. KIMMEL: It's not necessary-- No, not necessary at all. I mean, we're prepared to own the hospital, own the property. But we don't want ultimately -- ultimately we've chosen not to tie up our capital in property. We want to tie up our capital in our hospitals, and we've been able to do that.

SENATOR VITALE: So it sounds to me as though you're going to enter into a REIT if you were to take over the hospitals. I mean, you may not have to say that on the record, publicly now, but it's sort of what you're saying. If you don't want to be a landlord and you don't want to be a property owner -- so you want someone to be a property owner. So you'll lease it back from them. You'll be a tenant and they'll be the property owner, and that's how you get the cash to invest in this hospital or in another hospital, for that matter.

MR. KIMMEL: That's true.

SENATOR VITALE: Okay. So it's likely you'll enter into a REIT.

The other ones that you have around the country -- is there an average length of term for them, or does it vary?

MR. KIMMEL: It varies a lot. I'll make an educated guess that the average is 50 years -- the term of the lease.

SENATOR VITALE: When did Prime start acquiring hospitals -- their first hospital?

MR. KIMMEL: In 2001 was the first.

SENATOR VITALE: In all the hospitals that you've purchased so far, you still own all of them -- is that right?

MR. KIMMEL: Yes. We have not closed a hospital or sold a hospital, and not closed a service.

SENATOR VITALE: Okay.

In the out-of-network issue-- Well, let me back up for a second and talk about the pension issues. Are there pension obligations at Saint Mary's and at Saint Mike's?

MR. KIMMEL: There are pension obligations at both. You heard testimony earlier about Saint Michael's, that the union pension is fully funded -- it is. The non-union is not. At Saint Mary's, Ed can comment better than I can, but we have not taken on the pension obligation. Our point to the board there was it's your call about what to do with the money involved in the sale and how much of that goes to pension, how much of it goes to long-term debt that the State is behind -- at both Saint Mary's and Saint Michael's.

SENATOR VITALE: So the potential purchase price for Saint Mary's -- the money that-- What would you do with it? May I ask you that question, then? What do you contemplate, in terms of the pension, for Saint Mary's -- what happens there?

EDWARD CONDIT: A portion--

SENATOR VITALE: Yes, put your button on red (referring to PA microphone)

MR. CONDIT: A portion of the proceeds from the sale were going to be used towards addressing of non-union church plan pensions.

SENATOR VITALE: So what does that mean -- addressing it? How do you address it? What's the-- Is it fully funded now, or is it partially funded now?

MR. CONDIT: No, it's not fully funded at all.

SENATOR VITALE: Is it like--

MR. CONDIT: It's severely underfunded. At this point it's hard to say exactly how we're going to address it, because we're trying to determine exactly how much money we're going to be able to have from the proceeds -- and a decision that the board has to make once we determine that. But we know for a fact that a significant portion of the proceeds will be used to try to address the pension.

SENATOR VITALE: Do you know what the overall debt of the hospital-- If you say the pension obligation is *X*, what are the other cost obligations of the hospital?

MR. CONDIT: It's, obviously, accounts payable -- that's that part of the debt. We have the bond debt, and you have the third party liability associated with Medicare and Medicaid.

SENATOR VITALE: What's the bond debt there?

MR. CONDIT: It's close to \$40 million.

SENATOR VITALE: That's all State debt -- all State bond money?

MR. CONDIT: That is State bonds.

SENATOR VITALE: And Mr. Kimmel, is there-- Are you still in negotiations to purchase the hospital? Or is it-- have you signed an agreement?

MR. KIMMEL: Yes.

SENATOR VITALE: So what part of the \$40 million bond obligation will Prime assume, if any?

MR. KIMMEL: Prime will not assume the pension or debt obligation. Prime purchased the hospital with the expressed intent that the board -- the selling board would determine the proportion that goes to each.

SENATOR VITALE: What is the purchase price of the hospital?

MR. KIMMEL: It is \$25 million. So \$25 million towards the \$40 million and/or the pension obligation.

SENATOR VITALE: But there are other debts: there are accounts payable, there are other cost obligations that you have today.

MR. KIMMEL: Prime assumes the working capital -- current assets, current liabilities -- so the accounts payable--

SENATOR VITALE: Is assumed by Prime.

MR. KIMMEL: That's assumed by us.

SENATOR VITALE: Are there other elements of the hospital's debt, besides accounts payable, or the bond, or the pension -- are there

other obligations? Are there any real estate obligations or any other obligations?

MR. CONDIT: The asset purchase agreement-- Actually, Prime will take on all liabilities associated with the hospital except for the bonds and the non-union pensions.

SENATOR VITALE: The non-union pensions. So the union pensions, you're going to assume.

MR. CONDIT: That's part of the contract.

MR. KIMMEL: They're funded.

SENATOR VITALE: They are funded, rather. They are funded and you will continue your responsibility to continue to fund them.

MR. CONDIT: Right.

SENATOR VITALE: So how many employees are affected by the Catholic pension?

MR. KIMMEL: Two hundred?

MR. CONDIT: About 600 people -- employees.

SENATOR VITALE: Six hundred, but not--

MR. KIMMEL: The church?

SENATOR VITALE: How many are in the Catholic system -- the Catholic pension?

SENATOR GORDON: The non-union part.

SENATOR VITALE: The non-union part.

MR. KIMMEL: On the church plan?

MR. CONDIT: Yes, the church plan -- the non-union--

SENATOR VITALE: Yes, the church plan. I'm sorry; I shouldn't say Catholics -- the church plan.

MR. CONDIT: About 600 employees.

SENATOR VITALE: Six hundred in the church plan?

MR. CONDIT: Yes -- employees.

SENATOR VITALE: And how many are in the union plan, roughly?

MR. CONDIT: There are 1,200.

SENATOR VITALE: Total? So it's roughly half and half.

MR. CONDIT: Twelve hundred employees -- yes.

SENATOR VITALE: So it's half and half. So those 600 employees who are part of the church pension aren't really going to see very much of their pension, right? What will happen to them, going forward?

MR. CONDIT: It's still being determined how much money will be able to be towards that, and how that will be handled.

MR. KIMMEL: Well, going forward, they'll become part of Prime; they'll be eligible to participate in an employer-matching 401(k), and--

SENATOR VITALE: So you'll have a defined benefit for those who are currently in the church system?

MR. KIMMEL: It's a defined contribution plan, but contributory from the employer -- Prime -- and they retain the seniority that they had coming in.

SENATOR VITALE: What about the retirees in the church pension? Are they receiving any pension benefit at all now?

MR. CONDIT: Saint Mary's is handling and covering the entire pension as it is today. So everybody is receiving their benefits.

SENATOR VITALE: They are receiving their benefits.

MR. CONDIT: Yes.

SENATOR VITALE: The retirees are receiving their full benefits.

MR. CONDIT: Yes, everybody is.

SENATOR VITALE: But those who are in the system now, if they were to retire, if they were to move on, if they were to whatever, the money is not there to support them.

MR. CONDIT: Excuse me -- what was the question?

SENATOR VITALE: I'm sorry. There are 1,200 active employees -- 600 in the church system and 600 in the other system. So those who are-- There are 600 active employees in the church plan?

MR. CONDIT: Yes, that's correct.

SENATOR VITALE: Mr. Kimmel, you talked about -- we briefly touched on the out-of-network issue, and there is a lot of testimony before you came to the table about some of the models that have existed in New Jersey. And you and I had talked about this issue privately -- that you would honor the -- through the law, of course -- you would follow the law. If the law said that out-of-network -- that waiver of cost share for out-of-network services was to be defined as fraud as it is in Medicare -- that you would live up to the law, of course.

MR. KIMMEL: Certainly.

SENATOR VITALE: And anyone would be expected to. But right now it is not the law. And we saw with Saint Joe's, and we saw with Bayonne and Hoboken -- more specifically with Bayonne -- that they were actively waiving cost share, actively trying to incent patients to come to their hospital -- those who were not in-network. And to incent them by

saying, "We'll waive your cost share, any co-pay, any co-insurance, or at least charge you what you would have paid if you were in-network." Is that a practice that Prime prides itself on today? Or is that something that you don't do, as a policy?

MR. KIMMEL: It's not something that we do today. I would not say, on the record, that we would never resort to that as long as it's not against the law. It depends on the status of the negotiations. But again--

SENATOR VITALE: The existing contracts at Saint Mary's and at Saint Mike's that you -- if Saint Mike's still goes through as well -- are you going to honor all the existing insurance contracts for the length of the term?

MR. KIMMEL: Yes.

SENATOR VITALE: And what happens-- After that, it's just another negotiation for the contract, of course.

MR. KIMMEL: Correct.

SENATOR VITALE: Okay.

The issue in New Jersey-- Part of the issue with the out-of-network problem that we have is with the radiologists, and pathologists, and anesthesiologists, and others who are out-of-network. So I plan a scheduled surgery at your hospital, and my surgeon is in-network, and he has privileges there or she has privileges at your hospital. And the hospital is in-network. I have the procedure done; two days later I come home and a week later I get bills from the anesthesiologist, the pathologist, the radiologist, and everyone else. And without explaining why it is that that's a huge issue in New Jersey, what's the position of Prime? Are all of the

anesthesiologists who perform work at that hospital -- at your hospitals -- are they required to accept the insurance that you do?

MR. KIMMEL: Yes -- all of them in every Prime hospital.

SENATOR VITALE: And I don't mean just employees at the hospital; I mean those who have privileges at your hospital.

MR. KIMMEL: Correct.

SENATOR VITALE: Okay.

MR. KIMMEL: Anesthesiology, pathology, radiology, and emergency room physicians are the classically defined hospital-based physicians -- they are all required, by virtue of their contract, to participate in the plans that the hospital does.

SENATOR VITALE: Okay.

What about a hospital -- what about a plan that you may not have a contract with? So pick United, or Aetna, or Horizon -- let's just say, in the future, that you're-- Through negotiations, and the term for Horizon expires, the contract has expired and you negotiate. And you haven't been able to reconcile a negotiation. So Horizon is now out-of-network. But the patients coming to your hospital may still be Horizon patients. The anesthesiologist now is not in-network. What happens to them? What happens to the patient?

MR. KIMMEL: I don't know the answer. I expect that we would work with the doc -- the group -- to adopt the same approach that we had. And if that was out-of-network, it was out-of-network. If it was along the lines as described earlier, then we'd want to present a unified front to the patients as well as to the insurer.

SENATOR VITALE: I just want to turn your attention to Saint Mike's for a moment, in Newark. There is an existing bond that Catholic Health East received when they purchased that hospital from Cathedral. And I don't recall the total amount of that; it was over \$100 million -- that bond. Some of that money was used to outfit the new ER and to build a new emergency department. But there is still outstanding debt. Do you know how much outstanding debt there is on that bond -- how much bond is still outstanding?

MR. KIMMEL: I don't.

SENATOR VITALE: Well, there is spent and unspent. So the unspent goes -- potentially, goes back.

MR. KIMMEL: I think the unspent is in the range of \$125 million to \$150 million. I'm not fully informed.

SENATOR VITALE: So any of the-- Do you know what the outcome of the current bond indebtedness that currently exists with CHE -- Catholic Health East -- is, and what to do -- what they or you are going to do about that -- or the State? Do you have a sense of what that is?

MR. KIMMEL: Again, like I described for Saint Mary's, we said to the seller -- we wrote a check to the seller. And what they decide to do with it is up to them. How much of that gets applied towards the debt, how much of it gets applied to an unfunded pension liability is the responsibility of the seller.

SENATOR VITALE: So part of the negotiation of the purchase of the hospital at Saint Mike's was to contemplate what all the debt was, right?

MR. KIMMEL: I'm sorry?

SENATOR VITALE: You consider what all the debt was?

MR. KIMMEL: Yes.

SENATOR VITALE: Right -- including the pension?

MR. KIMMEL: Yes.

SENATOR VITALE: And including the bond, and all those other elements; okay.

Some hospitals -- not just when they convert from for- to not-for-profit, but in certain hospital sales -- the new buyers will inflate or change their charge masters. Is that a practice of Prime?

MR. KIMMEL: No.

SENATOR VITALE: To change your-- You adopt the exact same charge master as--

MR. KIMMEL: Yes, we do.

SENATOR VITALE: --the existing hospital?

MR. KIMMEL: We have in every instance.

SENATOR VITALE: Okay, good.

I have no other questions for now, but thank you for coming. I'm sure we'll have other discussions in the future, but I appreciate the opportunity that you took to be here today.

I will say that we are disappointed, as a Committee, that your friends in Hudson Holdco and CarePoint did not attend. They were invited; they declined to come. As I said earlier in testimony today, they were invited to tell their story of the three hospitals that they currently own in New Jersey. They declined to come. That's not good for them and that's not good for us. And a hospital license is a privilege; it's not a right. They may have that license, but it's owned by the citizens of this State, and

they're obligated -- and everyone, for that matter -- every hospital owner is obligated to behave professionally and to appear before a Committee when they're asked to come. Particularly when it is that they receive-- Well, they take care of our patients, but they also receive plenty of State charity care dollars and other resources that we provide through them, i.e. bonding and the like.

But thank you for coming -- taking the time to come out from California to be here.

SENATOR RICE: Mr. Chairman.

SENATOR VITALE: Senator Rice.

SENATOR RICE: Yes, just in closing, for the record.

Let me just say that we need to look into the bond debt piece up there at Saint Mike's -- number one -- and the numbers, (indiscernible) numbers. And number two, after our delegation meeting, all of a sudden I know that Newark residents were inundated almost every other day with postcards about how well Prime is going to treat them and the patients, because everybody is falling apart now, and they're going to save the hospital. You need to look into the issues of the property that they're going to sell and the amount of money that they're putting up -- allegedly going to put up.

But I just want, you know, to thank you also for coming, because I already said, I like your style. You come up front, and you tell me, by any means necessary, you are out to make money. So if we get hurt in the process, that's okay -- you have stockholders. But let the workers know and the patients know that I've gotten all the phone calls. You can't even pick the phone up anymore because they're calling me like every 30

seconds. So you're doing a good job getting them to jam the phones. I don't have a problem with that.

Again, panic -- the workers there are panicked because they are calling and saying, "Mr. Rice, we know you, I work over here. And they told us to call because you're going to close that hospital." And we tell them, "We're not trying to close any hospital. We're just trying to bring integrity to the process."

And by the same token, as I said to you before, when this deal first came down there would be other people --- and I think there should still be other people, Mr. Chairs -- looking at this deal. Because if you listen to Prime, it's a done deal. And it shouldn't be a done deal, primarily because the bond aspect of it is not longer a part of an obligation to whomever actually gets that institution if, in fact, they can get it and save it. I think that's a very, very important piece, because there are others who do have experience with New Jersey -- that we have regulated, we do (indiscernible), we clean them up -- that would have an interest knowing that that debt--

And then we need to find out exactly who is paying that debt. The bond piece -- and we know it's us -- what it's going to cost us, etc., etc. But I don't think we're talking about \$40 million here, if I'm being correct. We're talking about a heck of a lot more than that. And I'm not sure what's left on the debt, but there are still a lot of other questions to be asked. And while we're holding hearings, and asking questions, and not getting any response back of substance from the Administration, they're trying to move like this. And, you know, all the big guns and the big money pouring in because they promised to spend a lot of money -- I don't have a

problem with that. But we're still the Legislature, and we need to get answers.

And by the same token, I understood you then, and I understand you now, about California. And you ask people, and we can call out there and the Attorney General and clean all this stuff up. No, no, no, no. no. We need to be talking to the Federal government as well as the state government out there because, number one, everybody doesn't agree. And we're smart enough to know that in California it's no different than New Jersey. There are people out there who have relationships with the legislature; and we know that the people out there, who are supposed to be oversighting, also have relationships. And so it goes beyond just asking. There really needs to be some cleansing if it comes before us, because if what you are saying is true, then we're likely to believe that. Right now there are a lot of questions and (indiscernible). And I would have to be respectful today -- some of my friends down here who are not legislators and folk, and I am respectful. But I do like your style because you come, and you take your heat, and you lay it out there, and you articulate very well. But there is still a real serious question mark in this country in places where Prime operates. Not against you, personally, because you didn't sign it. You work, like we do for somebody; and you're doing good job at that. And you're carrying their message.

So Mr. President (*sic*), in Oversight, I know that the Legislature can ask some of these questions with the Federal government people, too. We can't just rely on the Administration because, once again, there's a real serious movement towards privatization of a lot of things.

So thank you once again, Mr. Chair, for allowing me to, at least, be on record so that the archives will reflect my opinions when I pass on.

SENATOR GORDON: I want to add my thanks to our witnesses for coming here. Senator Whelan; also, for--

SENATOR WHELAN: I tried not to dominate today, Senator Gordon. (laughter)

SENATOR GORDON: --Senator Ruiz.

And I want to thank everyone who testified today and attended. This is the beginning -- in my view, the beginning of a process that I hope will end in some legislative changes that will improve the system.

I, for one, really don't have strong feelings as to whether the provider is for-profit or not-for-profit, as long as the State is monitoring and making sure that our standards are being adhered to.

And we obviously have heard about some weaknesses in the existing system, and we're going to endeavor to fix that.

Again, thanks to all for appearing here today, and for attending. And with that, I'll adjourn the meeting.

(HEARING CONCLUDED)