



*State of New Jersey*

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES  
P.O. Box 712  
Trenton, NJ 08625-0712

CHRIS CHRISTIE  
*Governor*

ELIZABETH CONNOLLY  
*Acting Commissioner*

KIM GUADAGNO  
*Lt. Governor*

VALERIE HARR  
*Director*

**STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE  
AND HEALTH SERVICES**

ATLANTICARE REGIONAL MEDICAL :

CENTER, et als., :

PETITIONERS, :

v. :

DIVISION OF MEDICAL ASSISTANCE :

& HEALTH SERVICES :

RESPONDENTS. :

**ADMINISTRATIVE ACTION**

**FINAL AGENCY DECISION**

**OAL DKT. NOs. HMA 5152-2014, etc.**

As Director of the Division of Medical Assistance and Health Services, I have reviewed the record in this case, including the Initial Decision, the OAL case file and the documents filed below. Both parties filed exceptions and cross exceptions in this matter. Procedurally, the time period for the Agency Head to file a Final Agency Decision is August 14, 2015 in accordance with a second Order of Extension.

This matter concerns the consolidation of forty-eight appeals filed by twenty-five hospitals challenging the calculations, methodologies and constitutionality of their 2013

Medicaid reimbursement rates that were issued on December 14, 2012. Based on the motions and briefs filed including oral argument, the Initial Decision identified the following issues to be decided:<sup>1</sup>

1. Interpretation, application and alleged arbitrariness of the new “merit” standard under N.J.A.C. 10:52-14.17 that replaced “marginal loss” of N.J.A.C. 10:52-9.17 in 2009.
2. TEFRA 1995-1998 economic factor calculation error and derivative carry-forward.
3. Compliance with federal Medicaid regulations with respect to the 2013 FY Appropriation legislative mandate of 0% inflation factor.
4. Unconstitutional takings argument with respect to charity care obligation of the Hospitals being unmatched by regulatory rate recognition of the charity care expenses of fulfilling that mandate.

(ID at 3).

In reverse order, the Initial Decision determined that Respondent was entitled to summary judgement on issues numbered 2-4 and Petitioner was so entitled on the first issue which required remand to the DMAHS “for an ‘interactive process’ to take place on the ‘merit’ of any financial impact.” ID at 17. After review of the voluminous record, the briefs and exceptions filed by both parties, I hereby ADOPT the Initial Decision with regard to the last three issues and REVERSE the determination with regard to the first issue.

With regard to what was titled below as the alleged TEFRA error, the Initial Decision found that the TEFRA error was not appealed after the re-basing of the rate in 2009 and that the hearing that is pending before ALJ Richard McGill is irrelevant to the pending cases due to the reset of the rates. ID at 14. See N.J.A.C. 10:52-14.6(a) and

---

<sup>1</sup> As discussed herein and acknowledged by both parties, the first issue was not raised below by the parties.

10:52-14.17. There is no pending challenge of the 2009 rebased rates nor is there any appeal in the years since the rebase on a TEFRA issue. To raise the alleged TEFRA error in 2013 rate year is not permitted. N.J.A.C. 10:52-14.17(b).

The Initial Decision properly noted the 0% inflation factor was duly noticed in the appropriations act as well as a public notice that appeared in state-wide newspapers and was approved by the Centers for Medicare and Medicaid Services (CMS). The budget language, enacted on June 29, 2012, clearly sets a prospective implementation date on January 1, 2013.<sup>2</sup>

Notwithstanding the provisions of any law or regulation to the contrary, of the amounts hereinabove appropriated to Payments for Medical Assistance Recipients - Inpatient Hospital, effective January 1, 2013, the Medicaid inpatient fee-for-service payment rates will not be adjusted to incorporate the annual excluded hospital inflation factor, also referred to as the economic factor recognized under the Centers for Medicare and Medicaid Services Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248 (TEFRA) target limitations.

---

P.L. 2012, c.18 (FY2013 Appropriations).

The change's effective date was apparent in the Appropriations Act for FY 2013 and the State Plan Amendment was not submitted to CMS for approval until after the comment period expired. Indeed over a year passed from the enactment of the Appropriations Act on June 29, 2012 to CMS's approval in September 2013 and as a highly regulated industry, the Hospitals cannot complain that they were not given "a reasonable opportunity to review and comment." See Allstate Ins. Co. v. Greenberg, 376 N.J. Super. 623, 637 (2004): "It is well settled that individuals who practice in highly

---

<sup>2</sup> Moreover, almost identical language appeared in the prior year's appropriations act. See <http://www.state.nj.us/treasury/omb/publications/12veto/pdf/Senate%20Bill%20S4000.pdf>



regulated industries are charged with knowledge of the laws and regulations which govern that particular industry. See e.g. Graham v. New Jersey Real Estate Comm'n, 217 N.J. Super. 130, 138, 524 A.2d 1321, 1326 (App. Div.1987) ('Every person is conclusively presumed to know the law, statutory and otherwise.').” Thus, for the reasons set forth in the Initial Decision, as amplified above, I ADOPT those findings.

In so far as the Initial Decision determined that issue of excluding charity care expenses from Medicaid rates has been settled, the Hospitals cannot advance the argument that the failure to use charity care expenses constituted “a violation of the Takings Clauses of the Federal and State Constitutions.” ID at 4. The Appellate Division has clearly stated that the Medicaid rate’s exclusion of expenses incurred for charity care recipients is proper. See In the Matter of the Adoptions of Amendments to N.J.A.C. 10:52, 2007 N.J. Super. Unpub. LEXIS 372, (App. Div. April 26, 2007) certif. denied 192 N.J. 296 (2007). and In re Hospitals’ Petitions for Adjustment of Rates for Reimbursement of In-Patient Services to Medicaid Beneficiaries, 383 N.J. Super. 219, 242 (App. Div.), certif. denied, 187 N.J. 82 (2006).

Rather the Initial Decision opined that the proper state actor in a challenge regarding the cost of charity care under the Take All Comers statute is the Department of Health as it administers charity care subsidies. N.J.S.A. 26:2H-18.64. Indeed such a challenge of that statute does exist in the Appellate Division against the Department of Health, not DMAHS. In exceptions Petitioners relied on Franklin Mem. Hosp. v. Harvey, 575 F.3d 121 (1<sup>st</sup> Cir. 2009) but fail to acknowledge that the court affirmed the lower court’s dismissal of the hospital’s takings argument based on the reimbursement rate set by Maine’s Medicaid program without regard to actual costs or actual losses as well as finding the free care laws of Maine do not constitute an unconstitutional taking as

they “adjust the benefits and burdens of economic life but leave the core rights of property ownership intact.” *Id.* at 129. Thus, I hereby ADOPT the Initial Decision regarding the takings argument.

However, I am troubled that the first issue regarding the new “merit” standard under N.J.A.C. 10:52-14.17(c) was not raised below. Nevertheless, the Initial Decision found that the term “merit” was akin to the use of the term “marginal loss” used in the prior regulations and warranted a remand to DMAHS to engage in an interactive process regarding that term. *ID* at 22-23. See In re Zurbrugg Memorial Hospital’s 1995 Medicaid Rates, 349 N.J. Super. 27 (App. Div. 2002).

The current regulation, effective August 3, 2009, sets forth the following:

3. In order to be considered a valid rate appeal, the hospital's submission shall meet the following requirements:

i. A detailed description of the rate appeal issue shall be provided, including, but not limited to, the basis of the issue, such as whether certain portions of the Division's rate setting methodology are being challenged; and

ii. Detailed calculations showing the financial impact of the rate appeal issue on the hospital's final rate and its estimated impact on the hospital's Medicaid inpatient reimbursement for the rate year.

4. If the Division finds the rate appeal issue to have merit, a financial review shall be undertaken by the Division to determine whether the hospital is efficiently operated in order to qualify for a rate adjustment. The financial review shall include, but not be limited to, the following:

i. Financial ratios;

ii. Efficiency indexes;

iii. Occupancy and length of stay;

iv. Debt structure;

v. Changes in cost, revenue and services;

vi. Analysis of the hospital's audited financial statements, including all related entities; and

vii. Comparison to appropriate state and national norms.

The Initial Decision summarizes the rate appeal as a three step process, to wit “1) identification of the rate issue being appealed; (2) estimated financial impact of that issue on the rates and the annual Medicaid reimbursement; and (3) if DMAHS finds “merit” in the preceding, then an operational efficiency review,” ID at 19. The Initial Decision then found that the Hospitals’ argument that they could not complete the second step as actual costs were not available was fatally flawed by the use of the term “estimated” as well as a general understanding that the 2013 rates issued in that year are prospective. Neither DMAHS nor the Hospitals use actual costs for the rate year as they are simply not known under a prospective rate process. Instead the Hospitals were directed to access the NJMMIS website to review the relevant data used to set their rates.

Despite finding that the Hospitals failed to provide estimated financial impact, a condition precedent to DMAHS finding “merit” to an appeal, the Initial Decision determined that remand was appropriate as the term “merit” is not defined. ID at 19-20 and 22.<sup>3</sup> In relying on the Appellate Division’s decision in Zurbrugg that the term “marginal loss” was “neither self-explanatory nor self-defining”, the Initial Decision fashions a remedy to a problem that was not advanced below. The Hospitals’ argument that they could not supply the information in the time frame was based on their allegation that their actual costs including charity care were needed to support their position on unconstitutional takings and not on any confusion over the term “merit”.<sup>4</sup> Cf. N.J.A.C. 10:52-14.17 and N.J.A.C. 10:52-9.1(b)(2)(1995).

---

<sup>3</sup> The comments to the rules published on August 9, 2009 contain no allegations that the term “merit” is confusing. 41 N.J.R. 2895(a)

<sup>4</sup> Moreover, the Appellate Division, while finding the failure to define marginal loss as arbitrary, stated “Where documentation is provided, the agency must consider the application on the merits consistent with N.J.A.C. 10:52-9.1(c). If after review, analysis and, if necessary, a request for supplementary material, the agency concludes that a hospital has not met its burden of establishing the three core requirements, the agency may deny the requested relief



The Hospitals readily agree that they did not raise this “merit” issue before the Administrative Law Judge but are now arguing in exceptions filed two years after their initial rate appeals that the term “merit” is “so vague” it warrants remand to DMAHS.<sup>5</sup> Petitioner’s Cross-Exceptions at 2. It is clear that the data that the Hospitals wish to submit on this remand is in support of its unconstitutional takings argument to show actual costs and actual losses but primarily the effect of N.J.S.A. 26:2H-18.64. Indeed Petitioner’s cross-exceptions dated April 17, 2015 stated that the Hospitals welcome the chance to use a Zurbrugg “interactive process” “to support the constitutional taking claim.” Petitioner’s Cross-Exceptions at 3. As the overall takings argument was rejected earlier in the Initial Decision based on prior Appellate Division cases, there is no reason for remand and I hereby REVERSE the Initial Decision on this issue.

---

with appropriate fact-finding by the agency demonstrating the agency's consideration of the merits of the application.” (emphasis added.) In re Zurburgg Memorial Hospital’s 1995 Medicaid Rates, 349 N.J. Super. 27 (App. Div. 2002). There is no definition of merits in the prior regulations and the Appellate Division had no concern of confusion when using the term “merit” to describe what DMAHS must do **when documentation is provided**.


<sup>5</sup> The term “merit” has been in the regulation since 2009. See Rule Proposal 41 N.J.R. 1351(a)

THEREFORE, it is on this <sup>11<sup>th</sup></sup> day of AUGUST 2015

ORDERED:

That the Initial Decision is hereby ADOPTED in Part with regard to the conclusions on the TEFRA 1995-1998; the 2013 FY Appropriation legislative mandate of 0% inflation factor; and the unconstitutional takings issues; and

That the Initial Decision is hereby REVERSED as to the remand for further proceedings regarding the term "merit" under N.J.A.C. 10:52-14.17(c)(4) .

  
Valerie Harr, Director  
Division of Medical Assistance  
and Health Services

*Chief of Staff*  
*on behalf of*  
*Valerie Harr*