

The Prince George's Hospital System Improvement Task Force

Draft Final Report on

Ensuring the Long-Term Viability of
The Prince George's Hospital System
An Analysis and Recommendations

Dr. George C. Malouf, Chair

December 2002

I. Origin of the Task Force

Dimensions Hospital System plays a vital role in ensuring the health of the residents of Prince George's County and surrounding jurisdictions. For the past several years, the System has been facing serious financial difficulties. Out of concern about the impact of these difficulties on the State, the Maryland General Assembly enacted Chapter 342, Acts of 2002, to establish the Prince George's Hospital System Improvement Task Force. The purpose of the Task Force is to identify strategies that will help the System achieve long-term financial stability. Chaired by Dr. George S. Malouf, the Task Force consists of 22 members, who were selected because of their expertise in finance, health care, or State and local government (see Attachment I for complete membership list).

II. The Work of the Task Force

The Task Force is required by statute to issue its final report by September 2004. As the first order of business, the Task Force decided to complete its work much earlier, given the pressing nature of Dimension's financial difficulties. This final report, completed in December 2002, should be timely enough to provide guidance to newly elected officials on the local and State levels. The Task Force plans to monitor the implementations of its recommendations for the remainder of its existence.

The Task Force began its work by holding a series of meetings to hear from the major stakeholders in the process, including Dimensions Health Care System, University of Maryland Medical System, and the Prince George's County Executive Office (see Attachment II for complete list of presenters). These stakeholders provided useful information on Dimensions itself and the climate in which it operates. Topics of discussion included the hospital rate-setting system, uncompensated care, and the nursing shortage.

Following the presentation of major stakeholders, the Task Force members conducted independent research into the pertinent issues. With the findings from this research, the members developed their recommendations. These draft recommendations will be presented at a public hearing on December 18, 2002.

III. The Importance of Dimensions' Role in the Community

As the largest provider of inpatient and emergency services in the county, Dimensions is a cornerstone in the health care system of Prince George's County. However, its importance extends beyond county borders. Residents of surrounding jurisdictions rely on many of Dimensions' services, particularly emergency care. Therefore, access to quality health care for the whole region depends on the continuation of Dimensions' services. In the past fiscal year, Dimensions has been the primary provider of care to:

- 22,614 individuals who need surgery or other medical care in an inpatient setting;
- 130,748 individuals who require emergency care, including 2,500 individuals at the only Level II trauma center in the region;
- the majority of the uninsured and Medicaid beneficiaries who need inpatient and emergency room services;
- the majority of high-risk pregnant women and infants, given that Dimensions has the only Level III NICU and perinatal diagnostic center in the area; and
- 16,670 individuals who require ambulatory surgery.

IV. History of Dimensions Health Care System

Dimensions Health Care System is a 501(c)(3) non-profit which includes (see Attachment III for complete organizational chart):

- Prince George's Hospital Center (PGHC), a 284 bed acute care hospital;
- Laurel Regional Hospital (LRH), a 107 bed acute care hospital;
- Bowie Health Center (BHC), an ambulatory surgery and emergency room facility; and
- Full and partial ownership in several long-term care facilities.

Although Dimensions is now a private non-profit organization, the hospital system has a long history of being a county-owned entity. In 1970,

Prince George's County adopted a charter to make Prince George's Hospital Center, then a private community hospital, into a county department. Shortly thereafter, the County expanded its service capacity by building LRH and the BHC.

In 1983, the County made its first attempt to move away from direct management of the hospital system. A 10-year lease was negotiated with Community Hospitals and Health Care System (CHHCS). However, CHHCS came close to collapse. Local officials stepped-in and helped restructure the system. With a reconstituted board, the name of the system was changed to Dimensions.

Dimensions negotiated with the County for a one-time payment of \$10 million and an annual subsidy of \$2.5 million for indigent care. The annual subsidy, subject to review and the availability of funding, was established so that Dimensions could continue to serve individuals in need.

Dimensions, as CHHC had, leased all its facilities and grounds from the County. In 1992, Dimensions extended the term of the lease to 2042, with a one-time payment of \$13.3 million from a bond issuance and \$1 annual lease payment (See Attachment IV for a detailed analysis of Dimensions' relationships with its bond trustees and Prince George's County).

The County ended its annual indigent care payment to Dimensions in 1994, although the payment has remained an option under the lease agreement. Dimensions initially could sustain itself without this subsidy because the system was in good financial health. However, the financial tide began to turn for Dimensions in the late 1990's. Like many other providers, Dimensions has struggled to adjust to major changes in the health care system. Throughout these difficult times, the hospital system has remained committed to ensuring all individuals in need have access to care.

As a result of its financial difficulties, Dimensions is exploring a potential sale or merger with another hospital system. Such a transaction could bring in an infusion of funds. Dimensions is now reviewing proposals from six hospital systems. Once the review has been completed in early 2003, more details will be known about the impact of a potential sale or merger.

V. Dimension's Current Financial Status

Dimensions experienced \$45.8 million in operating losses between fiscal 1999 and 2002, as shown in **Exhibit I**. To cover these losses, Dimensions used

Exhibit I
Dimensions Health Care System
Consolidated Statement of Revenues and Expenses
(\$ in Thousands)

	<u>FY 1999</u> <u>Audited</u>	<u>FY 2000</u> <u>Audited</u>	<u>FY 2001</u> <u>Audited</u>	<u>FY 2002</u> <u>Audited</u>	<u>FY 2003</u> <u>Budget</u>
Revenue					
Patient Revenue					
Gross Patient Revenue	\$251,143	\$255,377	\$284,828	\$314,619	\$323,602
Contractual Allowances	(\$13,895)	(\$15,201)	(\$19,509)	(\$21,933)	(\$22,041)
Physician Fee Allowance	(704)	(1,291)	(1,979)	(4,113)	(3,983)
Bad Debts & Charity	<u>(35,814)</u>	<u>(38,778)</u>	<u>(35,001)</u>	<u>(34,190)</u>	<u>(35,472)</u>
Net Patient Revenue	\$200,730	\$200,107	\$228,339	\$254,383	\$262,106
Other Operating Revenue					
Other Revenues	8,682	6,601	7,111	12,733	8,094
Investment Income	<u>651</u>	<u>624</u>	<u>-</u>	<u>-</u>	<u>-</u>
Total Other Operating Revenue	\$9,333	\$7,225	\$7,111	\$12,733	\$8,094
Non-Operating Investment Income	\$2,202	\$1,898	\$1,074	\$1,671	\$480
Total Operating and Non-Operating Revenue	\$212,265	\$209,230	\$236,524	\$268,787	\$270,680
Expenses					
Operating Expenses					
Salaries	\$99,803	\$100,277	\$111,252	\$121,101	\$122,270
Employee Benefits	16,616	16,039	15,227	17,352	19,461
¹ Physician-Related Compensation	9,937	11,216	12,820	13,663	14,567
Supplies	35,948	39,173	40,728	44,885	44,986
Utilities	3,284	3,431	3,517	3,473	3,855
Purchased Services	<u>36,218</u>	<u>40,098</u>	<u>44,301</u>	<u>56,989</u>	<u>49,541</u>
Total Operating Expenses	\$201,806	\$210,234	\$227,845	\$257,463	\$254,680
Interest and Depreciation					
Interest Expense	\$5,803	\$5,680	\$5,669	\$5,397	\$5,329
² Depreciation & Amortization	<u>11,587</u>	<u>11,300</u>	<u>10,891</u>	<u>10,629</u>	<u>10,421</u>
Total Interest and Depreciation	\$17,390	\$16,980	\$16,560	\$16,026	\$15,750
Total Operating Expenses	\$219,196	\$227,214	\$244,405	\$273,489	\$270,430
(Deficit)/Surplus from Continuing Operations	(\$6,931)	(\$17,984)	(\$7,881)	(\$4,702)	\$250
Gain/(Loss) from Discontinue Operations	(\$9,341)	\$1,000	\$0	\$0	\$0
(Deficit)/(Surplus) from Continuing and Discontinued Operations	<u>(\$16,272)</u>	<u>(\$16,984)</u>	<u>(\$7,881)</u>	<u>(\$4,702)</u>	<u>\$250</u>

¹ Includes physician subsidies at PGHC, Laurel Regional Hospital and Bowie Health Center. The Task Force identified the physician subsidy at PGHC as one of the reasons behind Dimensions' financial difficulties.

² Depreciation mostly stems from 7-year depreciation on equipment.

Source: Dimensions HealthCare Systems Audited Financial Statements

its cash reserves and the subsidies from the County and State. This effort has drained Dimensions' rainy day resources. As of the end of October 2002, Dimensions only had 9 days of cash on hand.

Dimensions may reverse the trend of severe operating losses in fiscal 2003 with a positive margin of \$250,000, as shown in the budgeted projections under Exhibit 1. This positive margin could fall if projected revenues are lower or projected expenses are higher. The modest improvement in Dimensions budget projections is the result of several key actions taken by the hospital system:

- **Contract with Cap Gemini:** Dimensions recognized that its bottom line could be improved by more efficient management. To identify operational improvements, Dimensions contracted with Cap Gemini, a nationally-known management consulting firm. Cap Gemini has helped Dimensions to enhance collection of patient revenue and reduce expenditures through efficiency measures.
- **Working with the Health Services Cost Review Commission (HSCRC):** Since 1974, the HSCRC has regulated the rates of all hospitals in Maryland. This rate-setting system has benefited hospitals because it provides for more stability in revenues. When Dimensions began experiencing financial difficulties, it appealed to the HSCRC for financial relief. The HSCRC worked with Dimensions to enhance rates at PGHC, which has been hit hardest by operating losses:
 - After a full rate review in fiscal 2001, the HSCRC agreed with Dimensions that PGHC's overall rate structure was not sufficient. The HSCRC allowed PGHC to raise its rates by almost 4%, in addition to an annual inflation factor.
 - The HSCRC recognized that PGHC has one of the largest shares of uncompensated care in Maryland. To help PGHC recoup some of its lost revenue, the HSCRC allowed the hospital to raise its rates by another 3.9%. However, the revenue from this rate increase only covers a portion of PGHC's losses. Therefore, the HSCRC covers the remaining losses with an annual grant of about \$12 million from the Uncompensated Care Fund, which is collected from hospitals across the state.
- **Initiating Partnerships with the County and State:** Facing severe cash-flow problems, Dimensions reached out to its partners in County and State Government. In fiscal 2002, Dimensions was able to secure \$3 million from the County and \$2.5 million from the State. Without these funds, the operating losses shown in Exhibit 1 would have been

more severe. If the County provides a \$3 million match in fiscal 2003, the State is willing to renew its commitment with another \$2 million.

Despite the modest improvements in Dimensions' projections for fiscal 2003, the hospital system is still in a very tenuous financial position. The projected profit margin cannot begin to meet Dimensions' most pressing needs. Dimensions will still be left without the funds to make much needed investments in staff, facility improvements, and equipment. More long-term debt, at this point, is not an option given that Dimension's percent of debt to total capitalization has already reached 81%.

If there is an unexpected drop in revenue or increase in expenses, Dimensions will soon be facing a negative operating margin again. It would be very challenging for Dimensions to address ongoing losses, given that it has already used much of its rainy day reserves.

VI. Reasons Behind Dimensions' Ongoing Financial Difficulties

Dimensions' financial difficulties are the result of ongoing problems within its system and the greater operating environment. These problems were exacerbated in the late 1990's by one-time only losses stemming from the failure of Prime Health, a Medicaid managed care organization, and the divestment of group medical practices. Dimensions acknowledged that the purchase of group practices did not benefit the system as expected, but many other hospital systems had similar strategies at the time.

The problems still facing Dimensions include: 1) a uniquely competitive market; 2) difficulty in building a medical and health professional staff for the future; 3) the need to subsidize physicians; 4) lack of access for capital funding; and 5) an inflexible governance structure;

A. Difficulties in Maintaining Market Share in a Uniquely Competitive Market

Dimensions operates in a very aggressive health care market. The system is surrounded by highly competitive hospitals in Prince George's County, the District of Columbia, Montgomery County, Anne Arundel County, and Baltimore City (see Attachment V for map of competitors).

Most of Dimensions competitors have far better facilities and equipment. Some even have nationally-renowned clinical programs. This makes it difficult for Dimensions to attract patients and maintain its market share. Dimensions also has difficulty in competing for managed

care contracts because PGHC has relatively high rates because of the increase built-in to recoup some of its uncompensated care losses.

B. Difficulty in Building a Strong Patient Base with a Solid Physician Network

A strong patient base is the backbone of any viable health care system. This base depends on referrals from a solid physician network. Dimensions' because many members of its physician network are near retirement. The hospital system is experiencing great difficulty in recruiting new physicians because its competitors have better facilities and payor mixes.

Dimensions is also having difficulty recruiting and retaining other health care professionals, particularly nurses in this time of nursing shortages. Many employers in the area offer more competitive compensation packages.

C. The Need for Physician Subsidies

Dimensions has continued its commitment to ensuring that the most vulnerable citizens have access to medical care. As a result, Dimensions has one of the more unfavorable payor mixes in the State. Dimensions estimates that it shoulders 78% of the uncompensated care burden in the county, with most of that care provided by PGHC. This fact is reflected in PGHC's payor mix, which is 22.5% uninsured, 28.8% Medicaid or Medicaid pending, and 48.7% other major payors. With this payor mix, Dimensions must provide an \$11 million annual subsidy to its physicians at PGHC. This subsidy drains resources that could otherwise be used for much needed capital improvements.

There has been some relief from the need to subsidize physicians with high Medicaid caseloads. Under the leadership of Secretary Georges C. Benjamin, M.D., the Department of Health and Mental Hygiene (DHMH) recently implemented the first step of a rate enhancement plan for Medicaid physicians, with the approval of Governor Glendening and the General Assembly (see Attachment VI for DHMH's plan). The first step focuses on fee increases for primary care physicians, thus reducing the need to subsidize those physicians. However, Dimensions will still need to provide a full subsidy to its specialty physicians because they do not receive fee increases on the first step of the plan.

The Medicaid fee increase partially addresses the need to subsidize physicians with high Medicaid case loads, but they do not address the problem of uncompensated care. While the HSCRC rate-setting system

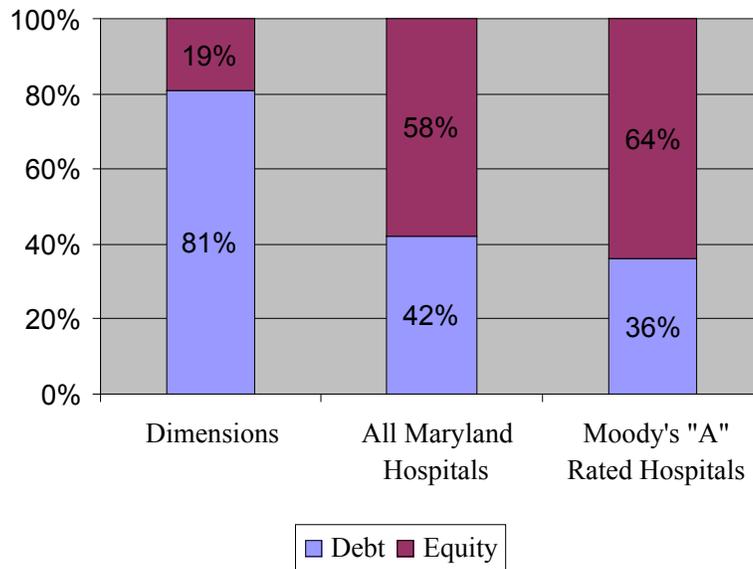
shields hospitals from unfavorable payor mixes, it does not protect physicians because of restrictions in federal statutes.

D. Lack of Access to Capital Funding

Dimensions needs capital funding to update facilities and equipment. Without these improvements, Dimensions cannot build its physician and patient bases. However, Dimensions’ ability to borrow capital funding is limited because of its inadequate operating margin, insufficient liquidity, and high debt to capital ratio.

Dimensions has a high debt ratio because the County still owns all of Dimensions’ facilities and grounds. Without these assets, Dimensions’ debt to equity ratio is too high to secure favorable bond ratings, as shown in **Exhibit 2**:

Exhibit 2
% of Debt to Total Capitalization



Source: University of Maryland Medical System

With such a high debt to equity ratio, Dimensions cannot easily access any additional long-term debt. Moody's has downgraded Dimensions to B-.

E. An Inflexible Governance Structure

Dimensions' board has oversight of every facility in the hospital system. Each facility has a separate board that advises the members of Dimensions' board. The facility boards do not have the ultimate authority over facility operations. Only the Dimensions' board can make final decisions.

The structure of Dimensions' board is mandated by the terms of the hospital system's lease agreement with the County. The lease requires that 8 of the 11 seats on the board be filled by representatives of the following stakeholders: the PGHC Board, the LRH Board, the BHC Board, the Prince George's County Medical Society, PGHC medical staff, LRH medical staff, the Prince George's County Executive Office, and the Prince George's County Council.

The composition of the board does not include enough outside community and business leaders. As a result, Dimensions has experienced difficulty in building a broad base of support. Dimensions needs this support in facing its current financial challenges.

VII. Task Force Recommendations about Dimensions

As required by statute, the Task Force's goal is to identify possible solutions to assist the hospital system in achieving success. This success is essential in ensuring that residents of Prince George's County and surrounding jurisdictions continue to have access to quality health care.

The hospital system needs a sufficient level of operating funds in the short-run, but the hospital system's long-term survival depends on capital funding. Thus, the Task Force's recommendation addresses both the short- and long-term financing needs of the hospital system:

Recommendations on Short-Term Solutions

- 1. Funding for Short-Term Operating Needs:** In fiscal 2002, the hospital system received \$2.5 million from the State and \$3 million from the County. The funding commitment was in recognition that the hospital system's financial viability is critical to ensuring access to quality

care. The State has continued its commitment with another \$2 million in fiscal 2003. To draw-down these State funds, the hospital system must receive a matching commitment of \$3 million from Prince George's County. **The Task Force recommends that Prince George's County provide the \$3 million in matching funds, given that an annual indigent payment is already an option under the current lease agreement. Once these matching funds are provided, the Task Force recommends that the Maryland General Assembly release the State funds for the hospital system, in accordance with the provisions of the Fiscal 2003 Budget Bill. The Task Force strongly recommends that both the County and State grants be used by the hospital system exclusively to fulfill its mission to the public.**

Recommendations on Long-Term Solutions

- 1. Enhancing Access to Long-Term Debt:** When the hospital system became a private entity, the County retained ownership of the grounds and facilities. This arrangement has severely restricted the hospital system's ability to obtain long-term debt and make necessary capital improvements. This problem was avoided in other public-to-independent non-profit conversions by transferring ownership of the assets to the private entity, on the basis that the private entity would continue its commitment to the public. **The Task Force recommends that Prince George's County and the hospital system develop an agreement to transfer ownership of its assets by July 1, 2003. Transferring assets will give the hospital system the flexibility to restructure capital debt, enhance its position in the bond market, and ultimately create more opportunities for financial solvency. If the assets are transferred, the lease between the hospital system and the County will be dissolved. It is understood that any changes would not impact the security interests of existing bondholders.**
- 2. Ongoing Operating Support:** Under the current lease agreement, Prince George's County has the option of making an annual indigent care payment to the hospital system. The hospital system will continue to need this support, even if the lease agreement is dissolved because of an asset transfer. **While the lease arrangement continues,**

the Task Force recommends that Prince George's County renew its commitment to an annual indigent care payment to the hospital system. If the lease agreement is dissolved, the County should continue this commitment for at least three years to assist the hospital system in achieving long-term financial stability. The hospital system should demonstrate how it will achieve this stability in a long-term financial plan.

- 3. Obtaining Capital Support from the County and State:** Even if the assets are transferred, the hospital system will need capital support from the County and the State. This capital support has been an important factor in the success of other public-to-independent non-profit conversions. The hospital system, like similar institutions in Maryland, needs capital support because it provides a high-volume of services to the most vulnerable individuals – the uninsured, Medicaid beneficiaries, and trauma patients from many jurisdictions. **The Task Force recommends that the County and State assist the hospital system with its long-term capital needs, given that capital support has been an important factor in other successful public-to-private conversions. The hospital system needs this capital support to continue its mission to serve the public. The hospital system should work with the County and State to develop a long-range capital plan.**

- 4. Examining Sale and Merger Opportunities:** A sale or merger could provide the hospital system with a much needed infusion of funding. **If the hospital system continues to explore any sale or merger options, the Task Force recommends that the hospital system should only consider proposals that are from entities with a proven track record that can ensure that: 1) the system will continue its mission of serving those most in need. Without the hospital system's services, many uninsured individuals and Medicaid beneficiaries would have great difficulty in accessing quality health care; 2) the system will continue to deliver quality care to all its clients; and 3) good management practices will keep the system financially viable.**

5. **Restructuring the Hospital System's Board to Build More Community Support:** The board's structure is mandated by the terms of the hospital system's lease agreement with Prince George's County. As the result of the inflexibility of this lease agreement, the board does not include the most important stakeholders in the community. **The Task Force recommends that the hospital system board be restructured. If the lease remains, the agreement should be amended to expand the board and minimize the number of designated seats. If the lease is terminated, then there should be a new board materially larger than the current board and without a significant number of designated positions. In either event, there should be substantially new board membership. Recruitment should build a board of extraordinary quality that is focused on the hospital system's fiscal health. New members should facilitate the following: 1) the hospital system's ability to build strong relationships with business leaders, community groups, and elected officials on the local and State level and 2) the board's consideration of community needs in making management decisions.**

6. **Developing a Long-Term Clinical Services Plan:** The hospital system has made some short-term financial progress by implementing Cap Gemini's recommendations on enhancing patient revenue collections and increasing efficiency. To ensure financial viability in the long-run, the hospital system needs a strategic clinical services plan with a strong marketing component. **Therefore, the Task Force recommends that the Board make the development of a long-term clinical services plan a top priority. To strengthen its clinical services, the hospital system should explore affiliations with other health care entities, particularly academic medical centers. During the planning process, the Task Force recommends that the hospital system work with the Maryland Health Care Commission to determine unmet health care needs and identify potential Certificate of Need Opportunities.**

7. **The Study Panel on the Funding Needs of Trauma Centers:** The General Assembly established the study panel to examine the operating budget needs of the regional trauma centers in Maryland. Dimensions, like other

hospital systems with trauma centers, struggles to provide around-the-clock coverage. **Therefore, the Task Force recommends that the Study Panel consider the hospital system's needs in developing funding solutions for regional trauma centers. During the 2003 legislative session, the Governor and General Assembly should carefully consider the Study Panel's recommendations, given the importance of ensuring that all residents of the State have quick access to high-quality emergency care. There should also be consideration that a closer affiliation between the hospital system and an academic medical center could strengthen the trauma system.**

8. **Working with the HSCRC to Develop an Optimal Rate Structure:** The hospital system has worked closely with the HSCRC on rate issues. The HSCRC has allowed Dimensions to raise PGHC's rates to cover its operating losses, particularly in the area of uncompensated care. However, the higher rates have a negative impact on Dimensions' ability to compete for managed care contracts. To prevent rates from being even less competitive, the HSCRC covers some of PGHC's losses with a grant from the Uncompensated Care Fund. **The Task Force recommends that the hospital system continue to work closely with the HSCRC to obtain a rate structure that strikes the right balance between rates that yield sufficient revenue and rates that are competitive. The HSCRC can assist the hospital system in identifying possible market competitiveness, market efficiencies, and the best method for recouping uncompensated care losses.**

9. **Enhancing Medicaid Rates:** To maintain its provider network, Dimensions must subsidize its physicians because they lose money from uncompensated care and low Medicaid rates. In fiscal 2003, Governor Glendening and the General Assembly supported the first step of a plan to raise Medicaid rates to a sufficient level. With their support, DHMH was able to update fees for primary care physicians, but little was done for specialty physicians. **The Task Force recommends the continued implementation of the Medicaid fee enhancement plan so that physicians do not have to rely on hospitals for subsidies.**

VIII. Conclusion

Prince George's Hospital Center, Laurel Regional Hospital and the Bowie Health Center are the cornerstones of the health care system in the Prince George's County region. Access to quality care, particularly for individuals in need, depends on continuation of the hospital system's services. To ensure the future of those services, the Task Force urges that its recommendations be implemented expeditiously. Successful implementation will require a strong relationship between the hospital system and its partners in the public and private sectors. The hospital system, as well as the people it serves, needs the support of the Governor, General Assembly, Prince George's County Executive and Council, and other community leaders.

Attachment I
Membership List
The Prince George's Hospital System Improvement Task Force

Dr. George S. Malouf, Chair

The Honorable Dorothy Bailey

Dr. Georges C. Benjamin

Mr. Robert G. Brewer, Esquire

Mr. Robert A. Chrencik

Mr. Alvin C. Collins

The Honorable Ulysses Currie

The Honorable Wayne Currie

The Honorable Barbara A. Frush

Mr. Larry L. Grosser

Ms. Debra B. Humpries

Mr. Gary W. Michael

Ms. Shirley H. Morgan

Ms. Robin O. Oegerle

Mr. K. Mark Puente

Ms. Sylvia Quinton, Esquire

The Honorable Howard P. Rawlings

Ms. Sheila K. Riggs

Rev. Robert J. Williams

Ms. Phyllis Wingate-Jones

Dr. Melville Wyche

Staff: Uma Ahluwalia, Robyn S. Elliott, and Howard Cohen

Attachment II
List of Presenters to
The Prince Georges Hospital System Improvement Task Force

Cap Gemini
City of Laurel Representative
Dimensions
Department of Budget and Management
Health Services Cost Review Commission
Maryland Hospital Association
Medical Staff Representative from Laurel Regional Hospital
Medical Staff Representative from Prince George's Hospital Center
Nursing Association at Prince George's Hospital Center
Prince George's Chamber of Commerce
Prince George's County Executive Office
Town of Laurel Representative
University of Maryland Medical System