MORRIS VIEW NURSING HOME,  
Petitioner,  
v.  
DIVISION OF MEDICAL ASSISTANCE  
AND HEALTH SERVICES,  
Respondent.  

Initial Decision: July 7, 1983  
Final Agency Decision: September 23, 1983  

Approved for Publication by the Division of Medical Assistance  
and Health Services: May 6, 1985  

SYNOPSIS  

Petitioner, a county run long term care facility, contested the reimbursement rates included in respondent’s rate setting mechanism in three areas: 1) non-legend drugs; 2) pharmaceutical consultant services; and 3) medical supplies. Petitioner based its request for a review on N.J.A.C. 10:63-3.6(a)8, which permits such review when inequities become apparent in rate setting due to unusual circumstances.  

Petitioner argued that such inequities stemmed from its higher indigent, elderly and handicapped patients as compared to other institutions. In addition petitioner argued that the lack of any private paying patients in its care prevented it from receiving any reimbursements higher than the standard Medicaid rate, unlike other institutions. The petitioner also objected to the failure to include information from government-run homes in the calculation of reimbursement rates and the use of total number of patient days rather than Medicaid patient days in those calculations.  

The administrative law judge assigned to the case determined that no evidence had been presented to conclude that the practice of using only proprietary nursing homes in arriving at a rate for pharmaceutical consulting, medical supplies and non-legend drugs, had any effort on the rate in these areas. The judge found that petitioner’s patient population was sicker than the average population but could not conclude that this need could not be accommodated within the present rate structure. The judge found, however, that private billing of patients could lead to an inequitable calculation of petitioner’s rates and ordered respondent to recalculate the median cost with regard to private patient billing.  

Upon review, the Director of the Division of Medical Assistance and Health Services rejected the initial decision, concluding that the
judge had failed to afford respondent’s rate methodology the presumption of reasonableness to which it was entitled and had improperly shifted the burden of proof to the agency to justify its rate scheme. The Director determined that insufficient hearsay evidence had been presented to challenge the existing rate methodology and had not proved any industry-wide practice different from that which is assumed in that methodology.

Accordingly petitioner’s request for an adjustment to its reimbursement rate screens was denied.

Daniel W. O’Mullan, Assistant County Counsel, for petitioner
(Armand L. D’Agostino, County Counsel, attorney)
Robert J. Haney, Deputy Attorney General, for respondent (Irwin I. Kimmelman, Attorney General of New Jersey, attorney)

Initial Decision

KLEIN, ALJ:
Petitioner, Morris View Nursing Home, is contesting the rate setting mechanisms as applied to the Morris View Nursing Home by the Division of Medical Assistance and Health Services (DMAHS) in three areas:
1. The screens applied to reimbursement rates for non-legend drugs.
2. The screens applied to reimbursement rates for pharmaceutical consultant services.
3. The screens applied to reimbursement rates for medical supplies.

This matter specifically concerns the petitioner’s appeal of Medicaid reimbursement rates effective July 1, 1981 in the three areas cited above. The parties have agreed, however, that this decision will be applied to pending appeal of the 1982 reimbursement rate.

On February 2, 1982, petitioner requested a fair hearing before an administrative law judge and on March 3, 1982, the matter was transmitted to the Office of Administrative Law as a contested matter pursuant to N.J.S.A. 52:14F-1 et seq. A hearing was held on March 2 and 3, 1983 at the Office of Administrative Law, Newark, New Jersey and continued to March 18, 1983. The record was closed on May 27, 1983 following receipt of briefs filed by both parties which are included in the record.
BACKGROUND

Medicaid is a cooperative Federal-State program for the purpose of providing medical assistance on behalf of certain indigent, aged, blind, and disabled persons whose income and resources are insufficient to meet the costs of necessary medical services. 42 U.S.C.A. §1396. The Medicaid Program is jointly funded by State and Federal government and is administered by the State.

Due to the presence of Federal funding, when a state elects to participate in the Medicaid Program, it must adhere to certain Federal statutory and regulatory requirements. Although states must comply with federal requirements, routine administration of the Medicaid Program is placed in the hands of the state agency which transmits payments to the providers of services. New Jersey participates in the Medicaid Program pursuant to the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1 et seq., enacted in 1968. Payments to long-term care facilities are governed by regulations entitled the Cost Accounting and Rate Evaluation (CARE) Guidelines, N.J.A.C. 10:63-3.1 et seq., which were developed jointly by the Department of Health and the Department of Human Services. Computations and initial processing of rates are performed by rate analysts at the Department of Health, but final decision-making authority over Medicaid rates rests solely with the Department of Human Services. N.J.S.A. 30:4D-7b; Atty. Gen. Form Op. 1976-No. 8. Providers seeking Medicaid reimbursements are required to follow a uniform system of cost reporting established by the CARE Guidelines See, N.J.A.C. 10:633.21. All rates are based on actual costs reported by the facilities. Rates are set to reflect the lower either of “historical costs” together with a return on equity or the so-called “screened rates.” N.J.A.C. 10:63-3.2. To obtain the screened rates, services are broken down into several components defined in the regulations. Equalized costs attributable to each component are compared with a reasonableness limit or “screen” to determine whether the amount charged by the facility for that particular service is excessive. Screening devices vary from component to component, but are derived from the median of cost incurred by comparable facilities for similar services. Any excess above the applicable screen is disallowed in calculating the screened rate.

Petitioner, citing unusual circumstances and hardships is seeking a review under N.J.A.C. 10:63-3.6(a)8:
The department will review on an individual basis any inequities which owners believe are brought about by unusual circumstances.
The forward to this subchapter 10:63-3 provides some guidelines for such appeal.

These regulations describe the methodology ("guidelines") to be used by the State of New Jersey to establish prospective per diem rates for the providing of routine care to patients under the State's Medicaid program. These guidelines have been developed jointly by the State Department of Human Services and the State Department of Health ("the departments").

The departments believe that the strict application of these guidelines will generally produce equitable rates for the payment of long-term care facilities (LTCF) of the reasonable cost of providing routine patient care services. The departments recognize however, that no set of guidelines can be developed which might not result in some inequities if applied rigidly and indiscriminately in all situations. Inequities could be in the form of rates that are unduly low or rates that are unduly high.

Accordingly, in the case where a LTCF believes that, owing to an unusual situation, the application of these guidelines results in an inequity, the departments are prepared to review the particular circumstances with the LTCF. They should not address the broader aspects of the guidelines themselves.

... All rates established pursuant to these guidelines will be subject to on-site audit verification, of costs and statistics reported by LTCFs.

The regulations at N.J.A.C. 10:63-3.8 describe the application of guidelines for "routine patient care expenses" and treat patient care services, other than nursing, very cursorily as follows:

(c) Reasonableness limits for patient care services other than nursing will be those established from time to time by the State Division of Medical Assistance and Health Services.

THE DISPUTE

Petitioner argues that the screened reimbursement rates applied in these three areas, pharmaceutical consulting, non-legend drugs, and medical supplies, are inadequate and inappropriate for Morris View for several reasons as follows:

First, petitioner argues that Morris View is not a comparable institution to those used in establishing screens in these three areas, but is unique. Petitioner claims that Morris View is an institution of last resort for almost all its patients. It is 100 percent Medicaid, a county-run institution caring for only an indigent population. Almost 100 patients a year die at Morris View. Very few patients leave the facility except for temporary hospitalization.

Petitioner alleged that it cares for a sicker and a more handicapped patient population than do proprietary and voluntary nursing homes or even those other county nursing homes which are not 100 percent Medicaid. These more acutely ill patients allegedly require more medication and more medical supplies but the screened per patient rate
does not have the flexibility to respond to the greater needs of such patients. Petitioner relies upon the statistics showing an increase in Skilled Nursing Facility (SNF) patients and a decrease in Level IV-B patients at its facility to bolster the argument. Petitioner also presented testimony from Dennis Hett, Executive Director of the New Jersey Association of Nonprofit Homes for the Aging, that the 22 county homes represent ten percent of 230 long term care facilities in the state, yet have 16 percent of the total nursing beds in the state, provide almost 20 percent of the Medicaid beds and a little over 25 percent of the total skilled nursing beds in the state. Mr. Hett testified that thus 10 percent of the homes are providing 25 percent of the skilled nursing care. The average nursing home skilled care occupancy is 6 percent and Morris View’s 18 percent skilled care occupancy is three times as high as the average.

Petitioner also cited the higher number of multiple sclerosis patients (16) and comatose patients (9 at the time of testimony but 7 in 1980) as evidence of the uniqueness of patient population of Morris View, providing grounds for special consideration in rate setting.

Secondly, petitioner argues that the absence of any private paying patients prevents Morris View from receiving reimbursements from any patients at a rate above the Medicaid rate. Counsel for respondent objects strenuously to any implication that private patients “subsidize” Medicaid patients but the courts have recognized and the Federal regulations permit that nursing homes charge private patients a higher rate and are able thus to pass on some Medicaid unreimbursed costs to the private sector. The Federal and State regulations do not require Medicaid to pay full cost of care. Petitioner argues that in the absence of private patients who can be charged higher rates, Morris County government has become an equal partner with State and Federal government combined in paying for nursing care of county patients in the 100 percent Medicaid facility. Petitioner contends that even many county homes have 15 to 20 percent non-Medicaid beds and that since Morris View does not, this constitutes grounds for special consideration for Morris View in the rate setting mechanism.

Thirdly, petitioner argues that in establishing the screened rate for the three areas under dispute, Medicaid does not include the cost reports of county facilities, but only the cost reports of those proprietary and voluntary homes which have more than 20 percent Medicaid population. Since county facilities and particularly Morris View handle an indigent population with a greater degree of need and
therefore higher costs, it is disadvantageous to Morris View to omit the reported costs of these institutions from computation of the screen.

Fourthly, petitioner argues that the method of computing the screens is particularly disadvantageous to Morris View because in the challenged cost centers the reported costs are divided by the total number of patient days in a facility, not by the number of Medicaid patient days. Petitioner presented testimony that nursing homes sometimes charge private patients for their medication, medical supplies and pharmaceutical consulting service. Although these nursing homes bill Medicaid only for these services as provided to the Medicaid patients the reported Medicaid costs are divided by the total patient days in the institution to arrive at a per capita cost which is the basis of setting the screened rate. Under this method, petitioner argues that a nursing home with 50 percent Medicaid beds, charging private patients separately, would appear to have a cost 50 percent lower than its actual per patient cost. This, according to petitioner, distorts the figure used in setting the screen and is onerous to Morris View.

It is respondent’s position that although Morris View has high costs in the three areas under dispute and exceeded the screened rates there is nothing remarkable or unique about this since the existence of a median means that some providers will be above the median and some below it. None of Morris View’s costs were outside the limits of the sample used. Respondent alleges that no special factual circumstances have been demonstrated to warrant unusual relief from the effective CARE screens and that the omission of governmental nursing homes from the reported cost analysis used in arriving at the screened rate in the three cost centers does not affect the outcome.

**UNDISPUTED FACTS**

From the testimony and other evidence in this matter, I adduce and adopt the following finding of facts which are not in dispute.

Petitioner, Morris View Nursing Home, is a county run long term care facility in Morris County, New Jersey with 100 percent of its beds dedicated to Medicaid patients who receive skilled Level IV-A and Level IV-B nursing care as defined in N.J.A.C. 10:631.2.

An analysis of Morris View patients in the period of six years from 1976 to 1982 indicates that the percentage of patient days of skilled nursing care increased from 8 percent of the total to almost 17 percent. The percentage of patient days of Level IV-A care declined from 66.3 percent to 63.35 percent; and the percentage of patient days of Level IV-B care declined from 25.3 percent to 19.66 percent.
Morris View operates its own pharmacy with a main pharmacy and a satellite to serve its three separate buildings. There are 11 employees including three full-time and one part-time pharmacist under the supervision of a chief pharmacist who provide dispensing of legend and non-legend drugs and pharmaceutical consulting service. Morris View is on the unit dose system and dispenses approximately one and one-half million unit doses of legend and non-legend drugs a year to patients in the 371 bed facility—an average of 11.2 unit doses per day per patient. The pharmacists allot part of their time to performing the services of pharmaceutical consultant.

In July 1981, Morris View's reported cost for pharmaceutical consultant was $28,500 or 22 cents per patient day. The screened rate for this service in 1981 was six cents per patient day. Morris View received $7,855 in total reimbursement.

In July 1981, Morris View reported costs of 31 cents per patient day to purchase non-legend drugs or $43,270. This was the raw cost of drugs ordered under the State bidding system. The July 1981 maximum rate was set at 18 cents per patient day. Morris View received $23,421 in total reimbursement.

In July 1981, Morris View reported $1.17 per patient day costs or $165,267 for medical supplies. The 1981 rate for medical supplies rose from 60 cents to 68 cents. Morris View was reimbursed a total of $88,485.

It is undisputed that in computing the screened rates for reimbursement in the three areas under dispute, respondent does not use the cost reports of governmental nursing homes when arriving at the median per patient day costs for all LTCFs. Respondent also excludes from the survey the reported costs of nursing homes having less than 20 percent Medicaid patients and those which report no costs in the service under consideration.

It is also undisputed that the respondent's method of computing the screen is to divide reported costs of the LTCF by the total number of patient days in the nursing home in order to arrive at a per patient day cost. Respondent applies formulas to equalize costs among nursing homes by geographical regions. Respondent uses no such formula to differentiate among homes according to the proportion of Medicaid patients served.

Respondent did not use the median cost arrived at as the screened rate but set the rate at 110 percent of the median in pharmaceutical services and non-legend drugs and 150 percent of the median for
medical supplies. The process for deciding upon the override percentage was not explained.

FURTHER FACTUAL CONCLUSIONS

The evidence supports petitioner's claim that governmental nursing homes care for a higher percentage of the indigent patient population than do most other nursing homes. This finding rests upon the fact that 10 percent of the nursing homes in the State—the governmental homes—supply 20 percent of the Medicaid bed. There is no evidence that Morris View having 100 percent Medicaid beds, is unique among all nursing homes. No evidence was entered to indicate how many other nursing homes are in this category but it is clear that since the Medicaid standard of payment does not require full reimbursement for cost of care, incurred costs not covered by Medicaid must be met through other sources of income such as endowment, contributions, higher charges to private payees or, as in this case, county taxes.

The population at Morris View is sicker and requires more care than that in the general population of nursing home. I base this upon the fact that the average nursing home cares for six percent of its population in skilled nursing home beds, while Morris View has three times that percentage of skilled care beds. The fact that 10 percent of the nursing homes (governmentals) care for 25 percent of the skilled care patients in the state does not lead to the conclusion, as argued by respondent, that Morris View is caring for fewer skilled care patients than other governmentals. Respondent, in using this argument, is mixing the proverbial apples and oranges. Governmentals are, as a category, caring for proportionately two and one-half times their share of the skilled care patients (25 percent in 10 percent of the total homes). Morris View with a skilled care capacity of 18 percent has three times as many skilled care beds as the average nursing home with six percent. From the evidence, no conclusions can be drawn as to whether the number of comatose patients is unique but the fact that a specialized facility for multiple sclerosis, in Welkind Hospital, in the same county, has a total of 32 patients with multiple sclerosis and Morris View has 16 such patients in its population further supports Morris View's contention that, as a county hospital of last resort it handles a greater number of patients requiring intensive levels of care. This fact appears to be buttressed by the mortality rate of 100 out of 371 patients although no facts were offered regarding mortality rates in other nursing homes.

With these basic facts in hand, I will now discuss further facts in regard to each of the disputed cost centers.
Re: Medical Supplies

Morris View is reporting more for medical supplies than are most of the nursing homes used in arriving at a reimbursement rate for medical supplies. Morris View’s, reported costs of $1.17 per patient day are exceeded by only six homes in the sample. Only 29 homes in the total of 166 reported costs higher than the screened rate of 68 cents and ten of these did not exceed 76 cent.

Testimony by Reginald Selden, a rate analyst with the Department of Health, is that if the 24 county nursing homes reporting costs of medical supplies, nine of which had reported costs above the median, were added to the sample, the median would not change. I CONCLUDE therefore that the omission of the governmentals’ cost reports in calculating the median for medical supplies, does not, of itself, affect the median or disadvantage Morris View.

A question then arises as to whether sicker patients require more medical supplies. Meredith Nansen, chief nurse at Morris View, gave extensive detailed testimony regarding the type of medical supplies required in caring for patients who are comatose, incontinent or in need of special equipment. Nurse Nansen testified only to those things which she knew from personal experience. She was conscientious and cautious in her testimony and did not draw broad conclusions dispositive of the question. Although no statistical data was offered relating the amount of medical supplies to the intensity of care, her testimony leads me to conclude that caring for a sicker more disabled population requires more medical supplies of the type described. Since Morris View has 18 percent of its population in skilled nursing beds, it requires comparatively more medical supplies to care for this population than if it had the average six percent skilled care beds. It seems reasonable to assume, however, that the generous 50 percent override in this cost center if applied to a true and reliable median would satisfy such an anomaly.

Re: Pharmaceutical Consulting

Morris View’s per patient day reported costs of 22 cents for pharmaceutical consulting is very high. All but 13 nursing facilities in the voluntary and proprietary sector reported costs under ten cents and only three reported costs higher than Morris View. Although 18 of 24 governmental nursing homes reported pharmaceutical consulting costs above the median of five cents, inclusion of the governmentals in the formula for computing the median would not have changed the median because 46 homes reported costs at the median. In fact,
only 25 homes reported costs above the screened rate of 110 percent of the median.

Morris View has four full-time and one part-time pharmacists at least two of whom spend part of their time reviewing patient charts. This allocated time is reported by the chief pharmacist for purposes of calculating the cost of the service. This method of distributing the responsibility of pharmaceutical consulting appears to produce a result which is at wide variance with the reported costs of most other nursing homes.

On April 2, 1981, Jesse Gaynor, assistant chief pharmacist of Medi- caid wrote to John Sugameli, chief pharmacist at Morris View regarding the Division’s complaints about the adequacy of pharmaceutical consulting services at Morris View. In that letter, Mr. Gaynor stated, “using a rule of thumb average of ten minutes per chart review, this function would require 60 hours per month. Certainly, the approximately 30 hours being devoted to this is totally inadequate.”

On April 14, 1981, Mr. Sugameli replied to Mr. Gaynor stating that two pharmacists were devoting two to three hours each per day to chart review. This would amount to 20 to 30 hours a week or between 80 and 120 hours a month for chart review.

The duties of a pharmaceutical consultant are defined in the Long Term Care Services Manual. N.J.A.C. 10:63-1.10. They include utilization review of all medication, control of all drug supplies and dispensing procedures, establishing, monitoring and implementing written policies and procedures, provision and documentation of in service training programs, and quarterly reporting to the Pharmaceu- tical Services Committee.

Using the Division’s standard of a minimum of ten minutes a month for review of each patient’s chart (62 hours a month) and considering the other mandated requirements of the pharmaceutical consulting service, it is reasonable to conclude that this service in a 371 bed facility would require a minimum of 80 hours a month or approximately two thirds of the time of one full time pharmacist. Thus, the 1981 rate of reimbursement to Morris View $7,855 appears to be inadequate to meet the standard of reasonableness for reimbursement for pharmaceutical consulting while the reported costs of $28,500 by the petitioner appears reasonably high. The fact remains that most of the institutions whose costs were used in computing the state median are reporting costs which are at, below, or close to the six cent a day per patient rate.

Petitioner alleges that the section of those institutions whose reports
were utilized in reaching the median was inappropriate because none of the governmental nursing homes were included. Testimony by the rate analyst, Mr. Reginald Selden, however, establishes the fact that inclusion of all of the governmental institutions would not affect the median arrived at. Therefore, Morris View is not adversely affected by the fact of omission of governmental nursing homes from the sample used in computing the median rate for pharmaceutical consulting.

Re: Reimbursement for Nonlegend Drugs

Morris View’s reported costs of 31 cents per patient day for non-legend drugs is high. Only 13 homes in the sample of 167 reported costs above Morris View but 61 homes had costs above the screened rate of 15 cents with 44 reporting costs above 20 cents.

Mr. Reginald Selden testified that of the 24 governmental homes which were excluded from the sample 13 had costs above the median and that including the governments in the sample would not change the median. Therefore, Morris View’s rate was not adversely affected by the practice of excluding governmental homes in the calculation of the rate of reimbursement for nonlegend drugs.

Morris View uses the State bidding system for the purchase of non-legend drugs and is therefore able to buy these drugs at the lowest available price. It seems probable, therefore, that the higher per patient costs of non-legend drugs may be related in part to the amount of drugs prescribed. The testimony of Mr. Sugameli, chief pharmacist contributes to this finding. Mr. Sugameli testified that all drugs, including non-legend drugs are dispensed only by order of a physician; that most patients at Morris View have multiple diagnoses and that the principal treatment in Morris View is drug therapy. “Generally what happens, each diagnosis is possibly treated with drugs separately. So this gives us as large a number of drugs being prescribed by the physician of all sorts. Okay. With non-legend drugs, possibly our physicians or, well, the institution, tends to be conservative and they will attempt to use a non-legend drug where possible instead of a legend drug.” Morris View dispenses 5.4 patient daily doses of legend drugs and 5.8 patient daily doses of non-legend drugs. The present state coverage for legend drugs is 4.8 cents. No State averages were given for non-legend drugs.

This court has no evidence by which to evaluate the efficacy or usualness of patients in a nursing home receiving an average of 11.2 daily doses of medication. The testimony indicates that patients re-
ceive medication from several doctors simultaneously for different ailments. There is no evidence that the non-legend drugs are being substituted for legend drugs since use of legend drugs is higher than average. This higher use may be related to a sicker than average population.

SUMMARY CONCLUSIONS

I CONCLUDE from the facts in this case that there is no evidence that the practice of using only voluntary and proprietary nursing homes in arriving at a median cost for establishing rates for pharmaceutical consulting, medical supplies, and non-legend drugs has any effect upon the rate in these three areas of service. The inclusion of the governmental facilities would not change the median which was arrived at in 1981 and petitioner was not disadvantaged by this procedure in the three disputed cost centers. Petitioner in his arguments has tried to broaden this issue to show that omission of governmental nursing homes from the calculation of medians for all cost centers affects the overall per diem rate. The matter before me is limited to the three cost centers under consideration and that broader issue is not properly before me.

I CONCLUDE that the patient population at Morris View requires more medical supplies than would an average population but I cannot CONCLUDE from this evidence that such greater need cannot be accommodated within a screen which is 150 percent of a true and reliable median cost.

I CONCLUDE that the patient population at Morris View is such that more medicines are probably required than for the average nursing home population but Mr. Sugameli’s testimony leads to a further conclusion that the described “unique” practice at Morris View of many staff doctors prescribing medication simultaneously for each patient exacerbates the rate of utilization. Without such exacerbation, the ten percent override of a true and reliable median is a way to address the additional requirements of these patients.

While there is no evidence that the make up of the patient population at Morris View is related to the excess cost of pharmaceutical consulting, the facts do indicate that the requirements for pharmaceutical consulting are such that both the reported costs of most institutions and the established rate of six cents per patient day are not compatible with the actual costs of economically and efficiently performing properly the mandated service. There are no identifiable reasons, however, why Morris View should be affected differently than
other providers since Morris View has no different mandates or responsibilities than do all other Medicaid providers in regard to pharmaceutical consulting. If unusual costs arise because of the unique internal structure of the pharmaceutical department at Morris View, the Medicaid Program is not required to accommodate such a structure in the rate seeking. The Medicaid Program is required, however, to have a rational method for arising at a true reliable median.

**DISCUSSION OF THE TRUE MEDIAN**

All of the above conclusions are based upon an assumed premise that the mechanism for arriving at the median costs in the three costs centers is rational and reliable and that the median cost arrived at is a valid true median for similar institutions providing similar services.

While I can find no factual merit in petitioner's claim that omitting the costs of governmental nursing homes affects the median, I do find merit in petitioner's allegation regarding the method of dividing reported costs by total patient days in the three disputed cost centers when arriving at per capita daily costs, establishing the median and setting the rate.

Petitioner contends that the reported costs do not, in fact, represent the costs of serving the entire patient population in most nursing homes, but only the costs of serving the Medicaid population. The per capita costs, therefore, petitioner argues are distorted in proportion to the percentage of Medicaid patients in the institution. The result is to severely penalize Morris View—a 100 percent Medicaid facility. This practice, petitioner argues, is capricious and arbitrary.

Mr. Sugameli testified that he personally knows of two facilities Holly Manor and Dover Christian Nursing Home which bill private patients for these three services and report only their costs for Medicaid patients. The witness explained that Dover Christian Nursing Home contracts for pharmacy services. Private patients are billed by the pharmacist and Dover Christian is billed only for Medicaid patients and reports these costs. Dover Christian has a 50 percent Medicaid population. Dividing the reported pharmaceutical consulting costs for these patients by the total patient days results in a per capita alleged cost of 12 cents per patient day whereas the real per patient day cost is 24 cents. Dover Christian shows costs for non-legend drugs at 27 cents and medical supplies at 32 cents. Holly Manor with a 20 percent Medicaid population shows zero costs for pharmaceutical
consulting, zero costs for medical supplies and zero costs for non-legend drugs.

Mr. Sugameli’s testimony is that it is industry-wide practice to bill private patients separately—but “not in every instance.” Respondent’s only witness Reginald Selden had no knowledge of whether or not private patients are billed separately in the three disputed area. This issue has never been raised before to his knowledge. He acknowledged that such a practice would distort the medians arrived at.

If medical supplies, pharmaceutical consulting and non-legend drugs are provided to all patients as part of the services of the nursing home, as for instance are food or heat or social service, the patient day cost can reasonably be determined by dividing that cost by the total number of patient days. If, however, these services are contracted for and billed separately to private patients, the reported cost to the nursing home only reflects the service provided to Medicaid patients, dividing that cost by the total number of patient days would yield figure distorted by the percentage of Medicaid patients in the home. In that case, the true per patient day cost would only be obtained in nursing homes with 100 percent Medicaid patients and in those which provide these services to all patients at no additional charge.

The only evidence on this issue presented by petitioner is the testimony of Mr. Sugameli that billing private patients separately is industrywide practice “but not in every instance” and his personal knowledge of billing practice is two nursing homes. The issue was not raised by petitioner prior to the last date of hearings. Respondent and this court had no prior knowledge that this issue was part of the complaint. While Mr. Sugameli’s testimony is unrefuted on the record, it stands alone without any corroboration or documentation.

Mr. Sugameli’s testimony, however, cannot be lightly dismissed. He is an experienced professional with knowledge of the industry. His testimony provides a rational explanation for the otherwise unexplained fact that 16 nursing homes are able to report no costs for pharmaceutical consulting a required service, and an additional 32 homes report costs under three cents. How else explain that 16 homes caring for persons, at least 20 percent of whom are sick enough to meet medical standards of Medicaid eligibility, report no costs for nonlegend drugs and an additional 24 report costs of four cents or less. No other explanation has been offered either for why the median reported costs for medical supplies is so unreasonably low that the
division saw fit to add a 50 percent override to the median.

The allegation that nursing homes bill private patients separately for pharmaceutical consulting also provides a rational explanation for the incompatibility. I FIND between the time required to perform this service and the unrealistically low reported costs of so many institutions.

While I FIND no reason to question the basic guidelines for arriving at a screened rate by establishing the median costs of similar institutions providing similar services and providing override to accommodate differences in patient populations, I am troubled by a methodology which, in calculating per capita daily costs for these three services, omits the very important ingredient of how many patients receive the service and how many are billed separately. It is, of course, possible and may be demonstrable that correcting this omission from the calculation would not affect the median. If, in fact, the practice of billing private patients separately is scattered and infrequent rather than usual as is alleged, the median would probably not be affected. Respondent never addressed that issue. The question here is substantial and raises the spectre of arbitrariness and capriciousness. No reasonable or rational justification has been offered for a mathematical procedure which ignores a factor having the potential so significantly to distort the results.

On the basis of the information available in this matter, no judgment can be made as to how much, if any, relief petitioner is entitled. However, I CONCLUDE that petitioner is entitled to a review of the screen placed upon these three disputed cost centers based upon data which has been corrected to include the factor of private billing.

The decision, therefore, is to ORDER the respondent to recalculate the median for the three disputed cost centers. In these computations respondent shall use the same methodology except that those patients in each institution who are billed privately for the service under consideration shall not be counted in the calculation of patient days. It is further ORDERED that petitioner's reimbursement rate shall be no less than the median arrived at under this recalculation to which shall be added to override in medical supplies and non-legend drugs and that any resultant adjustment shall be applied retroactively to the 1981 and 1982 reimbursements. The overrides in the two cost centers are ordered because the facts show that Morris View cares for sicker people who require more services in these two areas.
FINAL DECISION BY THE DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES,
THOMAS M. RUSSO:

The Director, Division of Medical Assistance and Health Services, has reviewed and considered the entire record in this matter, including the initial decision of the Honorable Ann Klein, the exceptions thereto filed on behalf of the Agency by Deputy Attorney General Robert J. Haney, and the exceptions filed on behalf of the petitioner by Daniel W. O'Mullan, Esq. The Director also received a letter from Alvin N. Geser, R.P., J.D., Executive Officer of the New Jersey Pharmaceutical Association urging that the recommended decision be affirmed.

The record indicates that the administrative law judge filed her initial decision with the agency head on July 11, 1983.

The statutory forty-five day time period for the agency head to affirm, modify or reverse the initial decision was scheduled to expire on August 25, 1983.

Pursuant to an Order of Extension entered on August 24, 1983 the time period for the agency head to render a final decision was extended for an additional thirty days until September 24, 1983.

Having reviewed in detail the record in this matter and having considered the arguments advanced by both parties, the Director hereby REVERSEs the recommended decision.

The basis for the Director's reversal is that the judge did not afford the agency's methodology in determining the medians the presumption of reasonableness to which it is entitled.

In this regard the judge shifted the burden of proof to the agency based upon the highly speculative hearsay testimony of the petitioner's pharmacist, John Sugameli.

In addition to the errors mentioned above, the judge in her initial decision, in reference to Sugameli's testimony, states that:

The issue was not raised by petitioner prior to the last day of hearings.
Respondent and this court had no prior knowledge that this issue was part of the complaint.

Therefore, based upon her own analysis the judge concedes that the methodology used by the agency in arriving at a median cost for establishing rates for pharmaceutical consulting, medical supplies and non-legend drugs was not an issue in the case, and implicitly acknowledges the presence of the element of "surprise" regarding this testimony.

In reviewing Sugameli's testimony it is evident that it is insufficient to overcome the presumption of reasonableness of the agency's me-
dians.

In essence, Sugameli testified that some unspecified percentage of nursing homes failed to report actual costs in the areas of pharmaceutical consultant, non-legend drugs and medical supplies, and as a result the agency's medians are distorted.

In support of this allegation Sugameli cited only two examples, namely Holly Manor Nursing Home and Dover Christian Nursing Home. In the first instance the witness testified that Holly Manor reported zero costs in each of the three areas in issue. Regarding the second instance, Sugameli testified that Dover Christian reported 12 cents per patient day for the cost centers in issue.

The witness claimed knowledge of these facilities' cost reporting even though he was not in their employ or had not filed their cost reports.

Sugameli's limited testimony does not prove the existence of an industrywide practice to report zero costs for medical supplies, pharmaceutical consulting and non-legend drugs.

In conclusion, Sugameli's testimony did not provide competent evidence of unreasonableness sufficient to overcome the presumption of the reasonableness of the agency's established medians.

Regarding the judge's recommendation that the agency recalculate the medians for the three disputed cost centers using the same methodology with exception that those patients in each institution who are billed privately for the service under consideration shall not be counted in the calculation of patient days, the Director finds that this relief is an administrative impossibility.

The agency cannot recalculate the medians because there is no data available regarding which nursing homes may have misstated their costs on the cost reports.

Furthermore, the agency's current cost reporting format cannot be utilized to obtain this information.

In conclusion, it is the Director's opinion that the CARE Guidelines have been properly applied with regard to the calculation of the medians in the areas being appealed in this case.

THEREFORE, it is on this 23rd day of September, 1983, ORDERED:

That the initial decision is hereby REVERSED; and

IT IS FURTHER ORDERED:

That the petitioner's request for an adjustment to the screens applied to reimbursement rates for pharmaceutical consultant services,
non-legend drugs and medical supplies is hereby DENIED; and

IT IS FURTHER ORDERED:
That the findings, conclusions and recommendations contained in the initial decision are modified to the extent that they conflict with the holding in this decision.

You must check the New Jersey Citation Tracker in the companion looseleaf volume to determine the history of this case in the New Jersey Courts.