Forty Year Retrospective

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by Frank Ciesla

For acute care hospitals, 1975 was a seminal year for rate setting by the Department of Health ("DOH"). Brendan Byrne was sworn in as governor in January of 1974. He had appointed Joanne Finley as his Commissioner of Health and James J. Sheeran as his Commissioner of Insurance.

The system for setting the reimbursement rates paid by Blue Cross, was described by a court in 1973 as:

> Plaintiffs' contention overlooks the fact, however, [***7] that neither Blue Cross nor the hospitals control how much Blue Cross reimburses the hospitals for services rendered to Blue Cross subscribers. That function is vested in the Commissioner of Insurance of the State of New Jersey with the approval of the Commissioner of Health of the State of New Jersey by virtue of the Health Care Facilities Planning Act, *N.J.S.A. 26:2H-18(d).* On the other hand, the power and duty to determine charges made to the general public remain [*394] vested in the governing bodies of defendant hospitals. The rate-making process under the above act requires the rate of payment by Blue Cross to participating hospitals to be approved annually. The actual procedure is that in October or November of the preceding year each hospital prepares and submits its proposed operating budget for the coming calendar year to the Budget and Advisory Committee appointed by the Commissioner of Insurance. The Advisory Committee consists of three physicians, five hospital administrators, and four hospital trustees. The Committee is assisted in its review by the Budget Review Staff, a division of the Hospital Research and Educational Trust of New Jersey. The Health [***8] Care Facilities Planning Act requires the Commissioner of Health, in consultation with the Commissioner of Insurance, to determine and certify the costs of providing health care services based on reports prepared by the hospitals in accordance with a uniform system of cost accounting. N.J.S.A. 26:2H-18(c).
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> The Committee recommends to the Commissioner for his approval a tentative per diem reimbursement rate for the operating year for admissions to each hospital.
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> It is conceded by the hospitals and Blue Cross that in computing reimbursement [**588] rates by Blue Cross the Commissioners of Insurance and Health omit from consideration some of the costs necessary to the operation of hospitals (*e.g.,* the cost of providing indigent care). As a result the rates hospitals charge others, including plaintiffs, is computed to permit the hospitals to recapture their omitted costs. The difference in rates is said to approximate 20%.[1]

In a report published in 1974[2], this reimbursement system was roundly criticized as being controlled by the industry and not in the interests of the public. The Hospital Research and Educational Trust of New Jersey ("HRET"), referred to in the opinion, was a component of the New Jersey Hospital Association.

In response to this criticism, in the early part of January 1975, the Commissioner of Health issued guidelines to members of the DOH, for use in reviewing the budgets of all the acute care hospitals. The guidelines were known as the Standard Hospital Accounting and Rate Evaluation System ("SHARE"), a more complex rate setting system than the hospitals had been using up to that point in time.[3] These guidelines were not adopted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1, et seq. (hereinafter "APA"). Further, in January of 1975, the Commissioner of Health published proposed appeal rules, which were adopted and filed with the Secretary of State on March 12, 1975.

In response to the action of the Commissioner of Health, five hospitals (Monmouth Medical Center, Community Medical Center, Point Pleasant Hospital, Riverview Medical Center and Freehold Area Hospital) filed suit against the Commissioner of Health and the Commissioner of Insurance, as well as the Hospital Service Plan of New Jersey (Blue Cross). While this suit sought various forms of relief, the main focus of the complaint involved the failure of the DOH to have adopted the SHARE guidelines pursuant to the APA, the nature of the appeals process, and the delay in setting the rates for the hospitals.

continued on page 34

continued from page 33

As set forth in the litigation, the hospitals had submitted, pursuant to the pre-SHARE procedures, their budgets for 1975 in the late summer and fall of 1974. The decision to apply the new SHARE guidelines, after the year 1975 began, by its very nature created an issue for the hospitals, since the SHARE guidelines were not in effect at the time that the hospitals' 1975 budgets were prepared and submitted.

It was the initial position of the DOH that the proposed SHARE "guidelines" did not need the approval of the Health Care Administration Board ("HCAB") and could be implemented solely by the adoption of the Commissioner of Health and the Commissioner of Insurance.

The only issue that the court decided, was that the guidelines were, in fact, regulations and that the Commissioner of Health had not followed the APA in adopting these "guidelines." The court remanded the matter back to the Commissioner of Health, but did not rule upon any of the other issues in the litigation.

After some additional activity before the courts, the Attorney General issued a formal opinion on April 30, 1975, which stated that:

> In the instant situation, the Appellate Division reviewed the 1975 guidelines in Monmouth Medical Center, et al v. State of New Jersey, et al, Docket No. A-2147-74, et seq., decided April 30, 1975 and opined:
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> > We have no hesitancy in deciding that the guidelines issued were rules as the term is defined in N.J.S.A. 52:14B-2. The procedures are clearly established to implement the task of the Commissioners in carrying out their respective responsibilities under the provisions of N.J.S.A. 26:2H-18(c) and (d) and N.J.S.A. 17:48-7.
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> > The court further concluded that the health care facilities should be sufficiently apprised in advance by proposed administrative regulations of the criteria used to determine the reasonableness of the reimbursement rates.
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> > You are accordingly advised that in the event the 1975 guidelines are used to determine the reasonableness of the 1975 reimbursement rates, under N.J.S.A. 26:2H-18(d), these guidelines are administrative regulations subject to the approval of the HCAB and should be adopted in accordance with the Administrative Procedure Act.[4]

In light of this Attorney General opinion, a meeting of the HCAB was convened. Prior to that meeting, there were significant discussions between the members of the HCAB and the various hospitals, Blue Cross as well as the representatives of the Commissioners of Health and Insurance. The role of the five hospitals involved in the litigation attacking the SHARE guidelines was now superseded by the New Jersey Hospital Association ("NJHA"). NJHA led the discussions as to the role to be played by the HCAB in adopting the SHARE "guidelines". As counsel to Monmouth Medical Center, I had been informed by the CEO of my client, Felix Pilla [who was also the father of Mark Pilla, who previously served as both the President of Community Medical Center as well as the Executive Vice President of Barnabas Health] that it appeared that the HCAB would vote not to adopt the SHARE guidelines by a one vote majority. The HCAB meeting was a very tense meeting, probably attended by every hospital administrator, executives of Blue Cross and the various governmental departments, as well as other third party payors. When the vote was taken, the guidelines were approved by one vote. It is interesting at this point in time, to look back at the fact that the public members (those not associated with the governmental agencies or the hospitals) voted not to approve the guidelines as regulations. The two votes which made the adoption possible were the votes of Lloyd Wescott, who was on the Board of Hunterdon Medical Center and the vote of Monsignor Raymond Pollack, who was the Director of Hospitals for the Newark Archdiocese. To say there was disappointment on behalf of the hospitals would be an understatement in light of the effort, both "political" and legal, to force the matter before the HCAB.

As Felix Pilla opined after the meeting, "the bad news is that we will look back on SHARE as the good old days."

The SHARE System was an attempt by the DOH, through regulations, to control the cost of health care to Blue Cross beneficiaries. This was done by redefining cost centers, comparing the cost being recorded by different hospitals in cost centers, and disallowing costs that were over and above the corridors permitted under SHARE for the various cost centers.

After the initial determination as to the allowable costs and initial meeting then a "final cost schedule" would be issued which was ultimately the subject of an administrative appeal. One must look at this as an attempt by the DOH to micromanage the activities of each hospital (with approximately 100 acute care hospitals in the State of New Jersey in existence at that time), even though SHARE was applicable only to the Blue Cross and Medicaid payors. One of the issues that SHARE did not take into consideration was the various management approaches to providing services, which resulted in costs "being out of line" in some cost centers, because they were significantly below the comparisons in other cost centers. Also, certain unique circumstances, particularly payor mix, were not addressed.

Two of the issues not addressed by the court then came into play. The first issue was the timeliness of the rates being set for the hospitals. As argued in the brief, on behalf of the hospitals,

the rates set for 1975 were not final in 1975.

Under SHARE, after the "informal discussions between the hospital and the DOH" if there was not an agreement, the hospital was entitled to take an administrative appeal. The initial administrative appeal was structured, so that the hearing panel would consist of eight experts in the health care field, who would be able to judge the reasonableness of the costs being incurred by the hospital in each one of the cost centers. The difficulty with this approach turned out to be that an appeal hearing for a hospital could run for days.

The first hospital to enter into the hearing process was Monmouth Medical Center and after two and one-half days of hearings, when Monmouth Medical Center returned for the afternoon session of the third day, the Assistant Commissioner, John Reiss, was the only person sitting where the panel had sat for the two and half days and not a single member of the panel was present. At that point, Monmouth Medical Center was informed that the panel had resigned and felt that it was impossible for that mechanism to work in light of the fact that almost all, if not all hospitals, had requested an appeal and that it appeared that the average appeal would run for a number of days. So while the court and the litigation never addressed the hearing process, pragmatically the hearing process proposed by the DOH was unworkable. The DOH then fell back on the normal hearing process laid out in the Administrative Procedure Act, which requires the appointment of a hearing officer. However, rather than referring the matters to the Office of Administrative Law, which would then assign one of its professional hearing officers, the DOH retained their own hearing officers for the initial appeals.

The use of hearing officers is important to note because the hearing officer approach that the DOH employed was to use a hearing officer who was a lawyer, not an expert in the health care field. The reality is that once the SHARE appeals were no longer heard by the experts on a hearing panel, the "lawyer hearing officer" more and more relied upon the expertise of the DOH witnesses, which were given considerable weight. By the time the original court challenge to SHARE reached the Appellate Division, the Appellate Division relied upon the legal principle of administrative deference and determined that the Appellate Division would defer to the administrative expertise of the Commissioner of Health.

The implementation of the SHARE system also demonstrated that the judicial appeal process was inadequate due to the time delay in the processing of appeals. As an example, a case ultimately decided by the Appellate Division in May of 1982[5] dealt with the rate appeals for the years 1975 for Passaic General Hospital, 1976 for Saddle Brook General Hospital and Millville General Hospital, 1977 for Millville General Hospital and Passaic General Hospital, 1978 for Millville General Hospital and Passaic General Hospital, 1979 for Millville General Hospital and Monmouth Medical Center, and 1977 for Monmouth Medical Center.

The complexity of the SHARE system and the fact that it was only applicable to the Medicaid and the Blue Cross payors led the DOH to obtain a waiver to create a single rate making system, not a single payor system. At this time, the State of New Jersey developed and tested a DRG system. While it had a few of the elements of the DRG system now used by the Medicare program, overall the Medicare DRG system is not the DRG system developed and implemented by the DOH in many of its aspects. The New Jersey DRG system was ultimately abandoned after litigation was brought by various third party payors against the DOH, even though the validity of New Jersey's DRG system was upheld by the Court of Appeals for the Third Circuit.[6]

It makes sense to look back and see what can be learned and applied going forward. If one looks at the methodologies in use today, you have the largest payor, the Medicare system, unilaterally setting its payment rates without a complex rate making system, based on each hospital submitting its budget annually. And while those payment rates may fall into broad categories, they are not, as in New Jersey SHARE and subsequent New Jersey DRG systems, hospital-specific.

Today, the commercial third party payors, the labor unions, and other payors negotiate their payment rates with the hospitals, and, the complex rate setting system embodied by SHARE has been abandoned. The lesson learned is that the acute care hospital delivery system is a very complex system and cannot effectively be micromanaged by a state imposed payment system.

Endnotes

[1]Borland v. Bayonne Hospital, 122 N.J. Super. 387 (Ch. Div. 1973), aff'd, 136 N.J. Super. 60 (App. Div. 1975), aff'd, 72 N.J. 152 (1977), cert. denied, 434 U.S. 817 (1977)

[2]The Center for the Analysis of Public Issues by R. Powell, entitled "Bureaucratic Malpractice"

[3]The SHARE regulatory system required hospitals to obtain outside expertise. This could be described as the full employment for accountants, consultants and lawyers.

[4]Office of the Attorney General Formal Opinion No. 12 – 1975.

[5]In Re 1977 Rate Appeal of Monmouth Med. Ctr., 185 N.J. Super. 20 (App. Div. 1982).

[6]United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179