REPORT

of the

NEW JERSEY

STATE COMMISSION OF INVESTIGATION (S.C.I.)

on

HOSPITAL PHASE OF THE MEDICAID PROGRAM

April, 1977

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CONTENTS

Abbreviations:

DMAHS - Division of Medical Assistance and Health Services

NJHA - New Jersey Hospital Association

SHARE - Standard Hospital Accounting Rate Evaluation

HEW - Department of Health, Education and Welfare

SRS - Social and Rehabilitation Service

AID - Approval by Individual Diagnosis

PAT - Pre-Admission Testing

PRESSO - Program for Elective Surgical Second Opinion

PSRO - Professional Standards Review Organization

PAR - Proposed Administrative Rate

APR - Administrative Payment Rate

INTRODUCTION

This is the sixth report prepared by the New Jersey State Commission of Investigation as part of its evaluation and probe of the entire Medicaid program in New Jersey, as requested by Governor Brendan T. Byrne. Prior reports covered nursing homes, independent clinical laboratories and professional practitioners receiving program funds. This report concerns the in-patient hospital phase of the Medicaid program and the adequacy of fiscal controls developed by the state to insure efficiency, economy and integrity.

Medicaid is a grant-in-aid program jointly financed by the Federal government and the State of New Jersey. Nationwide, the Federal share ranges from 50 to 83 percent; in the State, funding of health services is shared on a 50:50 basis.

The Commission found in the course of its investigation that the New Jersey Medicaid program began in January 1970 at the mid-point of an unprecedented hospital cost-increase spiral. An April 26, 1976 Presidential Council on Wage and Price Stability report indicated that:

- the cost of an average hospital stay (was) up from $311 in 1965 to $1,017 in 1975;
- health expenditures as a percent of our Gross National Product rose to an unprecendented level of

8.3 percent in 1975, up 41 percent from the 5.9 level in 1965;

- health care expenditures tripled since 1965, up from $39 billion to $119 billion; the 1974 to 1975 increase of $15 billion was the biggest in our history.

In the course of the hospital phase of the Medicaid probe, S.C.I. personnel were assigned to provide expert technical assistance to the Public Advocate (1) in the matter of the 1976 Blue Cross rate hearings which were conducted by the Department of Insurance, and (2) in the area of hospital rate appeal hearings before the Department of Health. This participation at both forums provided an excellent opportunity for the Commission's staff to identify those elements in the hospital rate-setting system which were relevant to the production of a fair and equitable Medicaid rate (See Table I).

CONCLUSIONS AND RECOMMENDATIONS

It became apparent at the inception of the Commission's investigation that its limited manpower could be best utilized by a concentrated analysis of the emerging hospital rate making process known as SHARE -- the acronym for Standard Hospital Accounting Rate Evaluation.

To that end, the first section of this report deals with an in-depth analysis of the SHARE system.

Section II contains the results of the SCI's extensive analysis of budget processing by 12 high-volume Medicaid in-patient hospitals.

Section III reviews Medicaid eligibility problems, evaluates various utilization controls by hospitals and assesses the performance of the state's fiscal intermediaries' screening procedures in paying hospital reimbursement claims.

Finally, in Section IV the report evaluates the potential impact and current status of the Federal law mandating the use of the Professional Standards Review Organization (PSRO), a system designed to assess the "quality", "appropriateness" and "necessity" of in-patient hospital care rendered to Medicaid (and Medicare) recipients.

Based on the findings of the Commission's inquiry into the hospital phase of the Medicaid program, the following Conclusions and Recommendations -- section by section, and with page references -- are presented:

Section I

Standard Hospital Accounting Rate Evaluation (SHARE)

Conclusion (1):

"Through complex hospital cost categorization, peer comparison and analysis, the SHARE system attempts to determine prospectively the amount of money each hospital must spend to operate in an efficient manner...However, the SHARE system is not perfect." (see p. 31)

Recommendation (1):

The SHARE System is basically an effective hospital cost-control mechanism (and will be more so if its defects are eliminated) and should be used for Medicaid rate-setting in hospitals. However, the probable availability of other methods embodying the SHARE concept should also be considered in the development of reasonable hospital cost restraints.

Conclusion (2):

"The exclusive authority and power to set per diem rates under the Medicaid Program have been construed to rest with the Commissioner of the Department of Institutions and Agencies (now the Department of Human Services and hereinafter referred to as such)... Under present agreement, the Health Department uses the SHARE system to recommend an interim rate of hospital reimbursement for use in the Medicaid Program by the Department of Human Services... It is unclear whether or not the SHARE system is required by law to be utilized in the setting of per diem rates under the Medicaid Program." (p. 29)

Recommendation (2):

It is imperative that the methodology of the SHARE System be utilized in the handling of Medicaid patients as quickly as possible.

Conclusion (3):

"To the degree that SHARE cost center challenges depend upon a determination of excessive unit costs, a risk may exist that

hospitals having cost centers lower than the challenge limit might increase the cost center claims to the 'ceiling', thereby unfairly maximizing the rate of reimbursement. Through this procedure, hospitals inclined to do so would be able to obtain higher rates of reimbursement than those to which they in fact were entitled, and be rewarded for inefficiency...In the Commission's opinion, the temptation to recast excessive costs of one center to costs of centers falling below the 'norm' is too great a temptation to place on any hospital presenting unaudited budget submissions." (p.31-32)

Recommendation (3):

In addition to the prescribed SHARE analysis presently being made, a detailed audit of cost center budgets submitted by Hospitals should be performed as a matter of routine, since only through such audits will the Department of Health be able to assure the accuracy of cost estimates and volumes presented by hospitals.

Conclusion (4):

"The Health Department perceives their analysts as professionals whose job is to determine what constitutes reasonable costs for individual health care facilities. The S.C.I. believes that, in effect, there is a dual role for the analysts. Since they set the administrative payment rate, they are directly responsible for the determination of the component costs to Medicaid." (p.32)

Recommendation (4):

Health Department analysts should be aware of this dual responsibility and subjective decisions made by them which may materially affect reimbursement rates should be scrutinized closely by superiors.

Conclusion (5):

"SHARE practices and procedures to some extent embody adversarial principles. Appellate proceedings are held before a hearing officer, a formal record is made and hospitals are permitted to present reasons for appeal through a legal representative. The Public Advocate appears in these rate-making proceedings to represent the public interest...Under current procedures, questions have been raised as to the power of the Public Advocate to 'discover' detailed hospital cost-related information relevant to setting of a 'reasonable' rate of reimbursement." (pp.32-33)

Recommendation (5):

Because of its importance to the public interest, the adversary representation of the Public Advocate at rate-making proceedings not only should continue but should be strengthened, particularly his authority to obtain cost-related data from hospitals. Any information reasonably relevant to the setting of a reasonable rate of hospital reimbursement should be available to all interested parties.

Conclusion (6):

"Even though SHARE in New Jersey will provide a fair method to determine hospital per diems, there is a gap with respect to out-of-state hospital services...Naturally some of the dollars paid to out-of-state hospitals are emergency-type treatments or other situations where certain kinds of treatment may not be available in New Jersey." (pp.33-34)

Recommendation (6):

Added costs resulting from a situation in which it is purely the free choice of the recipient to cross state lines without advance authorization or approval for hospital care should be financially minimized, perhaps by not permitting the out-of-state hospital a higher per diem reimbursement than is permitted at a comparable New Jersey hospital.

Section II

S.C.I. Analysis of 12 High-Volume Medicaid In-Patient Hospitals

Conclusion (1):

"The S.C.I. analysis...illustrates the significant savings which could be obtained for the Medicaid Program by the operation of the SHARE system when that system is applied to the 12 facilities. It is regrettable that, as previously discussed, it is unclear whether or not these cost saving determinations derived by the SHARE system will be adopted by the Division of Medical Assistance and Health Services for the purposes of the Medicaid Program... On the basis of a Division of Medical Assistance and Health Services estimate of one million patient days for 1976, the Commission has projected savings approximating $7 million which could accrue to the Medicaid Program." (p. 40)

Recommendation (1):

The Commission's in-depth costs analysis of these 12 high-volume hospitals bolsters the need for incorporating the cost containment benefits of the SHARE system into the Medicaid Program.

Conclusion (2):

"The S.C.I. anaylsis disclosed that mathematical errors were made in the computation of the hospital reimbursement rate. Several such calculations were alarmingly large." (p. 41)

Recommendation (2):

The Health Department should institute a system to consistently cross-check mathematical accuracy in calculations of

reimbursement rates. The model developed by the S.C.I. in its analysis of the 12 hospitals and which is discussed in this report easily can be adopted. To further guarantee the accuracy of hospital figures and to insure that facilities will not be rewarded for inefficiencies, the Health Department should regularly request copies of management consultant reports on individual hospitals, since these reports would be extremely helpful in identifying areas of operational and administrative inefficiency.

Conclusion (3):

"At present, SHARE does not adequately reflect comparable cost figures among peer groups in their cost centers due to the diversity in the methods of compensation, e.g., percentage of gross charges, fee for service, salary, etc...In the opinion of the S.C.I. until the SHARE system is capable of extracting reasonable cost data from these centers, the final reimbursement rate will not be truly reflective of 'presumptively reasonable budgets' because objective peer comparisons of these cost centers are not uniformly made at present." (pp.41-42)

Recommendation (3):

Hospitals must be required to submit detailed information regarding levels of compensation paid either to physicians or groups, or both, without regard to the method of payment.

Conclusion (4):

"Refinements must be made in SHARE's analysis of the specific physician components of the Radiology, Pathology and Anesthesiology cost centers...With further respect to the compensation arrangements between radiologists, pathologists and other specialists, the Commission notes the filing of anti-trust action alleging price-fixing in the Southern District of New York by relevant professional associations." (pp. 41-42)

Recommendation (4):

The Commission has urged the Anti-trust Section of the New Jersey Attorney General's Division of Criminal Justice to review and analyze the practices of such associations in New Jersey and determine whether similar action is warranted in this state.

Conclusion (5):

"Decisions of the (Health Department's) Licensing Unit--such as a determination as to the minimum acceptable amount of physician coverage in an emergency room--have a direct affect on hospital costs...The Health Statistics and Economic Unit presently operates the SHARE system. However, the licensing unit makes ad hoc decisions which have a direct and material impact on the cost of claims of hospitals." (p.43)

Recommendation (5):

There must be greater coordination between licensing and rate-making units within the Department of Health. Obviously,

cost-pivotal decisions by the licensing unit should not be rendered informally but should be made only after appropriate intra-departmental consideration.

Section III

Medicaid Eligibility Problems, Utilization Controls, Intermediary Performance

Conclusion (1):

"...Large urban hospitals still retain their status as the 'family doctor' for the medically indigent...Due to alleged red tape in enrolling recipients, other than those in the ADC (Aid to Dependent Children) program, the hospitals have become the initial contact point in filing medical benefits...It allegedly takes 5 weeks to get a recipient 'on' the computer (listed on the eligibility rolls). Note the average hospital stay is 6.5 days. Therefore, the hospitals must wait 28 1/2 days to find out if they are going to be reimbursed for medical services rendered to beneficiaries. Instances of payment denial for eligibility reasons were reported by fiscal officers surveyed even when a recipient had a medicaid card and a validated stub." (Pp.46 -47)

Recommendation (1):

Adapting a process successful in Florida, New Jersey should integrate Medicaid eligibility data maintained by the N.J. Blue Cross into the Blue Cross teleprocessing system, which has terminals in virtually every hospital in the state. This would give administrators added assurance their hospitals will be paid

for services rendered in the absence of any overutilization problems and will provide them with a "fail safe" method of determining the potential recipient's eligibility status.

Conclusion (2):

"...The State became the beneficiary of certain utilization controls such as Approval of Individual Diagnosis (AID), which controlled the length of hospital stays, and Pre-Admission Testing (PAT), which was designed to cut down on hospitalization for diagnostic reasons...The effective operation of well-designed utilization controls is a condition precedent to achieving substantial cost containment in the Medicaid Program." (pp.50-51)

Recommendation (2):

Such control programs must be maintained and improved since they are, as the Commission declares in its report, "important deterrents to temptations to overutilize hospital services, thereby limiting increases in hospital costs."

Conclusion (3):

"In the course of the Commission's investigation it came to light that the Medicaid Program permits the fiscal intermediaries (Blue Cross and Prudential) to use twice the number of days of hospitalization allowed under the AID program in processing certain kinds of in-patient hospital claims...The obvious question is...why does the State permit the fiscal

intermediaries to use in certain cases a screening process which, in fact, defeats the purpose and intent of this utilization control?" (p. 54)

Recommendation (3):

The Division of Medical Assistance and Health Services should issue a written directive obligating the intermediaries to follow specified utilization control procedures. It is the responsibility of the Division to establish, update and enforce clear utilization review procedures in the claims screening process.

Conclusion (4):

"Under the Medicaid Program, PAT is billed as an out-patient service. PAT is designed to shorten hospital stays by encouraging the performance of tests before admission to a hospital rather than during a patient's confinement. Blue Cross estimates that PAT can reduce the average length of hospital in-patient stays by as much as 2 days...but socio-economic problems unrelated to the delivery of health care services adversely affect the Medicaid hospital provider's ability to maximize its use. In order to solve transportation and broken appointment problems, some hospitals have been admitting patients for diagnostic, pre-operative tests and for reasons which lack medical necessity. Admission for the forementioned reasons are NOT reimbursable for medical purposes." (Pp.55-56)

Recommendation (4):

Agressive efforts must be made to use Pre-Admission Testing (PAT) consistently and uniformly, rather than haphazardly, for Medicaid patients.

Conclusion (5):

"Blue Cross and Blue Shield of Greater New York is experimenting with a Program for Elective Surgical Second Opinion (PRESSO), which is designed to reduce the number of unnecessary elective surgical operations...Movement leading to the adoption of PRESSO has been recently initiated by the N.J. State Benefits Council, which offers now the second opinion option to state and local employees under their respective health programs. N.J. Blue Shield has agreed to cooperate." (Pp.57-59)

Recommendation (5):

If the PRESSO program is evaluated favorably by providers and users after a test period, it should be adopted by the Medicaid Program as a mandatory requirement in all instances of non-emergency surgery. Strong efforts at least should be made to adopt PRESSO in Medicaid Program on a trial basis.

Conclusion (6):

"Hospital providers which are not covered by Blue Cross are serviced by the Prudential Insurance Co. (Pru)...Pru had reported savings of $217,717 in 1974 and $295,470 in 1975, as a result of

their claims review of 30 hospital providers in those years... Blue Cross realized savings of $4.8 million during the same period ...The disparity in savings results primarily from the difference in the number of hospitals each intermediary services. Blue Cross handles 89 while Pru handles only 30. Nevertheless, Pru's past program savings have not matched percentagewise Blue Cross savings ...Pru has recently adopted a limited screening process for Medicaid services which is more consistent with the AID manual, but it is applied only to those hospitals with higher than average 'length of stay' norms. This change occured in March of 1976, resulting in dollar savings in the first six months of 1976 in excess of those achieved for all of last year (1975). However, it is disturbing that Pru does not apply these more stringent screens to Medicaid claims from hospitals with low 'length of stay' norms." (Pp.62-64)

Recommendation (6):

For Medicaid patients, other than SSI (Supplementary Security Income) recipients, the length of stay provisions should be set at AID levels applicable to Blue Cross subscribers, giving the Medicaid Program parity with screens applied to commercially insured subscribers. As the S.C.I. states in this report: "The taxpayers of New Jersey deserve no less. This reform is necessary to reduce overutilization abuses and inflated costs in the Medicaid Program."

Section IV

Professional Standards Review Organizations (PSRO's)

Conclusion (1):

"The Commission finds that the fiscal intermediaries are performing a function (in regard to medical review of hospital reimbursement claims) which substantially would be assumed by Professional Standards Review Organizations, if PSRO's were in operation...State officials in key decision-making roles have expressed reservations regarding the efficacy of "peer review" in a PSRO structure and the requirement that PSRO's have ultimate discretion not only as to which claims to deny but also which to pay." (Pp. 72-74)

Recommendation (1):

PSRO's should be tested during a trial period as a supplementary check-and-balance on existing utilization review procedures. Once tested and made fully operational, they should be monitored carefully to insure that they continue, as the Commission emphasizes, "to function independently and agressively -- in short, in the best interest of the public."

SECTION I

THE SHARE SYSTEM

One cannot appreciate the complex problem of determining hospital rates of reimbursement without a historical perspective of the process utilized prior to 1975. From the time that The Hospital Service Plan of New Jersey, commonly called Blue Cross, was founded in 1938 until 1971, the system of cost reimbursement to the hospitals in this State was based upon informal rate-making conducted on a "one-to-one" basis between Blue Cross and each individual hospital. The first Medicaid hospital rates were pegged to Blue Cross reimbursement rates. As the reimbursement rates (per diems) escalated, the public and government officials became increasingly alarmed.

Bureaucratic Malpractice, a 1974 report by the Center for Analysis of Public Issues, traced the history of health care reimbursement in New Jersey. In 1963, the Commissioner of Banking and Insurance set a "fixed ceiling" beyond which hospital costs would not be reimbursed. The Commissioner set this ceiling without the benefit of effective or systematic checks and balances or review of cost data supplied by the New Jersey Hospital Association or its individual member institutions. This system was criticized by many reports.

All other attempts to accurately determine reasonableness

of hospital costs or to define real hospital costs were opposed by the New Jersey Hospital Association (NJHA) and, therefore, were not adopted. NJHA proposed a committee to advise the Commissioner of Banking and Insurance in 1968, but the advice rendered was ineffective in achieving meaningful cost containment.

In 1969, T. Girard Wharton, who was special counsel to the Department of Banking and Insurance, submitted a report highly critical of the entire rate-making process. The report criticized the overly informal and unstructured nature of the rate-making process and of the procedure by which important legal opinions were rendered. In addition to these criticisms, the report proposed adoption of controls to reduce costs (e.g., use of a standard system of accounting, prospective hospital rate-setting, pre-admission testing, tougher utilization review, joint purchasing, physician review of questionable diagnoses, competitive bidding for services and closer surveillance of operations).

In 1971, a new system was tried whereby the Hospital Research and Educational Trust (HRET), an affiliate of NJHA, began to review hospital per diem budgets. This purported review was done retroactively and the hospitals' cost claims and recommendations were virtually "rubber stamped" with the approval of the Commissioner of Banking and Insurance. Hospital budgets were generally approved with little or no modification. In the Bureaucratic Malpractice report, this system was criticized.

In May 1971, the Health Care Facilities Planning Act, (N.J.S.A. 26:2H-1, et seq.) was adopted. This important and beneficial legislation greatly expanded the power of the Department of Health over the health care industry. The Health Care Administration Board was created with power to approve rates and standards relating to the licensing of health care facilities. The new powers and responsibilities created by the legislation and relevant administrative regulations for the Department of Health included the power to:

1. Approve hospital charges to the Medicaid Program (section 18b).
2. Protect all patients against improper hospital accounting policies (section 18c).
3. Determine reasonableness of hospital charges to Blue Cross jointly with the Commissioner of Insurance (section 18d).
4. Create adversarial rate-making.

Drastic changes take time and this one did. The Standard Hospital Accounting and Rate Evaluation (SHARE) system was adopted by the Department of Health in 1975, four years later. Hospitals submitted budgets in the fall of 1975 for prospective rates for the calendar year 1976.

Legal Challenges to SHARE

On June 11, 1975, a hearing was held with respect to SHARE with the specific purpose of determining whether the details of that system met the test of reasonableness (N.J.S.A. 26:2H-18d). The hearing officer, Judge Sidney Goldman, found that arguments proposed against SHARE were unfounded. The Health Care Facilities Planning Act provided that "reasonable rates...(would be derived) ...in light of overall consideration and analysis of health care costs, derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health" (from Hearing of June 11, 1975, Report of Hearer, In the Matter of the 1975 Hospital Rate Review Program Guidelines Promulgated by the Commissioners of Health and Insurance in February 1975).

The result of this decision was to make possible the implementation by the Department of Health of the Health Care Facilities Planning Act.

Explanation of SHARE

Through the SHARE system, the State Department of Health attempts to analyze budgets submitted by each hospital, compare them with facilities of similar operation, complexity and location and set a per diem reimbursement rate sufficient to fund "presumptively reasonable" budgets. The SHARE system also requires that

each hospital submit its proposed budget pursuant to standardized budgetary forms and procedures.

The SHARE budget forms which must be submitted by each hospital are lengthy and quite detailed, although much of the data required must of necessity be based on estimates since the per diem rates are set prospectively. The budget forms require detailed information relevant to approximately 40 cost categories, including acute care, intensive care, emergency room and administration.

One of the most significant changes between 1977 and 1976, documenting submission requirements by the various hospitals, were detailed timetables with deadlines which must be met by both the individual hospitals and the department of health. One of the causes of problems with the 1976 rates was the delay in issuance of rates and the hearing schedules.

Under the system now operating hospitals had to submit their 1977 budget by October 31, 1976. There are incentives included. All hospitals that had submitted "clean budgets", i.e. one that was internally consistent, mathematically correct and which could therefore be entered into the SHARE computer data base got a 3% increase over their 1976 approved rate beginning Jan. 1, 1977.

This must have been sufficient incentive because 113 hospital budgets for 1977 were received prior to the deadline and 110 were entered into the data base. In 1976 only 90 hospitals were included in the base. It is this "base" which is used in all subsequent comparisons of statistics. Further "timetable detail"

was set; all with the intention of defining and structuring the rate setting procedure in as orderly and predictable a routine as is possible.

The SHARE 1976 Budget Document for each hospital contains approximately 50 pages of cost and statistical information. Each budget is reviewed initially by a professional analyst employed in the Health Statistics and Economics Unit and thereafter by computer. The budget is broken down into cost component categories called "cost centers". Each center is compared and a "median" derived.

The System utilizes the technique of peer comparisons between comparable hospitals. Peer comparison is a process by which facilities are grouped according to similarity of operations, complexity and location. In order for such comparisons to be accurate and fair, special adjustments are made for cost factors uniquely relevant to a specific hospital. For example, adjustments are made in each cost center in each hospital budget to allow for differences among the fringe benefit packages of the employees of the respective hospitals. This procedure is called "fringing." The process allows increases in the budget for an individual cost center by a multiple of the salary dollars by the fringe benefit

percentage. For example, if the total dollars paid by a hospital for fringe benefits is $20,000 on a total payroll of $100,000, the fringe benefit percentage is 20%. If a cost center is $10,000, including an employee salary component of $8,000, the salary component would be increased by 20% (to a total of $9,600) then the balance of the cost center will be added in so that the cost center, after "fringing" would be $11,600.

The second major stage in the adjustment process to allow for equitable comparisons among hospitals is called "equalization". This is a series of adjustments made to each major cost component so that the dollars in the budget for that cost center are similar to the dollars requested in the same cost center of another hospital to which it subsequently will be compared. The objective of "equalization" is to permit a comparison between two hospitals which may be similar in type (e.g., major teaching), but dissimilar in location. For example, a major teaching hospital in a North Jersey urban area may have costs inherently higher than a major teaching hospital in a southern New Jersey area. After equalization, the budget dollars requested can be compared, with a resulting analysis that will be fair to both.

The comparisons under the SHARE system, which are made among hospitals, have, in 1976, resulted in important challenges by the Health Department to the budget requests and cost claims of hospitals. Such challenges are made pursuant to established criteria and

guidelines applied uniformly for all hospitals. For each separate cost center all the hospitals unit costs which have been "fringed" and "equalized" are listed. A median is determined for each cost center. For each cost center, a hospital will be challenged on any claimed amount exceeding the total of the median fixed plus a designated percentage applied to the median amount.

These challenged amounts, based on peer comparisons, are applied to the relevant base period. Depending on the cost center, a comparison may be made "Statewide" or within a "hospital category". In 1976, for example, the ACU (acute care) cost center was evaluated Statewide. The median established for 1976 rate-setting was $27.73. The challenge ratio for ACU was 1.1, therefore, the challenge limit was $30.50 (1.1 x $27.73). In another cost center, ORR (operating and recovery room), the peer comparison was not made among all hospitals, but rather peer groups were made since the nature of the costs are expected to vary by hospital category: major teaching, other teaching, other short-term acute-large, medium or small (3 separate categories), rehab centers or specialized. A median and challenge limit is determined for each hospital category. The median established for 1976 rate-setting in ORR-major teaching was $54.71. Since the challenge ratio was 1.1, the corresponding challenge limit in major teaching was $60.18; the median for other teaching was $50.08, challenge limit was $55.09, etc. In this way, the Department concludes that fair peer comparisons are made since

some cost centers can be compared among all hospitals inasmuch as cost components of those comparable centers are presumptively similar. Other cost centers (such as the emergency room example described above) are presumed to vary by hospital category.

The base period challenges are included in the challenged cost part of the computer analysis.

The net cost is the difference between the total costs reported on the SHARE budget submission minus the challenges determined in the manner described above. The "net cost" is divided by the estimated covered in-patient days to arrive at a per diem rate.

All expenditures by a hospital over and above that which they were permitted for the prior year are deducted from the base budget amount so that those hospitals which overspent prior budgets will not be rewarded. Since the system determines allowable budget cost in part by reference to operating costs incurred in prior years, hospital overspending would be rewarded if the Minimum Base Period adjustment were not made.

Once the acceptable base period expenditure amount is determined, this amount is adjusted for volume, intensity and inflation to predict the prospective year expenditure. Volume adjustments are based on increases in that particular hospital's admissions; intensity adjustments are based on unit cost by admission compared among hospitals in 1976, if the admissions were 90% of the median, a 3% intensity factor was granted, up to the median 2%, up to 100% of

the median a 1% and beyond that no intensity factor); inflation adjustments were based on a 6.5% economic factor, including the consumer price index and other economic indicators. Year end (1976) analysis upheld the estimate: the final 1976 economic factor was 6.5%. The 1977 economic factor calculated similarly is 5.4%.

There are three components in the SHARE analysis:

1. the budget submission
2. the cost center computer analysis
3. the rate summary

The first two have been discussed. The third is the final step in arriving at the proposed administrative rate (PAR). The analyst at the Department of Health prepares the rate review summary using the budget and the computer analysis of cost center norms. Subjective decisions are introduced at this point when the analyst makes certain value judgments pursuant to the general policies and goals of the Department of Health.

For example, in 1976, one particular hospital in New Jersey employs a fairly large staff of certified registered nurse anesthetists which reduces the amount of time that physician anesthesiologists are needed. This can effect important economies.

When that hospital was compared with its peers, it was challenged more than $100,000 for the relevant cost center. Since the analyst realized that this expenditure actually secured significant savings, the challenge was eliminated on the rate review summary.

Subsequent to the issuance of the PAR (proposed administrative rate), the hospital may appeal the rate. The first appeal level is

called an administrative review and is devoted to consideration of specific explanations and justifications urged by hospital respresentatives in an effort to demonstrate the allegedly unique cost factors for the appellant hospital. Justifications such as the one described above may result in challenge reductions.

The second appeal level is before a hearing officer who is appointed by the Commissioner of Health. Testimony is presented by the Department and the hospital which is transcribed by a certified court reporter. The public interest is represented by the Public Advocate's Office, Division of Rate Counsel. Arguments are presented by the hospital on each of the challenges under appeal. Generally, the Department of Health, represented by the analyst assigned to that hospital, presents the relevant section of the guidelines applicable to the issues raised.

Upon receipt of the transcript, the hearing officer has thirty (30) days to submit his findings of fact and conclusions of law to the Commissioner for a decision.

Gaps In the SHARE System

At present, the SHARE rate-making system is not applied to any patients other than those who are enrolled in the Hospital Service Plan of New Jersey (Blue Cross). This gap in the jurisdiction of the SHARE system at present is attributable to the provisions of the Health Care Facilities Planning Act.

The jurisdiction of this SHARE system would be expanded to include rate fixing for such patients under the provisions of a proposed amendment to such act contained in New Jersey Senate Bill 1454. Because the SHARE system effectively operates to control hospital costs in the public interest, the Commission endorses the enactment of Senate Bill 1454 in order that these controls be extended to all consumers of hospital services.

There apparently exists still another gap in the jurisdiction of the SHARE rate-making system. At present, the exclusive authority and power to set per diem rates under the Medicaid Program have been construed to rest with the Commissioner of what is now the Department of Human Services. (Atty. Gen. F.O. 1976 No.8; but see N.J.S.A. 26:2H-18b). Under present agreement, the Health Department uses the SHARE system to recommend an interim rate of hospital reimbursement for use in the Medicaid Program by the Department of Human Services. There is a pending agreement between these two agencies to settle this issue and place authority for setting of the Medicaid rate with the Department of Health.

Traditionally, the Medicaid interim per diem rate has been the same as the Blue Cross rate. The interim per diem rate which is set by SHARE is technically based on costs allowable under the Blue Cross contract. Although certain costs allowed by Medicaid are dissimilar to costs allowable by Blue Cross, the fiscal intermediaries have generally paid the

same interim rate for both Blue Cross and Medicaid hospital in-patients.

It has been generally assumed that the Blue Cross rate closely approximated costs and, for convenience, the Medicaid interim per diem rate was set at the same level as the Blue Cross interim per diem rate, during the relevant year. This assumption is incorrect when applied to Medicaid in-patient costs.

The interim per diem rates for Blue Cross and Medicaid have, historically, been the same, as a result of this erroneous assumption. The final rates, set after actual allowable costs are determined for each at the end of the relevant year, have been higher for Blue Cross, resulting in an inflated interim Medicaid rate. In an attempt to preclude this traditional overpayment in the interim Medicaid rate, the Department of Health began in September, 1976 to subtract from the PAR (proposed administrative rate) those items which were not applicable (such as emergency room deficit, Rider J, radiology fee for service, outside collection costs, and other costing differences). Each of these items, commonly called Blue Cross contractual allowances or "add-ons", are not analyzed by SHARE, and, as a result, they are automatically added on to the Blue Cross rate as a result of a memorandum from Blue Cross officials sent to the Department of Health. Blue Cross, without cross-checking by SHARE administrators, determines the amount of such "add-ons."

For 1977 budgeting a decision was made to give the hospitals a 3% increase over their 1976 approved Blue Cross per diem. Similarly the Medicaid per diem was increased by 3% pending issuance of the 1977 PAR and appropriate 1977 interim Medicaid rate.

The New Jersey Hospital Association contends that there may

be elements of costs eligible for Medicaid reimbursement in the contractual allowances. The S.C.I. takes the position that, in many aspects, the allowable costs for Blue Cross and Medicaid, in the setting of the final rate are dissimilar. Therefore, the contractual allowances should not automatically be included in the Medicaid rate. The SHARE system should be used to analyze and cross-check all components of the interim Medicaid rate and the interim Blue Cross rate.

The 1975 financial statement for one large hospital showed an overpayment to that hospital, by Medicaid, in the amount of $1.4 million! This is directly a result of the prior system referred to above whereby the Medicaid rate was set equal to the Blue Cross rate. Although the hospital is now effectively paying this back (at a monthly rate of $35,000.) this situation should be avoided - it is unfair.

Through complex hospital cost categorization, peer comparison, and analysis, the SHARE system attempts to determine prospectively the amount of money each hospital must spend to operate in an efficient manner. The Commission views this system as an effective hospital cost control mechanism and, we recommend that it be used for Medicaid rate-setting. If the exclusive jurisdiction to set Medicaid rates remains with the Department of Human Services, then it is imperative that that Department utilizes the methodology of the SHARE system.

Strengthening SHARE

However, the SHARE system is not perfect. There are potential weaknesses in its present operation.

To the degree that SHARE cost center challenges depend upon a determination of excessive unit costs, a risk may exist that hospitals having cost centers lower than the challenge limit might increase the cost center claims to the "ceiling", thereby unfairly

maximizing the rate of reimbursement. Through this procedure, hospitals inclined to do so would be able to obtain higher rates of reimbursement than those to which they in fact were entitled, and be rewarded for inefficiency. The Commission, therefore, strongly recommends that in addition to the SHARE analysis presently being made, a detailed audit of cost centers' budgets submitted by hospitals routinely be performed. Only through such audits will the Department of Health be able to assure that cost estimates and volumes presented by hospitals are accurate. In the Commission's opinion, the temptation to recast excessive costs of one center to costs of centers falling below the "norm" is too great a temptation to place on any hospital presenting unaudited budget submissions.

The Health Department perceives their analysts as professionals whose job it is to determine what constitutes reasonable costs for individual health care facilities. The S.C.I. believes that, in effect, there is a dual role for the analysts. Since they set the administrative payment rate, they are directly responsible for the determination of the component costs to Medicaid. Health analysts should be aware of this duality, and in the opinion of the S.C.I., subjective decisions made by an analyst which may have a material effect on the reimbursement rate should be scrutinized closely by superiors.

We further note that present SHARE practices and procedures to some extent embody adversarial principles. Appellate proceedings

are held before a hearing officer, a formal record is made and hospitals are permitted to present reasons for appeal through a legal representative. The Public Advocate appears in these rate-making proceedings to represent the public interest. The Commission concludes that it is important to the public interest that this representation continue. This recommendation is consistent with the need to have checks and balances in the decision making processes of the Department of Health.

In fact, the role of the public Advocate should be strengthened. Under current procedures, questions have been raised as to the power of the Public Advocate to "discover" detailed hospital cost-related information relevant to the setting of a "reasonable" rate of re-imbursement.

The Commission strongly believes it to be in the public interest to resolve all such questions in favor of accuracy and candor. Any information reasonably relevant to the setting of a reasonable rate of hospital reimbursement should be available to all interested parties.

Even though SHARE in New Jersey will provide a fair method to determine hospital per diems, there is a gap with respect to out-of-state hospital services. During calendar years 1975 and 1976, Medicaid paid for in-patient hospital stays as follows:

Dollars Paid by Medicaid to Hospitals:	1975	1976
Hospitals in New Jersey	$103,823,736	$104,537,729
Hospitals out-of-state	4,557,685	5,280,059
Total	$108,381,421	$109,817,788

Naturally, some of the dollars paid to out-of state hospitals are emergency-type treatments or other situations where certain kinds of treatment may not be available in New Jersey. But added Medicaid costs resulting from the situation in which it is purely the free choice of the Medicaid recipient to cross State lines without preauthorization from DMAHS for hospital care should be financially minimized, perhaps by not permitting the out-of-state hospital a higher per diem reimbursement than a comparable New Jersey hospital.

SECTION II

S.C.I. ANALYSIS OF 12 HOSPITALS

Commission staff thoroughly analyzed the 1976 cost claims and budget requests submitted by twelve hospitals which are high volume Medicaid providers. The Commission transmitted the results of this analysis to the Department of the Public Advocate and the Department of Health. The Commission's technical assistance to the Public Advocate in SHARE system analyses and Blue Cross Rate Hearings totalled some 750 accountant hours over the course of this investigation.

An analysis was made by the S.C.I. of the budget submissions of 12 hospitals in New Jersey which are high volume Medicaid providers. The details of this analysis are set forth in the attached appendix lettered "A" through "L". This analysis reconciles the three aspects of SHARE previously mentioned; budget submission, cost center computer challenges - (SHARE), rate review summary. Our analysis contains a breakdown of the per diem among all the cost centers and recasts per diem costs after challenges to Hotel Services, Nursing Services, General Patient Care and Ancillary Services. The same four-way breakdown is used by New York Blue Cross in its rate requests. The S.C.I. analysis provides a "total financial picture" of each hospital budget as follows: total request, computer challenges, adjustments by health department

analysts, per diem breakdown among all cost centers and recast to the four general areas described above.

SCOPE OF S.C.I. REVIEW

Our review of the 12 hospitals' budgets provides an excellent example of the cost control factors inherent in the SHARE system.

The analysis described above of the 12 hospitals and two separate summaries of that analysis are presented in this report as follows:

1. Appendix I illustrates, for each of the 12 hospitals, the total cost presented in their 1976 SHARE budgets, the portion of that amount which are grouped as emergency room, clinic and private out-patient and non-eligible for reimbursement to the hospital. Of the amount appearing in column 2, certain covered in-patient costs were questioned or challenged under the SHARE system. The respective questioned costs appear in column 4. The Base is the amount which remains after total costs questioned is eliminated from covered in-patient dollars (Column 2 minus column 4 equals column 5).

For example, Appendix A, which presents the analysis applied to Monmouth Medical Center demonstrates by cost center,

the budgeted costs which support the totals shown as Appendix I.

2. Appendix II summarizes the second part of the analysis which was applied to the 12 hospitals. The requester per diem is the result of dividing the covered in-patient amount (column 2, Appendix I) by the estimated covered in-patient days which was submitted by the hospital.

The PAR (Appendix II, column 2) is the result of dividing the Base (column 5, Appendix I) by the estimated covered in-patient days projected by the hospital.

The only adjustments to the above-mentioned calculations result from Blue Cross considerations. These are presented in the respective hospital analyses (Appendices A-L). It should be noted that the PAR's in some of the Tables differ slightly, based on minor subsequent adjustments made by the hospitals prior to their formal appeals.

Additionally, Appendix II presents the breakdown of the PAR between the four groups of costs described above: Hotel Services*, Nursing Services, General Patient Care and Ancillary Services.**

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* Hotel services are those related costs, albeit in a hospital setting, which are generally associated with room and board.

** Ancillary services are costs related to departments grouped under the common reference: radiology, anesthesiology, pathology and emergency room.

With reference to Appendix A, Monmouth Medical Center, the analysis disclosed that the acute care cost center presented in the hospital's 1976 SHARE budget was $4,614,000. The covered in-patient portion was the same. The total costs questioned or challenged in that cost center was $191,000. Subtracting costs questioned from the covered in-patient amount results in the base of $4,423,000. This amount divided by the hospital's 1975 estimate of 161,500 covered in-patient days yields $27.39. This is the portion of the PAR which is attributable to the acute care cost center.

The $27.39 was apportioned between nursing services and general patient care as a result of the ratio of employees (nursing) salaries to other costs within the cost center.

Similarly, an attempt was made to apportion fairly all costs where they did not fall exclusively within one of the four categories.

At the time the analysis was done by S.C.I., the Department of Health had not acted to recommend the elimination of Blue Cross contractual allowances from the Medicaid rate. Therefore, the 1976 interim Medicaid payment rates were somewhat less than the per diems (PAR) presented in the analysis. (See Table I for the difference due to elimination of contractual allowances in the Medicaid rate).

The New York Blue Cross method of classification was used as the basis of re-classification.

The interim per diem paid by Medicaid during the years 1971-1976 has shown persistent escalation paralled to the per diems paid by New Jersey Blue Cross. (In 1976 the rate paid by Medicaid was a multiple of 106.7, the average between the 1974 and 1975 per diems. Judge George H. Barlow subsequently found this rate unacceptable in proceedings brought by the New Jersey Hospital Association).

Although the Medicaid per diem was equal to the Blue Cross reimbursement rate prior to 1976, Medicaid paid it on an interim basis only. At the end of each year, Blue Cross auditors reviewed costs (procedures) for Medicaid and a "final amount" was determined. There are basically two offsetting variables which affected the final cash settlement. Inflation and cost increases over the year increased the amount which had to be paid but the Medicaid patient generally stayed longer. Although this increase in length of stay would result in a lower cost per day, the cost per admission or procedure was higher for the average Medicaid patient.

SHARE Impact On Medicaid

The practical application of the SHARE system, in regard to the in-patient hospital cost of the Medicaid program, began to pay immediate dividends in savings by the elimination from the 1976 Administrative Payment Rate of those elements of that

rate which are not applicable to Title XIX recipients: (e.g., radiology fee for service, outside collection costs, Medicare "carve-out", Rider "J", self insurance and emergency room adjustment). These are commonly called Blue Cross contractual allowances. Rate reductions applicable to the 12 major hospital providers range from $2.37 to $14.86 per patient day.

The S.C.I. analysis, as set forth in Table I, illustrates the significant savings which could be obtained for the Medicaid program by the operation of the SHARE system when that system is applied to the 12 facilities.

For this reason, the Commission reiterates its conclusion that the cost containment benefits of the SHARE system must be incorporated into the Medicaid Program. On the basis of a Division of Medical Assistance and Health Services estimate of one million patient days for 1976, the Commission has projected savings approximating $7 million which could accrue to the Medicaid program if this recommendation is implemented. (See Table I).

Table II depicts the dollar and percentage increase in the hospital reimbursement rate from 1971-1975 inclusive. It also illustrates the increase (decrease) in the 1976 Medicaid rate. One only needs to compare the average annual increase through 1975 for each hospital to the increase (decrease) for 1976 for dramatic insights of the efficacy of the SHARE System.

Of the 12 hospitals analyzed by the S.C.I., 4 received a per diem rate reduction for 1976, only 1 facility's rate was virtually unchanged and 7 received over-all rate increases of 4.3%. These figures compare most favorably with the experience of these hospitals during the 4 year period 1971-1975 when the annual increase ranged from 10.4% to 22.3% per year.

Results of S.C.I. SHARE Audit

The analysis of the 12 budgets brought to light certain weaknesses in the operation of the SHARE system. These weaknesses can be divided into categories:

1. The S.C.I. analysis disclosed that mathematical errors were made in the computation of the hospital reimbursement rate. Several such calculations were alarmingly large in size. The S.C.I. recommends that the Health Department institute a system to consistently cross-check mathematical accuracy in calculations of reimbursement rates. The model developed by the S.C.I. in its own analysis of twelve hospital budgets which is discussed herein easily can be adopted for use.

2. Refinements must be made in SHARE's analysis of the specific physician components of the Radiology, Pathology and Anesthesiology cost centers. At present, SHARE does not adequately reflect comparable cost figures among peer groups in their cost centers due to the diversity in the methods of compensation,

e.g., percentage of gross charges, fee for service, salary, etc.

We recommend that hospitals be required to submit detailed information regarding levels of compensation paid to either these physicians or groups, or both, without regard to the method of payment. In the opinion of the S.C.I., until the SHARE system is capable of extracting reasonable cost data from these centers, the final reimbursement rate will not be truly reflective of "presumptively reasonable budgets" because objective peer comparisons of these cost centers are not uniformly made at present. It is believed that this recommendation would remove this weakness.

With further respect to the compensation arrangements between radiologists, pathologists and other specialists, the Commission notes the filing of an anti-trust action alleging price fixing in the Southern District of New York by relevant professional associations. We have urged the Anti-Trust Section of the State Division of Criminal Justice to review and analyze the practices of such associations in New Jersey and determine whether similar action is warranted in this state.

3. To further guarantee the accuracy of hospital figures and to insure that facilities will not be rewarded for inefficiencies, we recommend that the Health Department regularly request copies of management consultant reports on individual hospitals. These reports will be extremely helpful in identifying areas of operational or administrative inefficiency.

4. We recommend greater coordination between licensing and rate-making units within the Department of Health. Decisions of the Licensing Unit--such as a determination as to the minimum acceptable amount of physician coverage in an emergency room--have a direct affect on hospital costs. Such decisions should not be rendered informally but should be made only after appropriate Intra-Departmental consideration.

The Health Statistics and Economics Unit presently operates the SHARE system. However, the Licensing Unit makes ad hoc decisions which have a direct and material impact on the cost claims of hospitals.

For example, a Commission staff member discovered that Lydia Pabian of the Licensing Unit unilaterally and without consultation with the rate-making unit advised a hospital that an increase in emergency room physician staff was necessary to maintain State licensure. Acting on this advice the hospital increased its staff and sought a concommitant reimbursement increase approximating $150,000 in its budget.

At the same hearing, the head of the Licensing Unit, Dr. Solomon Goldberg, testified that it was not necessary for the hospital to increase its emergency room physician coverage.

The economics unit challenged the cost increase resulting from this ad hoc decision. The hearing officer then had to resolve this dilemma which we view as caused by a lack of coordination between the various units in the Health Department and by overly informal decision making.

TABLE I

SAVINGS-RESULTING FROM THE DIFFERENCE BETWEEN MEDICAID & BLUE CROSS PER DIEM

Hospital Name	1976 Medicaid per diem	1976 Blue Cross per diem	Difference	1976 Medicaid days	Savings
Monmouth Medical Center	151.72	156.44	4.72	16239	76,648
St. Michaels Medical Center	155.10	158.26	3.16	34390	108,672
St. Francis Com. Hlth. Center	143.79	146.16	2.37	12275	29,092
St. Mary's Hosp. Hoboken	130.53	139.04	8.51	11700	99,567
Cooper Hospital	121.00	129.44	8.44	23800	200,872
Perth Amboy General	123.67	127.70	4.03	15707	63,299
Newark Beth Israel	176.99	191.24*	14.25	33570	478,372
Saddle Brook General	107.76	111.23	3.47	14866	51,585
United Hospital Med. Ctr.	152.33	161.09	8.76	32940	288,554
Hospital Ctr. at Orange	135.19	142.93	7.74	11400	88,236
St. Joseph's Hospital	141.28	154.66*	13.38	22012	294,521
East Orange General	137.18	152.04	14.86	13000	193,180
				241,899	$1,972,598

Source: 1976 Budgets filed with N.J.S. Dept. Health

*Based on APR

TABLE II

MEDICAID PER DIEM SELECTED HOSPITALS

	Percentage Increase 1971-1975 (4 years)	1971	1972	1973	1974	1975	1976	1976 PAR	Percentage Increase In 1976
Monmouth Medical Center	65.5	89.94	100.99	117.68	130.43	148.81	151.72	153.98	1.96
St. Michaels Med. Ctr.	55.6	98.04	101.25	110.86	124.45	152.58	155.10	158.33	1.65
St. Francis Com. Hlth. Ctr.	79.8	75.45	90.41	101.67	112.33	135.68	143.79	144.14	5.98
St. Mary's Hospital, Hoboken	46.3	90.37	97.40	107.25	114.81	132.25	130.53	139.04	(1.30)
Cooper Hospital	89.2	64.30	73.68	83.76	97.67	121.63	121.00	127.31	(.01)
Perth Amboy General Hospital	41.5	84.69	87.56	97.68	106.54	119.85	123.67	127.70	3.19
Newark Beth Israel	65.0	105.43	119.58	131.90	150.56	173.95	176.99	184.26	1.75
Saddle Brook General	41.8	74.92	80.17	84.09	96.50	106.20	107.76	111.18	1.47
United Hospital Med. Ctr.	50.0	101.91	110.34	118.68	136.90	152.81	152.33	161.85	-
Hospital Center at Orange	57.8	93.54	98.88	112.13	126.65	147.64	135.19	142.93	(8.43)
St. Joseph's Hospital	49.7	82.98	90.64	97.84	108.50	124.23	141.28	148.18	13.72
East Orange General	43.7	98.81	99.94	102.24	119.92	142.01	137.18	152.60	(3.40)

The column "1976 PAR" is listed for information only; the "Percentage Increase In 1976" is determined by finding the difference between 1976 and 1975 and dividing that amount by 1975.

SECTION III

A. Medicaid Eligibility Problems

It is apparent from the State's commitment of expenditures for recipients to hospitals and out-patient clinics of $135,000,000 in 1975, as reported to the S.C.I. by DMAHS, that the large urban hospitals still retain their status as the "family doctor" for the medically indigent. The S.C.I. conducted surveys of major hospitals in Essex, Hudson, Monmouth, Atlantic and Camden Counties regarding admission problems which impact on the access of hospital care to Medicaid recipients and potential recipients.

Fiscal administrators advised S.C.I. agents that the principal problems relate to questions of current eligibility and patient utilization. Their complaints are enumerated as follows:

1. Due to the alleged red tape in enrolling recipients, other than those in the ADC program, the hospitals have become the initial contact point in filing for medical benefits, especially for "Medicaid only"* and Supplemental Security Income (SSI) recipients. Hospitals' personnel in "patient in-take" departments have been trained to prepare the necessary Medicaid enrollment and forward same to the County Welfare office or the Social Security Administration (for SSI recipients) as appropriate.

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*Medicaid only recipients do not receive welfare payments; they are only enrolled for medical services.

2. It allegedly takes 6 weeks to get a recipient "on" the computer (listed on the eligibility rolls). (Note the average Medicaid hospital stay is 6.5 days).

Therefore, the hospitals must wait 28 1/2 days to find out if they are going to be reimbursed for medical services rendered to beneficiaries. Instances of payment denial for eligibility reasons were reported by fiscal officers surveyed even when a recipient had a Medicaid card and a validated stub! In this context, a U.S. General Accounting Office Study of the Florida Medicaid program dated June 9, 1971 provided an example of an effective pre-authorization system which provides eligibility, utilization and fiscal control capability. The report said on page 18:

> "The Florida Bureau of Medical Services has established a system of preauthorization for medical services to Medicaid participants. Providers obtain authorization simply by telephoning (toll free) the nearest of the Medicaid terminals, which are located in all populous areas and requesting transaction numbers. Terminals are connected to a computer system in Jacksonville, which permits immediate processing and the furnishing of transaction numbers.
>
> "As the request for a transaction number is processed the eligibility of both the recipient and the provider is confirmed by reference to recipient and provider numbers. Remaining entitlement of the recipient for certain services, such as inpatient and outpatient hospital care, is calculated and recorded, and the estimated cost of the service being requested is established. The transaction number is recorded and used later in verifying the provider's claim. The bureau is able to maintain fiscal control and is assured that each transaction number issued involves a Medicaid recipient and a qualified provider."

Potentially, New Jersey has the same capability provided Medicaid eligibility data which is maintained by N.J. Blue Cross is integrated into its teleprocessing system. This procedure would provide the hospital admissions officer with (1) a practically "fail safe" method of determining the potential recipient's eligibility status and (2) the added assurance that the hospital will be paid for services rendered in absence of any over-utilization problems. Proposals regarding this system have been submitted by Blue Cross but budgetary restrictions have forstalled an implementation of the plan.

Several conditions favoring the adoption of the proposal appear to have merit:

1. H.E.W.'s persistent concern over program eligibility criteria for services rendered under the Title XIX program would appear to provide the needed impetus to solve the funding problems with Federal funds.
2. Some (not all) elements of discontent manifested by major hospital providers with the Medicaid program could be eliminated if the State took the initiative in solving the recipient eligibility problem relative to hospital services rendered.
3. Major New Jersey hospitals have the teleprocessing system in operation when admitting Blue Cross subscribers. Inasmuch as Blue Cross has been and is

compensated for maintaining Medicaid's eligibility files, the proposal does not contemplate the development of an entirely new system but the merging of the Medicaid eligibility data into the existing Blue Cross system which serves over 4 million people in this state. The long range benefits, in terms of program integrity and the maintenance of the good will of hospital providers, would, in the opinion of the S.C.I., dictate that H.E.W. through its S.R.S. Division and the DMAHS work out ways and means for implementing the Blue Cross proposal.

4. Hospital fiscal officers in the major urban areas of the State expressed extreme displeasure regarding the Supplemental Security Income program (SSI) as it relates to the enrollment of recipients as of January 1, 1974, covering Aged, Disabled and Blind eligible recipients.

We understand that the Division is giving serious consideration to placing physicians and other providers on an "on-line" computer system to facilitate a pre-authorization determination and instantaneous provision to physicians of recipient Medicaid histories. We urge implementation of this suggestion.

The Commission found that the SSI program was plagued by inadequate administrative "lead-in" time and an apparent inability of Federal agencies to adjust to necessary and important State procedures. Of course, these administrative deficiencies had a negative impact on the economic viability of a hospital facility serving a high percentage of SSI patients. One major hospital provider had over $500,000 in outstanding Medicaid receivables before the problem was resolved. As of the date of this report, the S.C.I. concludes that the "SSI problem" can be resolved by implementation of the teleprocessing concept.

B. Medicaid In-patient Utilization Controls

The State of New Jersey initiated its Medicaid program several years after similar programs were in operation in states such as New York and California. In this respect it was spared the fiscal trauma that afflicted those states which adopted liberal medical indigency provisions. Just as it benefited from the organizational experience of others, the State became the beneficiary of certain utilization controls such as Approval by Individual Diagnosis (AID), which controlled the length of hospital stays, and Pre-Admission Testing (PAT), which was designed to cut down on hospitalization for diagnostic reasons. These utilization controls and one other - "the second opinion" program - will be discussed in this section.

The effective operation of well-designed utilization controls is a condition precedent to achieving substantial cost containment in the Medicaid Program. We urge that such controls be maintained and improved as described more specifically in the following part of this report. These controls are important deterents to temptations to overutilize hospital services, thereby limiting increases in hospital costs.

A description of these controls and their application follows.

(1) - DESCRIPTION OF APPROVAL BY INDIVIDUAL DIAGNOSIS (AID) PROGRAM:

Approval by Individual Diagnosis is one of several utilization control tools used in connection with monitoring the Medicaid program for possible abuse. The foreword to the Second Revision of the AID manual provides a statement of the principles underlying its enactment:

"The Approval by Individual Diagnosis (AID) Program is based on the following principles:

1. The primary aims of the AID program are the improvement of patient care and the elimination of unnecessary hospital usage, through the cooperation of the hospitals and their physicians.

2. The AID program is not aimed at depriving Blue Cross members of the necessary hospitalization benefits provided by the subscription certificate. It in no way reduces the patient's rights, nor does it provide any benefits not authorized under the subscription certificates.

3. The Plan authorizes additional days of hospitalization beyond the initial AID days allowed, within the limits of subscription certificate, if the attending physician certifies that the continued stay is medically necessary. In this way, the AID Program preserves the right of the physician to practice medicine according to the approved standards of the profession and the dictates of his judgment.

4. The Plan does not interpose its own judgment on the medical reasons for continued hospitalization. It is, therefore, the responsibility of the hospital's utilization committee to review the certification to insure that hospital facilities are not being used unnecessarily.

In the first year, AID cut approximately one half day from Blue Cross subscriber's average length of stay, resulting in a savings of millions of dollars for New Jersey Blue Cross and Blue Shield subscribers. The potential of the AID program is obvious. However, this potential is not being fully realized.

A recent survey of the AID program revealed two areas that need strengthening: 1) Better timing of the certification by the physicians; and 2) Greater participation by the hospital's utilization review committee. The survey showed that only 76 percent of the hospitals obtained certification by the physician before the expiration of the AID days; the rest obtained certification after the AID days expired or even after the patient was discharged. Similarly, only 56 percent of the hospitals sent a copy of the certification form to the utilization review committee--a procedure that is an integral part of the AID program.

Significantly, the survey revealed that, in hospitals that obtained certification before the expiration of AID days, the average length of stay was 0.3 days less for all admissions, and 0.6 days less for Blue Cross patients, compared to hospitals that do not follow this procedure.

The twin aims of the AID program--improved patient care and the elimination of unnecessary use of hospital facilities--can only be achieved through the cooperation of the hospitals and physicians. Their thorough and whole-hearted implementation of the Program is in the best interests of the patients, the hospitals, the physicians and the community.

It is significant to note that this document was dated December, 1969 and was published prior to the commencement of the State Medicaid Program. The manual was prepared by leaders from the Medical Society of New Jersey, the New Jersey Hospital Association, Blue Cross and Blue Shield. It has been endorsed by every responsible segment of the medical establishment as an effective tool in controlling hospital utilization. The Commission endorses the maintenance of such systems.

In the course of the Commission's investigation it came to light that the Medicaid Program permits the fiscal intermediaries (Blue Cross and Prudential) to use twice the number of days of hospitalization allowed under the AID Program in processing certain kinds of in-patient hospital claims.

The obvious question is, if the AID program was adopted by the health industry why does the State permit the fiscal intermediaries to use in certain cases a screening process which, in fact, defeats the purpose and intent of this utilization control by using twice the length of stay provisions of the manual? For example, if the AID Program manual allows 6 days for a specific diagnosis such as an appendectomy, the fiscal intermediaries set a screen of 12 days before they examine the claim any further as to length of stay. In other words, even though AID sets 6 days as reasonable, the intermediaries are permitted by DMAHS to allow hospital claims for up to twice that (12 days) without further certification of medical necessity.

Dr. J.C. Breme, Medical Director of the Division of Medical Assistance, expressed surprise at the use by the intermediaries in certain cases of double the AID days and he could offer no justification for the apparent failure to follow the AID guildelines. Dr. Breme was unaware of this practice until the Commission brought it to his attention. It is the responsibility of the Division of Medical Assistance and Health Services to establish, update and

enforce clear utilization review procedures to be used by the fiscal intermediaries in the claims screening process. We urge DMAHS to issue immediately a written directive obligating the intermediaries to follow specified utilization review procedures.

(2) - PRE-ADMISSION TESTING - PAT

Another utilization control tool which is used by 88 percent of all New Jersey hospitals is the Blue Cross Pre-Admission Testing Program. Under the Medicaid program, PAT is billed as an out-patient service. PAT is designed to shorten hospital stays by encouraging the performance of tests before admission to a hospital rather than during a patient's confinement. Blue Cross estimates that PAT can reduce the average length of hospital in-patient stays by as much as 2 days.

The conditions under which PAT should be used include:

1. The attending physician has scheduled a hospital admission because a patient requires in-patient care.
2. The use of PAT will shorten patient stay.
3. Tests are the type that can be performed on an out-patient basis.
4. Results of pre-admission testing will be medically valid at the time of subsequent in-patient admission.
5. It is feasible for the patient to visit the hospital prior to admission.

Blue Cross officials advised the S.C.I. that, while the programmatic intent of PAT is laudatory, there are problems relating to its application to Medicaid patients, as follows:

1. Transportation to and from hospitals in certain urban areas by public carriers is either unreliable or non-existent. The cost of taxis eliminate this mode of transportation as an alternate source.
2. Patient cooperation in regard to rigid adherence to examination schedules is unsatisfactory. Recipients frequently break appointments or arrive hours after the time allotted to them.
3. Recipients generally do not have a primary physician, i.e., he doesn't see the same doctor whenever he visits a clinic. Therefore, doctors lose valuable treatment time in updating their familiarity with the patient's medical problems

Conceptually, the PAT program is a viable utilization control tool, but socio-economic problems unrelated to the delivery of health care services adversely affect the Medicaid hospital provider's ability to maximize its use. In order to solve transportation and broken appointment problems, some hospitals have been admitting patients for disgnostic pre-operative tests and for reasons which lack "medical necessity". Admissions for the aforementioned reason are NOT reimbursable for Medical purposes. The Commission

strongly recommends that aggressive efforts be made to use P.A.T. consistently and uniformly, rather than haphazardly, for Medicaid patients.

(3) - PROGRAM FOR ELECTIVE SURGICAL SECOND OPINION

In addition to the AID and PAT Programs, Blue Cross and Blue Shield of Greater New York is experimenting with a Program for Elective Surgical Second Opinion (PRESSO) which is designed to reduce the number of unnecessary elective surgical operations. The PRESSO program received its impetus from a re-examination study by Dr. Eugene McCarthy of Cornell University Medical College as reported in the New England Journal of Medicine of a sampling of 1,356 patients, for whom elective surgery has been recommended. As a result of these re-examinations by Board Certified Specialists the necessity for approximately 20 percent of all surgical procedures initially recommended was not confirmed by specialists. An additional 2.1 percent of the cases were confirmed but the surgical procedures recommended did not require hospitalization. The most common type of elective surgical operations include hysterectomies, hernia repair or gall bladder surgery. Briefly, the PRESSO program gives the New York subscribers the option to receive a second opinion--at no cost to the subscriber -- to determine the necessity of elective surgery. The New York Plan has been able to enlist the

cooperation of 1,700 specialists in the Southern 17 counties of New York State, nearby Connecticut and New Jersey (emphasis added). Subscribers are free to select any one of the participating specialists from the list and schedule an appointment. New Jersey Blue Cross and Blue Shield absorbs the cost of the second opinion, laboratory tests, diagnostic tests and x-rays as needed. As a further control, the cooperating second opinion specialists have agreed not to perform surgery or treat the condition for which the subscriber has requested consultation. According to Blue Cross, the patient is under no obligation to abide by the opinion of the specialists and he will not be denied insurance coverage for surgery and subsequent hospital confinement if he decides to undergo the operation. Blue Cross has also agreed to pay for another examination and opinion at the subscriber's request if the second opinion differs from the first.

Various medical organizations disputed the above findings of Dr. Eugene G. McCarthy of the Cornell University Medical College according to a New York Times article of March 16, 1976. However, it would appear that the participation of 1,700 specialists in the PRESSO program gives credibility to its aim and objectives which are to save money, but, more importantly, to save lives.

Health researchers, New Jersey Blue Cross and others must assess the data which the program will generate to determine its applicability to programs such as Medicare and Medicaid.

Actions leading to the adoption of PRESSO have been recently initiated by the N.J. State Benefits Council, which offers now the second opinion option to state and local employees under their respective health programs. N.J. Blue Shield has agreed to cooperate. In the event that the PRESSO program receives favorable evaluation by providers and users during operation of a reasonable test program, the S.C.I. recommends its adoption by the Medicaid program as a mandatory requirement in all instances of non-emergency surgery. Strong efforts should be made to adopt PRESSO in the Medicaid Program, at least on a trial basis.

C. Performance of Fiscal Intermediaries

S.C.I. inquiries directed to Blue Cross which serves 89 Institutional Providers produced the following information:

1. During the year 1974, 10-12% of all hospital reimbursement requests were subject to medical review. As a result, 25,130 patient days were not reimbursed due principally to "Lack of Medical Necessity". These rejected claims are sometimes referred to as "Medical Review Declines." These 25,130 days represent 51% of the 49,245 patient days which were subject to medical review. The "Medical Review Declines" made by this intermediary were upheld in 98% of the cases in 1974. In terms of dollars, the total billings were $4,157,512; payments made totaled $2,237,912 and unreimbursed receivables totaled $1,769,600.

2. Blue Cross' review process was intensified in 1975 to the extent that total disputed claims approximated 56,885 patient days and $6,543,592 claim dollars. Payment was ultimately made on 29,024 patient days in the amount of $3,474,887 or 53% of the total billed: 47% or 27,861 patient days, totalling $3,068,705 were not reimbursed. Hospital recoveries after "fair hearings" were only 4% of the unpaid bills. Although the claim disallowances based on "Medical Review Declines" totalled $1,769,600 in 1974 and $3,068,705 in 1975, several points were emphasized by Blue Cross:

1. The disallowances did not pertain to clerical errors nor to AID problems which are corrected in house and by correspondence.

2. The intermediary employs several back-up procedures to handle problem cases.

3. The intermediary was upheld in 98% of "fair hearing" cases in 1974 and 96% in 1975.

4. Final disallowances were due to:

   a. Lack of medical necessity

   b. Awaiting transfer to nursing homes

   c. Inappropriate level of care

   d. Pre-operation hospitalization over 48 hours, e.g. hospitalization for diagnostic reasons

   e. Ineligible services, e.g. drug addiction, diet therapy, etc.

5. Although Blue Cross covers 89 institutions, the hospitals with greatest number of disputed claims were:

Provider	Cases in Dispute 1974	1975
Newark Beth Israel	56	92
Clara Maass	28	60
Cooper Hospital	29	75
Bergen Pines	109	195
United Hospital Medical Center	74	134
Jersey City Medical Center	160	346
Saddle Brook	31	60
St. Michaels	117	146

In addition to the savings resulting from Medical Review Declines, the Blue Cross review process picked up 22,195 claims in 1974 in which other in-patient insurance coverage (e.g. Blue Cross-Blue Shield, Other Commercial Carriers, Medicare) existed. Savings due to this computed screening process totalled $4,402,967. In 1975, the same process reviewed 29,182 claims resulting in savings of $6,900,018. This "savings" data is not as firm as the Medical Review Decline data in that other types of insurance may have lapsed between the time that a Medicaid recipient reports such additional coverage when applying for Medicaid benefits and the time of his/her ultimate hospitalization. Nevertheless, declines for payment in 1974 and 1975 in excess of $11 million dollars is a noteworthy fiscal control.

Hospital providers which are not covered by Blue Cross are serviced by the Prudential Insurance Company (Pru). The Department of Human Services, Bureau of Health Statistics and Economics advised the S.C.I. that Pru had reported savings from Medical Review Declines of $217,717 in 1974 and $295,470 in 1975, as a result of their claims review of 30 hospital providers in those years. As noted above, Blue Cross realized savings of $4.8 million during the same period, as a result of Medical Review Declines.

The disparity in savings results primarily from the difference in the number of hospitals each intermediary services. Blue

Cross handles 89 while Prudential handles only 30. Nevertheless, Pru's past program savings have not matched, percentage wise, Blue Cross savings.

With respect to the general procedures of the intermediaries, the Commission discovered several beneficial practices in the operation of their hospital in-patient claims screening process:

-- The Pru and Blue Cross claims review procedure is heavily weighted toward the reliance on computer and clerical screening which is designed to detect "inter alia" questionable diagnoses - pre-operative hospitalization of over 48 hours - hospitalization for custodial care, etc.

-- At Pru and Blue Cross final denials of claims are made by professionally trained personnel, either doctors or registered nurses.

The Commission evaluated the performance of the fiscal intermediaries with reference to the extent of their use of the AID program guidelines in processing Medicaid claims.

Pru has recently adopted a limited screening process for Medicaid services which is more consistent with the AID manual, but it is applied only to those hospitals with higher than average "length of stay" norms. This change occurred in March of 1976, resulting in dollar savings in the first six months of 1976 in

excess of those achieved for all of last year. However, it is disturbing that Pru does not apply these more stringent screens to Medicaid claims from hospitals with low "length of stay" norms.

Our analysis of the performance of Pru in this regard led us to examine the average monthly number of Medicaid claims denied, number of days noncovered and savings. The aforesaid change in the screening process was made by Pru in March 1976 and the comparison in monthly averages is startling:

1976	Claims denied	Days Noncovered	Savings
January-March	25	287	$43,836
April-June	64	761	$127,671

The tightening of the screen used for further analysis of the claim from twice AID days to one (1) day over AID days resulted in nearly three times the monthly savings.

The S.C.I. believes that for Medicaid patients, other than SSI recipients, the length of stay provisions should be set by DMAHS at those AID levels applicable to Blue Cross subscribers. This procedure would give the Medicaid Program parity with screens applied to commercially insured subscribers. The taxpayers of the State of New Jersey deserve no less. This reform is necessary to reduce overutilization abuses and inflated costs in the Medicaid Program.

Blue Cross' screening process has also been altered to obtain more professional medical expertise in their utilization

review process. This change occurred in September 1975. Its screening process, while producing dramatic results in terms of program savings, regrettably still retains the allowance for double the AID days for Medicaid recipients, which practice allows unnecessary cost escalations in the Medicaid Program.

Blue Cross and Pru have serviced the Medicaid program as the State's fiscal intermediaries since the program's inception in 1970. To the extent "savings" have been realized during the period of our review (i.e. 1974-1975) of over $17 million, their performance is noteworthy and commendable. However, the Commission does not believe that the best interests of the State of New Jersey have been served by the application in certain cases of hospital utilization maximums which are double those applied to commercially insured subscribers. The Commission recommends that the standard for Medicaid hospital claims should be consistent with AID length of stay limits, with the possible exception of SSI recipients.

The Commission urges DMAHS Director Gerald Reilly to require (with the SSI exception noted above) the fiscal intermediaries to immediately lower all screening processes to the level with those currently in use by privately insured subscribers.*

*Between the time that the S.C.I. report was prepared and approved for publication, fiscal intermediaries agreed to (1) standardize their computer program to the extent that the twice AID screen has been eliminated; (2) provide for uniform diagnosis codes: (3) clarify review of psychiatric claims review, and (4) provide for closer liaison in the area of hospital claims review with the Department of Human Services.

D. FISCAL IMPACT OF UTILIZATION AND ELIGIBILITY CONTROLS ON PROVIDER HOSPITALS

Ineligible and non-compensable hospitals services ultimately cause serious financial problems for major Medicaid hospital providers.

A survey was conducted by the S.C.I. of hospitals reporting Medicaid receipts ranging from 10-31% of their gross revenue for the year 1974, in order to assess the impact of utilization and eligibility controls on their fiscal status. Those hospitals responding to our circularization letter included:

Hospitals	% Medicaid
1. Martland Hospital - Newark	31%
2. Beth Israel Hospital - Newark	24%
3. Jersey City Medical - Jersey City	20%
4. Atlantic City General - Atlantic City	12%
5. Cooper Hospital - Camden	11.5%
6. St. Mary's - Hoboken	10%
7. Hackensack General - Hackensack	2-1/2%
8. Mercer Medical Center - Trenton	10%
9. Monmouth Medical Center - Long Branch	12%

Several other institutions which provide a significant percentage of Medicaid patient care did not respond to the S.C.I. questionnaire because they did not maintain receivable data by reimbursement source nor did they "age"* their receivables. Hackensack General was included to test the fiscal experiences of

*"Age" - a determination of the length of time that uncollected receivables are outstanding. E.g., 30-60 or 90 days.

a facility with a nominal percentage of Medicaid revenue as compared to the major Medicaid providers.

The following schedule is fairly indicative of the "turn around"* time for 1974 Medicaid receivables as reported by responding hospitals:

Hospital	Current 30 days or less	More than 90 days
1. Martland	33%	37%
2. Beth Isreal	64%	27%
3. Jersey City Medical	37%	39%
4. Atlantic City General	47%	17%
5. Cooper Hospital	NA	17%
6. St. Mary's	56%	35%
7. Hackensack General	26%	57%
8. Mercer Medical Center	41%	43%
9. Monmouth Medical Center	36%	36%
Average excluding Hackensack General	47%	31%

Major certified public accounting firms, which serve the hospital industry, have generally agreed that the "Normal" collection cycle applicable to hospital receivables by source of revenue are:

Source	Days
Blue Cross	21 days
Self Pay	60 days
Medicaid	3-4 weeks
Medicare	3-1/2 weeks
Other Commercial Insurance	45 days
Workmen's Compensation	21 days or more

*"turn around" - the interval between the submission of a receivable and the payment thereof.

The obvious question posed by the results of this limited survey is, "What are the causes of the 90 delinquency problem?"

The Commission, not surprisingly, found that the major reasons for Medicaid receivable delinquency coincide with the reasons for claim denials by fiscal intermediaries, as follows:

1 - Unresolved eligibility problems, particularly as a result, as aforesaid, of the operation of the Supplemental Security Income program which became operative on January 1, 1974.

2 - Non-compliance by hospitals with the AID program with particular reference to diagnoses of multiple illnesses per patient despite liberal length of stay provisions.

3 - Hospitalization for diagnositc reasons which may be classified by the intermediaires as unneccessary and non-compensable hospital services.

4 - Hospitalization for ineligible services (e.g., drug addiction, diet therapy, alcoholism, etc.)

5 - Hospitalization of elderly patients beyond the normal "length of stay" because they are awaiting transfer to nursing homes.

6 - Other potentially dissallowable Medicaid claims in instances wherein reimbursement screening processes picked up instances of Medicaid recipients of hospital

services who carried other insurance coverage (e.g., Blue Cross, Medicare, etc.) and therefore were not eligible for Medicaid payment for their hospitalization until the question of dual coverage was resolved.

Several socio-economic problems have contributed to the fiscal plight of the large urban hospitals:

- Urban hospitals have lost and are continuing to lose their middle-class base of patients who are usually covered by commercial insurance carriers. Significant increases in the Medicaid and Medicare mix of patients in urban areas, in recent years, attest to this fact.

- Although the enactment and strict enforcement of New Jersey's Certificate of Need program has restricted increases in hospital beds in Newark and Jersey City which have a large base of Medicaid eligibles, there is an apparent excess of beds in these areas.

- The increase of 1.8 in 1950 to 3.1 in 1972 of the number of hospital employees required to care for the average patient, according to nationwide HEW studies*, necessitates proportionate increases in hospital revenue to pay for salaries and fringe benefits, operating costs, etc.

The denial of reimbursement by Blue Cross which serves most

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*NJHA claims the employee-patient ratio is presently 2.2 to 2.4 hospital employees per patient.

large northern facilities, in an amount equivalent to 25,130 patient days of Medicaid coverage in 1974, principally due to "Lack of Medical Necessity", and similar denials of 27,861 days in 1975 for the same reason, are distrubing in view of the dollar impact on the providers. The fact that this intermediary was sustained in 98% of the cases wherein claims were disallowed after appropriate hearings, in 1974 and 1975, raises questions regarding the merits of admission and utilization review policies of those hospitals which are located in large urban areas.

The Commission has found an additional cause of the cost escalations incurred by hospitals. This cause is described in the Stevens study appearing in the Duke University Law Review (Spring 1970, Vol. XXXV, "Medicaid: Anatomy of a Dilemma") which prophetically observed at page 422 --

> "If Medicare, (which was) designed to provide health care as an entitlement to the whole population over age 65, had been sufficiently comprehensive, Medicaid's substantial and growing commitment of services to the elderly would have been unnecessary. Similarly, if private health insurance had effectively covered the working population (including continuing coverage for survivors, and dependents, and in times of sickness and temporary unemployment) the concept of medical

indigency need not have been invented. As it was, Medicaid, with its uncontrollable budgets and rising costs, has been a reflection of broader deficiencies in the health sector." (underline added)

It is clear that ways and means must be found to insure that hospitals' day-to-day administrative and management practices conform to standards imposed by utilization and eligibility guidelines.

SECTION IV

PSRO'S AND MEDICAID

The Commission finds that the fiscal intermediaries are performing a function (in regard to medical review of hospital reimbursement claims) which substantially would be assumed by Professional Standards Review Organizations, if PSRO's were in operation. Therefore, it became relevant to evaluate the potential impact of the PSRO system on eligibility and decision making in the Medicaid program.

PSRO's were established under provision of the 1972 Amendments to the Social Security Act (Public Law 92-603) to monitor the delivery of health care to Medicaid, Medicare and Maternal and Child Care patients. As of the date of this report, five of the eight designated areas in New Jersey are conditionally funded. These areas include Area 1 covering Morris, Sussex and Warren; Area II Passaic; Area IV Essex; Area VII Central Jersey (Hunterdon, Mercer, Middlesex, Monmouth, Ocean and Somerset)* and VIII Southern Jersey (Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem). The balance of 3 PSRO's -- for Bergen, Hudson and Union -- are unfunded.

*According to PSRO officials, physicians in Area VII have voted against a PSRO affliation.

Several features of the law are worthy of note in the context of Medicaid in-patient hospitalization utilization control:

1. The basis of the plan is the requirement that no patient be admitted to a hospital under Medicare or Medicaid without prior approval from the PSRO (supervisory agency), unless it is an emergency.

2. In addition, the PSRO, as legislated, is responsible for determining whether services rendered to the patient were in fact medically indicated.

3. The PSRO program is not concerned with whether charges are reasonable; the law assumes that the financial aspects are adequately considered; the program is concerned with medical necessity of in-patient services.

4. To an extent, PSRO's rely on "good conduct" and computer normative analysis. Providers who have demonstrated that they treat patients within defined norms will be exempted from the need for prior approval. The internal review committees of these providers will then themselves act as certifying agents (some computer monitoring will continue): After several increasing higher 'courts' of review, the flow of public funds may be cut off. The doctors or provider could be fined for up to $5000.

The Commission believes that PSRO's might be able to serve the vital function of providing timely review of the quality of care rendered to Medicaid recipients at the time of the actual hospitalization of the patient. At present, in the absence of effective hospital based utilization review Committees, a medical review is conducted, after the patient's hospital confinement is concluded and only if the reimbursement claim fails to pass several computer checks. In our view, nothing can replace "on-site" utilization review by qualified medical personnel. PSRO would provide this kind of utilization review.

State officials in key decision making roles have expressed reservations regarding the efficacy of "peer review" in a PSRO structure and the requirement that PSRO's have ultimate discretion not only as to which claims to deny but also which to pay. It may be that these views are justified. PSRO's will be no better than the independence, integrity and initiative of the physicians who staff them. In a trial period, we suggest that PSRO's be used as a supplement to and check and balance upon existing utilization review bodies. These organizations, once tested and fully operational, should be carefully monitored to insure that they continue to function independently and agreesively - in short, - in the best interest of the public.

SUMMARY AND FOOTNOTES

(in thousands)[1]

Appendix I

Appendix	Hosp. No.	Hospital Name	Total Costs	Covered Inpatient	Emergency Clinic & Private Outpatient Non-eligible	Total Costs Questioned	Base
A	75	Monmouth Medical Center	$31,954	$26,120	$5,834	$1,589	$24,531
B	96	St. Michael's Medical Center	27,132	23,175	3,957	2,597	20,578
C	49	St. Francis Comm. Hlth. Ctr.	13,677	12,597	1,080	1,282	11,315
D	40	St. Mary's Hosp., Hoboken	16,886	15,236	1,650	1,868	13,368
E	14	Cooper Hospital	24,246	24,246		3,908	20,338
F	39	Perth Amboy General Hospital	20,289	20,289		1,413	18,876
G	2	Newark Beth Israel	34,932	29,486	5,446	2,313	27,173
H	85	Saddle Brook General Hospital	7,294	6,808	486	672	6,136
I	62	United Hospital Medical Ctr.	27,689	23,023	4,666	2,396	20,627
J	78	Hospital Center at Orange	21,150	18,169	2,981	3,785	14,384
K	19	St. Joseph's Hospital	30,854	27,464	3,390	4,594	22,870
L	83	East Orange General	13,882	11,844	2,038	788	11,056

Footnotes

[1]There may be differences due to rounding.
[2]Emergency, Clinic & Private Outpatient, Non-eligible
[3]Costs questioned by the Department of Health

State officials in key decision making roles have expressed reservations regarding the efficacy of the present PSRO structure and the requirement that PSROs have discretion not only as to which claims to deny but also which to pay. It may be that these views are misguided or will be overcome by better than the independence, integrity and objectivity of the physicians who staff them. In a trial period, we suggest that PSROs be used as a supplement to and check and balance upon existing utilization review bodies. Those PSROs once tested and fully operational, should be carefully monitored to insure that they continue to function independently and aggressively in the best interest of the program.

SUMMARY

Per Diem Analysis

Appendix II

Hosp. No.	Hospital Name	Requested per diem	PAR	Hotel	Nursing Services	General Patient Care	Ancillary Services
75	Monmouth Medical Center	$165.15	$153.98	$34.50	$39.95	$37.71	$41.82
96	St. Michael's Medical Center	178.15	158.33	39.57	41.49	35.26	42.01
49	St. Francis Comm. Hlth. Ctr.	160.42	144.14	40.11	42.06	30.15	31.82
40	St. Mary's Hospital, Hoboken	158.78	139.04	37.11	38.40	31.33	32.20
14	Cooper Hospital	151.36	127.31	28.44	35.03	29.99	33.85
39	Perth Amboy General Hospital	137.47	127.70	31.11	36.51	28.18	31.90
2	Newark Beth Israel	201.06	184.26	39.03	46.87	41.67	56.69
85	Saddle Brook General	124.51	111.18	20.94	32.67	27.12	30.45
62	United Hospital Medical Ctr.	180.16	161.85	34.87	40.38	41.49	45.11
78	Hospital Center at Orange	179.49	142.93	36.86	38.69	27.30	40.08
19	St. Joseph's Hospital	179.18	148.18	31.67	40.35	34.70	41.96
83	East Orange General	163.79	152.60	36.44	40.30	33.69	42.17

MONMOUTH MEDICAL CENTER - #75
(in thousands)[1]
Appendix A

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 4,614	$ 4,614	$	$ 191	$ 4,423
ICU intensive care	1,028	1,028		113	915
NBN newborn nursery	147	147		(20)	167
EMR emergency room	566	79	487	61	18
CLN clinics	509		509		
ANS anesthesiology	172	172		3	169
BBK blood bank	207	12	195	(1)	13
CSS central sterile supply	604	580	24	89	491
DEL delivery & labor	231	210	21	18	192
DIA dialysis	786	220	566	32	188
EDG electrodiagnosis	190	171	19	(1)	172
LAB laboratory	2,137	1,880	257	444	1,436
NMD nuclear medicine	237		237		
ORR operating & recovery	782	759	23	65	694
OPM other physical medicine	111	57	54	3	54
PHM pharmacy	908	890	18	137	753
PHT physical therapy	292	187	105	90	97
RAD radiological diagnosis	1,384	941	443	84	857
RSP respiratory therapy	301	298	3	96	202
THR therapeutic radiology	297		297		
OAS other ancillary serv.	297	184	113	(3)	187
PHY physicians coverage	600	477	123	30	447
RSD residents	1,464	1,180	284	130	1,050
A&G admin. & general	1,517	1,167	350	97	1,070
DTY dietary	1,692	1,593	99	65	1,528
FIS fiscal	1,466	1,127	339	(2)	1,129
HKP housekeeping	836	664	172	47	617
L&L laundry & linen	369	338	31	3	335
MRD medical records	230	222	8	18	204
MAL malpractice insurance	434	334	100		334
NAD nursing admin.	335	333	2	65	268
PCC patient care coord.	225	207	18	13	194
PLT plant	2,198	1,754	444	17	1,737
UTC utilities cost	875	698	177		698
OGS other general services	316	243	73	(11)	254
EDR education & research	470	447	23	52	395
LFB legal fringe benefits	1,392	1,136	256		1,136
PFB policy fringe benefits	598	488	110		488
PEN pensions	795	649	146		649
INT interest	342	273	69		273
MOH misc. overhead recov.		(24)	24	(24)	
Adjustments					
Ancillary cluster adj.				(425)	425
Minimum base period-Phy.				113	(113)
Emergency room adj.		385	(385)		385
TOTAL	$31,954	$26,120	$5,834	$1,589	$24,531

MONMOUTH MEDICAL CENTER - #75

Appendix A

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 27.39	$	$25.26	$ 2.13	$
ICU intensive care	5.67		4.96	.71	
NBN newborn nursery	1.03		1.03		
EMR emergency room	.11			.11	
ANS anesthesiology	1.05				1.05
BBK blood bank	.08				.08
CSS central sterile supply	3.04			3.04	
DEL delivery & labor	1.19				1.19
DIA dialysis	1.17				1.17
EDG electrodiagnosis	1.07				1.07
LAB laboratory	8.89				8.89
ORR operating & recovery	4.30				4.30
OPM other physical medicine	.33				.33
PHM pharmacy	4.66				4.66
PHT physical therapy	.60				.60
RAD radiological diagnosis	5.31				5.31
RSP respiratory therapy	1.25				1.25
OAS other ancillary services	1.16				1.16
PHY physicians coverage	2.77			2.77	
RSD residents	6.50			6.50	
A&G admin. & general	6.62			6.62	
DTY dietary	9.46	9.46			
FIS fiscal	6.99			6.99	
HKP housekeeping	3.82	3.82			
L&L laundry & linen	2.07	2.07			
MRD medical records	1.26			1.26	
MAL malpractice insurance	2.07			2.07	
NAD nursing admin.	1.66		1.66		
PCC patient care coord.	1.20		1.20		
PLT plant	10.76	10.76			
UTC utilities cost	4.32	4.32			
OGS other general services	1.57			1.57	
EDR education & research	2.45			2.45	
LFB legal fringe benefits	7.03	1.81	2.60	.27	2.35
PFB policy fringe benefits	3.02	.78	1.12	.11	1.01
PEN pensions	4.02	1.04	1.49	.15	1.34
INT interest	1.69	.44	.63	.06	.56
Adjustments					
Ancillary cluster adj.	2.63				2.63
Minimum base period-Phy.	(.70)			(.70)	
Emergency room adj.	2.38				2.38
Sub-total	$151.89	$34.50	$39.95	$36.11	$41.33
Per diem adj. (Net)	2.09	.		1.60	.49
TOTAL	$153.98	$34.50	$39.95	$37.71	$41.82

SAINT MICHAEL'S MEDICAL CENTER - #96
(in thousands)[1]
Appendix B

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 3,911	$ 3,911	$	$ 134	$ 3,777
ICU intensive care	498	498		12	486
NBN newborn nursery	359	359		152	207
EMR emergency room	463	93	370	58	35
CLN clinics	1,252		1,252		
ANS anesthesiology	383	383		(2)	385
BBK blood bank	203	97	106		97
CSS central sterile supply	711	704	7	214	490
DEL delivery & labor	250	250		201	49
DIA dialysis	114	114		24	90
EDG electrodiagnosis	298	254	44	105	149
LAB laboratory	1,409	1,250	159	120	1,130
NMD nuclear medicine	362	252	110	45	207
ORR operating & recovery	1,122	1,058	64	263	795
PHM pharmacy	778	766	12	167	599
PHT physical therapy	96	86	10	19	67
RAD radiological diagnosis	1,122	800	322	187	613
RSP respiratory therapy	195	195		13	182
THR therapeutic radiology	6	1	5		1
OAS other ancillary services	352	348	4	34	314
PHY physicians coverage	806	564	242	90	474
RSD residents	1,180	826	354	68	758
A&G admin. & general	938	770	168	77	693
DTY dietary	1,604	1,604		213	1,391
FIS fiscal	1,050	862	188	156	706
HKP housekeeping	810	761	49	36	725
L&L laundry & linen	692	656	36	245	411
MAL malpractice insurance	350	287	63	196	91
MRD medical records	407	346	61	126	220
NAD nursing admin.	302	257	45	9	248
PCC patient care coord.	118	118		3	115
PLT plant	1,543	1,506	37	160	1,346
UTC utilities cost	682	666	16	17	649
OGS other general services	354	291	63	42	249
EDR education & research	60	57	3	20	37
LFB legal fringe benefits	1,017	851	166		851
PFB policy fringe benefits	404	338	66		338
PEN pensions	575	481	94		481
INT interest	356	296	60		296
MOH misc. overhead recov.		(91)	91	(91)	
Adjustments					
Emergency room		310	(310)		310
Ancillary cluster adj.				(331)	331
General cluster adj.				(185)	185
TOTAL	$27,132	$23,175	$3,957	$2,597	$20,578

SAINT MICHAEL'S MEDICAL CENTER - #96

Appendix B

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 28.83	$	$27.97	$ .86	$
ICU intensive care	3.71		3.67	.04	
NBN newborn nursery	1.58		1.58		
EMR emergency room	.27			.27	
ANS anesthesiology	2.94				2.94
BBK blood bank	.74				.74
CSS central sterile supply	3.74			3.74	
DEL delivery & labor	.37				.37
DIA dialysis	.69				.69
EDG electrodiagnosis	1.14				1.14
LAB laboratory	8.63				8.63
NMD nuclear medicine	1.58				1.58
ORR operating & recovery	6.07				6.07
PHM pharmacy	4.57				4.57
PHT physical therapy	.51				.51
RAD radiological diagnosis	4.68				4.68
RSP respiratory therapy	1.39				1.39
THR therapeutic radiology	.01				.01
OAS other ancillary services	2.40				2.40
PHY physicians coverage	3.62			3.62	
RSD residents	5.78			5.78	
A&G admin. & general	5.29			5.29	
DTY dietary	10.62	10.62			
FIS fiscal	5.39			5.39	
HKP housekeeping	5.53	5.53			
L&L laundry & linen	3.14	3.14			
MAL malpractice insurance	.69			.69	
MRD medical records	1.68			1.68	
NAD nursing admin.	1.89		1.89		
PCC patient care coord.	.88		.88		
PLT plant	10.28	10.28			
UTC utilities cost	4.95	4.95			
OGS other general services	1.90			1.90	
EDR education & research	.28			.28	
LFB legal fringe benefits	6.50	1.90	2.38	1.13	1.09
PFB policy fringe benefits	2.58	.75	.95	.45	.43
PEN pensions	3.67	1.07	1.34	.64	.62
INT interest	2.26	.66	.83	.39	.38
Adjustments					
Emergency room	2.37			2.37	
Ancillary cluster adj.	2.53				2.53
General cluster adj.	1.41	.67		.74	
Sub-total	$157.09	$39.57	$41.49	$35.26	$40.77
Per diem adj. (Net)					
Medicare carve-out	1.24				1.24
TOTAL	$158.33	$39.57	$41.49	$35.26	$42.01

SAINT FRANCIS COMMUNITY HEALTH CENTER - #49
(in thousands)[1]
Appendix C

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 2,482	$ 2,482	$	$ 285	$ 2,197
ICU intensive care	377	377		25	352
EMR emergency room	398	18	380		18
CLN clinics	34		34		
BBK blood bank	15	15		(1)	16
CSS central sterile supply	365	360	5	20	340
EDG electrodiagnosis	82	70	12	7	63
LAB laboratory	796	727	69	196	531
NMD nuclear medicine	66		66		
ORR operating & recovery	517	502	15	6	496
PHM pharmacy	325	316	9	31	285
PHT physical therapy	49	32	17	7	25
RAD radiological diagnosis	578	399	179	105	294
RSP respiratory therapy	153	153		49	104
PHY physicians coverage	175	175			175
A&G admin. & general	805	700	105	112	588
DTY dietary	845	845		46	799
FIS fiscal	590	513	77	155	358
HKP housekeeping	439	407	32	17	390
L&L laundry & linen	254	245	9	21	224
MAL malpractice insurance	80	70	10	4	66
MRD medical records	194	190	4	48	142
NAD nursing admin.	171	171		6	165
PCC patient care coord.	113	112	1	18	93
PLT plant	1,231	1,140	91	32	1,108
UTC utilities cost	287	266	21		266
OGS other general services	213	185	28	26	159
EDR education & research	359	352	7	75	277
LFB legal fringe benefits	505	457	48		457
PFB policy fringe benefits	484	438	46		438
PEN pensions	153	138	15		138
INT interest	542	472	70		472
MOH misc. overhead recov.		(31)	31	(31)	
Adjustments					
Emergency room		301	(301)	(11)	312
Patient care cluster				(8)	8
Ancillary cluster				(260)	260
Minimum base period (global)				301	(301)
TOTAL	$13,677	$12,597	$1,080	$1,282	$11,315

SAINT FRANCIS COMMUNITY HEALTH CENTER - #49

Appendix C

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 27.92	$	$27.08	$ .84	$
ICU intensive care	4.47		4.25	.22	
EMR emergency room	.23				.23
BBK blood bank	.20				.20
CSS central sterile supply	4.32			4.32	
EDG electrodiagnosis	.80				.80
LAB laboratory	6.75				6.75
ORR operating & recovery	6.30				6.30
PHM pharmacy	3.62				3.62
PHT physical therapy	.31				.31
RAD radiological diagnosis	3.74				3.74
RSP respiratory therapy	1.32				1.32
PHY physicians coverage	2.22			2.22	
A&G admin. & general	7.47			7.47	
DTY dietary	10.15	10.15			
FIS fiscal	4.56			4.56	
HKP housekeeping	4.95	4.95			
L&L laundry & linen	2.85	2.85			
MAL malpractice insurance	.84			.84	
MRD medical records	1.80			1.80	
NAD nursing admin.	2.10		2.10		
PCC patient care coord.	1.19		1.19		
PLT plant	14.07	14.07			
UTC utilities cost	3.38	3.38			
OGS other general services	2.02			2.02	
EDR education & research	3.52			3.52	
LFB legal fringe benefits	5.81	1.43	2.23	.90	1.25
PFB policy fringe benefits	5.57	1.37	2.14	.86	1.20
PEN pensions	1.75	.43	.67	.27	.38
INT interest	6.00	1.48	2.30	.93	1.29
Adjustments					
Emergency room	3.97				3.97
Patient care cluster	.10		.10		
Ancillary cluster	3.30				3.30
Minimum base period (global)	(3.82)			(.98)	(2.84)
Sub-total	$143.78	$40.11	$42.06	$29.79	$31.82
Per diem adj. (Net)					
Medicare carve-out	.36			.36	
TOTAL	$144.14	$40.11	$42.06	$30.15	$31.82

SAINT MARY'S HOSPITAL, HOBOKEN - #40
(in thousands)[1]
Appendix D

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 2,955	$ 2,955	$	$ 311	$ 2,644
ICU intensive care	250	250		27	223
NBN newborn nursery	156	156		13	143
EMR emergency room	433	48	385	10	38
CLN clinics	295		295		
HHS home health services	77	2	75		2
ANS anesthesiology	1	1			1
BBK blood bank	91		91		
CSS central sterile supply	447	438	9	64	374
DEL delivery & labor	211	211		90	121
EDG electrodiagnosis	117	109	8	14	95
LAB laboratory	926	834	92	252	582
NMD nuclear medicine	39	8	31		8
ORR operating & recovery	624	580	44	61	519
PHM pharmacy	415	407	8	60	347
PHT physical therapy	104	91	13	49	42
RAD radiological diagnosis	587	405	182	36	369
RSP respiratory therapy	337	324	13	39	285
OAS other ancillary services	24	24			24
PHY physicians coverage	406	390	16	96	294
RSD residents	196	147	49	20	127
A&G admin. & general	668	568	100	110	458
DTY dietary	1,240	1,234	6	164	1,070
FIS fiscal	590	531	59	39	492
HKP housekeeping	462	430	32	38	392
L&L laundry & linen	310	288	22	12	276
MAL malpractice insurance	200	170	30		170
MRD medical records	159	151	8	15	136
NAD nursing admin.	256	228	28	18	210
PCC patient care coord.	63	50	13	5	45
PLT plant	1,234	1,148	86	(5)	1,153
UTC utilities cost	376	350	26		350
OGS other general services	309	263	46	104	159
EDR education & research	407	391	16	88	303
LFB legal fringe benefits	630	510	120		510
PFB policy fringe benefits	491	398	93		398
PEN pensions	500	405	95		405
INT interest	300	279	21		279
MOH misc. overhead recov.		(20)	20	(20)	
Adjustments					
Minimum base period				158	(158)
Emergency room adj.		482	(482)		482
TOTAL	$16,886	$15,236	$1,650	$1,868	$13,368

SAINT MARY'S HOSPITAL, HOBOKEN - #40

Appendix D

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 26.76	$	$26.09	$ .67	$
ICU intensive care	2.26		2.06	.20	
NBN newborn nursery	1.45		1.45		
EMR emergency room	.38			.38	
HHS home health services	.02			.02	
ANS anesthesiology	.01				.01
CSS central sterile supply	3.79			3.79	
DEL delivery & labor	1.22				1.22
EDG electrodiagnosis	.96				.96
LAB laboratory	5.89				5.89
NMD nuclear medicine	.08				.08
ORR operating & recovery	5.25				5.25
PHM pharmacy	3.51				3.51
PHT physical therapy	.42				.42
RAD radiological diagnosis	3.73				3.73
RSP respiratory therapy	2.88				2.88
OAS other ancillary services	.24				.24
PHY physicians coverage	2.98			2.98	
RSD residents	1.29			1.29	
A&G admin. & general	4.64			4.64	
DTY dietary	10.83	10.83			
FIS fiscal	4.98			4.98	
HKP housekeeping	3.97	3.97			
L&L laundry & linen	2.79	2.79			
MAL malpractice insurance	1.72			1.72	
MRD medical records	1.38			1.38	
NAD nursing admin.	2.13		2.13		
PCC patient care coord.	.46		.46		
PLT plant	11.67	11.67			
UTC utilities cost	3.54	3.54			
OGS other general services	1.61			1.61	
EDR education & research	3.07			3.07	
LFB legal fringe benefits	5.16	1.38	1.99	.58	1.21
PFB policy fringe benefits	4.03	1.08	1.55	.45	.95
PEN pensions	4.10	1.10	1.58	.46	.96
INT interest	2.82	.75	1.09	.32	.66
Adjustments					
Minimum base period	(1.60)			(.95)	(.65)
Emergency room adj.	4.88				4.88
Sub-total	$135.30	$37.11	$38.40	$27.59	$32.20
Per diem adj. (Net)					
Rider J	.18			.18	
Collection costs	.36			.36	
Medicare carve-out	3.20			3.20	
TOTAL	$139.04	$37.11	$38.40	$31.33	$32.20

COOPER HOSPITAL - #14
(in thousands)[1]
Appendix E

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 4,053	$ 4,053	$	$ 507	$ 3,546
ICU intensive care	1,390	1,390		454	936
NBN newborn nursery	300	300		186	114
SAC subacute care	111	111		5	106
EMR emergency room	579	78	501	(35)	113
CLN clinics	273		273		
ANS anesthesiology	536	482	54	182	300
BBK blood bank	441	12	429	1	11
CSS central sterile supply	1,525	1,403	122	419	984
DEL delivery & labor	301	301		120	181
EDG electrodiagnosis	402	350	52	189	161
LAB laboratory	1,588	1,413	175	288	1,125
NMD nuclear medicine	367		367		
ORR operating & recovery	816	751	65	134	617
OPM other physical medicine	136	27	109	10	17
PHM pharmacy	1,168	1,156	12	439	717
PHT physical therapy	141	109	32	46	63
RAD radiological diagnosis	1,338	829	509	93	736
RSP respiratory therapy	292	289	3	86	203
THR therapeutic radiology	540		540		
OAS other ancillary services	90	90		27	63
PHY physicians coverage	31	28	3		28
RSD residents	531	488	43	49	439
A&G admin. & general	1,163	930	233	128	802
DTY dietary	1,792	1,792		113	1,679
FIS fiscal	1,251	1,125	126	65	1,060
HKP housekeeping	744	620	124	41	579
L&L laundry & linen	376	354	22	27	327
MAL malpractice insurance	363	290	73		290
MRD medical records	281	259	22	64	195
NAD nursing admin.	271	252	19	24	228
PCC patient care coord.	146	146		35	111
PLT plant	1,365	1,173	192	20	1,153
UTC utilities cost	600	515	85		515
OGS other general services	462	370	92	56	314
EDR education & research	555	508	47	135	373
LFB legal fringe benefits	1,205	1,004	201		1,004
PFB policy fringe benefits	683	569	114		569
PEN pensions	545	454	91		454
INT interest	262	225	37		225
Adjustments					
Emergency room	(4,767)		(4,767)		
TOTAL	$24,246	$24,246	$ -	$3,908	$20,338

COOPER HOSPITAL - #14

Appendix E

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 21.13	$	$21.02	$ .11	$
ICU intensive care	5.58		5.55	.03	
NBN newborn nursery	.68		.68		
SAC subacute care	.63		.63		
EMR emergency room	.67			.67	
ANS anesthesiology	1.79				1.79
BBK blood bank	.06				.06
CSS central sterile supply	5.86			5.86	
DEL delivery & labor	1.08				1.08
EDG electrodiagnosis	.96				.96
LAB laboratory	6.70				6.70
ORR operating & recovery	3.68				3.68
OPM other physical medicine	.10				.10
PHM pharmacy	4.27				4.27
PHT physical therapy	.38				.38
RAD radiological diagnosis	4.39				4.39
RSP respiratory therapy	1.21				1.21
OAS other ancillary services	.37				.37
PHY physicians coverage	.17			.17	
RSD residents	2.62			2.62	
A&G admin. & general	4.78			4.78	
DTY dietary	10.01	10.01			
FIS fiscal	6.32			6.32	
HKP housekeeping	3.45	3.45			
L&L laundry & linen	1.95	1.95			
MAL malpractice insurance	1.73			1.73	
MRD medical records	1.16			1.16	
NAD nursing admin.	1.36		1.36		
PCC patient care coord.	.66		.66		
PLT plant	6.87	6.87			
UTC utilities cost	3.07	3.07			
OGS other general services	1.87			1.87	
EDR education & research	2.22			2.22	
LFB legal fringe benefits	5.98	1.38	2.28	.71	1.61
PFB policy fringe benefits	3.39	.78	1.30	.40	.91
PEN pensions	2.71	.62	1.04	.32	.73
INT interest	1.34	.31	.51	.16	.36
Adjustments					
Per diem adj. (Net)					
Outside collection costs	.36			.36	
Rider J	.50			.50	
Medicare carve-out	5.25				5.25
TOTAL	$127.31	$28.44	$35.03	$29.99	$33.85

PERTH AMBOY GENERAL HOSPITAL - #39
(in thousands)[1]
Appendix F

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 3,844	$ 3,844	$	$ 192	$ 3,652
ICU intensive care	670	670		29	641
NBN newborn nursery	336	336		117	219
SAC subacute care	278	278		212	66
EMR emergency room	592	95	497	3	92
CLN clinics	324		324		
ANS anesthesiology	109	109		1	108
BBK blood bank	119		119		
CSS central sterile supply	524	493	31		493
DEL delivery & labor	164	164		3	161
DIA dialysis	536	80	456	12	68
EDG electrodiagnosis	233	212	21	(10)	222
LAB laboratory	1,725	1,535	190	171	1,363
NMD nuclear medicine	105		105		
ORR operating & recovery	801	769	32	17	752
PHM pharmacy	492	462	30	(3)	465
PHT physical therapy	35	33	2	1	32
RAD radiological diagnosis	701	505	196	(9)	514
RSP respiratory therapy	173	173		16	157
PHY physicians coverage	44	7	37	1	6
RSD residents	551	541	10	33	508
A&G admin. & general	1,171	972	199	132	840
DTY dietary	1,510	1,510		59	1,451
FIS fiscal	1,160	1,067	93	43	1,024
HKP housekeeping	884	807	77	46	761
L&L laundry & linen	357	334	23	10	324
MAL malpractice insurance	159	132	27		132
MRD medical records	173	167	6	16	151
NAD nursing admin.	296	296		12	284
PCC patient care coord.	251	207	44	38	169
PLT plant	1,418	1,251	167	46	1,205
UTC utilities cost	539	476	63		476
OGS other general services	320	266	54	10	256
EDR education & research	615	576	39	215	361
LFB legal fringe benefits	1,091	887	204		887
PFB policy fringe benefits	755	614	141		614
PEN pensions	512	416	96		416
INT interest	30	25	5		25
MOH misc. overhead recov.		(20)	20		(20)
Adjustments					
Emergency room	(3,308)		(3,308)		
TOTAL	$20,289	$20,289	$ -	$1,413	$18,876

PERTH AMBOY GENERAL HOSPITAL - #39

Appendix F

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 23.93	$	$23.26	$ .67	$
ICU intensive care	4.20		3.93	.27	
NBN newborn nursery	1.43		1.43		
SAC subacute care	.43		.43		
EMR emergency room	.60			.60	
ANS anesthesiology	.71				.71
CSS central sterile supply	3.23			3.23	
DEL delivery & labor	1.05				1.05
DIA dialysis	.45				.45
EDG electrodiagnosis	1.45				1.45
LAB laboratory	8.93				8.93
ORR operating & recovery	4.93				4.93
PHM pharmacy	3.05				3.05
PHT physical therapy	.21				.21
RAD radiological diagnosis	3.37				3.37
RSP respiratory therapy	1.03				1.03
PHY physicians coverage	.04			.04	
RSD residents	3.33			3.33	
A&G admin. & general	5.50			5.50	
DTY dietary	9.51	9.51			
FIS fiscal	6.71			6.71	
HKP housekeeping	4.99	4.99			
L&L laundry & linen	2.12	2.12			
MAL malpractice insurance	.86			.86	
MRD medical records	.99			.99	
NAD nursing admin.	1.86		1.86		
PCC patient care coord.	1.11		1.11		
PLT plant	7.89	7.89			
UTC utilities cost	3.12	3.12			
OGS other general services	1.68			1.68	
EDR education & research	2.37			2.37	
LFB legal fringe benefits	5.81	1.59	2.05	.85	1.32
PFB policy fringe benefits	4.02	1.10	1.42	.59	.91
PEN pensions	2.73	.75	.96	.40	.62
INT interest	.16	.04	.06	.02	.04
MOH misc. overhead recov.	(.13)			(.13)	
Adjustments					
Per diem adj. (Net)					
Rider J.	.05			.05	
Outside collection Costs	.15			.15	
Medicare carve-out	3.83				3.83
TOTAL	$127.70	$31.11	$36.51	$28.18	$31.90

NEWARK BETH ISRAEL MEDICAL CENTER - #2
(in thousands)[1]
Appendix G

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 4,087	$ 4,087	$	$ 310	$ 3,777
ICU intensive care	2,153	2,153		103	2,049
NBN newborn nursery	191	191			191
EMR emergency room	658	46	612	35	11
CLN clinics	825	50	775		50
ANS anesthesiology	109	109		4	105
BBK blood bank	385	161	224	4	157
CSS central sterile supply	242	223	19	(4)	227
DEL delivery & labor	275	275		(22)	297
DIA dialysis	1,178	224	954		224
EDG electrodiagnosis	187	175	12	13	162
LAB laboratory	1,697	1,527	170	163	1,364
NMD nuclear medicine	202	42	160	19	23
ORR operating & recovery	1,366	1,366		85	1,281
PHM pharmacy	1,159	1,089	70	123	966
PHT physical therapy	152	88	64	35	53
RAD radiological diagnosis	1,039	738	301	55	683
RSP respiratory therapy	309	306	3	63	243
THR therapeutic radiology	104	21	83	10	11
OAS other ancillary services	1,738	940	798	117	823
PHY physicians coverage	721	721		97	624
RSD residents	1,630	1,434	196	308	1,126
A&G admin. & general	1,577	1,277	300	86	1,191
DTY dietary	1,463	1,444	19	58	1,386
FIS fiscal	1,192	1,132	60	117	1,015
HKP housekeeping	1,139	991	148		991
L&L laundry & linen	537	505	32	47	458
MAL malpractice insurance	188	153	35		153
MRD medical records	362	348	14	63	285
NAD nursing admin.	308	308		2	306
PCC patient care coord.	189	189		26	163
PLT plant	1,776	1,527	249	134	1,393
UTC utilities cost	874	752	122		752
OGS other general services	696	564	132	307	257
EDR education & research	202	202		63	139
LFB legal fringe benefits	1,407	1,182	225		1,182
PFB policy fringe benefits	996	837	159		837
PEN pensions	634	533	101		533
INT interest	985	847	138		847
MOH misc. overhead recov.		(109)	109	(109)	
Adjustments					
Emergency room		838	(838)		838
TOTAL	$34,932	$29,486	$5,446	$2,313	$27,173

NEWARK BETH ISRAEL MEDICAL CENTER - #2

Appendix G

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 25.35	$	$23.25	$ 2.10	$
ICU intensive care	13.76		11.71	2.05	
NBN newborn nursery	1.28		1.28		
EMR emergency room	.07			.07	
CLN clinics	.34				.34
ANS anesthesiology	.70				.70
BBK blood bank	1.05				1.05
CSS central sterile supply	1.52			1.52	
DEL delivery & labor	1.99				1.99
DIA dialysis	1.50				1.50
EDG electrodiagnosis	1.09				1.09
LAB laboratory	9.16				9.16
NMD nuclear medicine	.16				.16
ORR operating & recovery	8.60				8.60
PHM pharmacy	6.48				6.48
PHT physical therapy	.36				.36
RAD radiological diagnosis	4.58				4.58
RSP respiratory therapy	1.63				1.63
THR therapeutic radiology	.07				.07
OAS other ancillary services	5.52				5.52
PHY physicians coverage	4.19			4.19	
RSD residents	7.56			7.56	
A&G admin. & general	7.99			7.99	
DTY dietary	9.30	9.30			
FIS fiscal	6.81			6.81	
HKP housekeeping	6.65	6.65			
L&L laundry & linen	3.07	3.07			
MAL malpractice insurance	1.03			1.03	
MRD medical records	1.91			1.91	
NAD nursing admin.	2.06		2.06		
PCC patient care coord.	1.09		1.09		
PLT plant	9.35	9.35			
UTC utilities cost	5.05	5.05			
OGS other general services	1.72			1.72	
EDR education & research	.93			.93	
LFB legal fringe benefits	7.93	1.95	2.60	.93	2.45
PFB policy fringe benefits	5.62	1.38	1.84	.66	1.74
PEN pensions	3.58	.88	1.17	.42	1.11
INT interest	5.69	1.40	1.87	.66	1.76
Adjustments					
Emergency room	5.63				5.63
Sub-total	$182.37	$39.03	$46.87	$40.55	$55.92
Per diem adj.(Net)					
Rider J	.15			.15	
Rad. fee for serv.	1.67				1.67
Outside collection costs	.97			.97	
Medicare carve-out	(.90)				(.90)
TOTAL	$184.26	$39.03	$46.87	$41.67	$56.69

SADDLE BROOK GENERAL HOSPITAL - #85
(in thousands)[1]
Appendix H

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 1,401	$ 1,401	$	$ 179	$ 1,222
ICU intensive care	175	175		5	170
NBN newborn nursery	25	25			25
EMR emergency room	39		39		
ANS anesthesiology	26	23	3		23
BBK blood bank	22	4	18		4
CSS central sterile supply	338	328	10	28	300
DEL delivery & labor	14	14			14
EDG electrodiagnosis	81	77	4		77
LAB laboratory	515	438	77	5	433
ORR operating & recovery	382	363	19	17	346
PHM pharmacy	241	236	5	6	230
PHT physical therapy	12	12			12
RAD radiological diagnosis	354	273	81	45	228
RSP respiratory therapy	66	66		1	65
PHY physicians coverage	264	246	18	16	230
RSD residents	38	35	3		35
A&G admin. & general	408	382	26	54	328
DTY dietary	419	419		20	399
FIS fiscal	361	336	25	37	299
HKP housekeeping	215	187	28	17	170
L&L laundry & linen	149	144	5	11	133
MAL malpractice insurance	153	143	10	51	92
MRD medical records	163	160	3	25	135
NAD nursing admin.	71	70	1	3	67
PCC patient care coord.	109	109		6	103
PLT plant	345	299	46	11	288
UTC utilities cost	111	96	15		96
OGS other general services	36	34	2		34
EDR education & research	86	86		5	81
LFB legal fringe benefits	278	263	15		263
PFB policy fringe benefits	66	62	4		62
PEN pensions	150	142	8		142
INT interest	181	157	24		157
MOH misc. overhead recov.		(15)	15		(15)
Adjustments					
Emergency room		18	(18)		18
Minimum base period				130	(130)
TOTAL	$ 7,294	$ 6,808	$ 486	$ 672	$ 6,136

SADDLE BROOK GENERAL HOSPITAL - #85

Appendix H

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 21.53	$	$21.14	$ .39	$
ICU intensive care	3.00		2.90	.10	
NBN newborn nursery	.44		.44		
ANS anesthesiology	.41				.41
BBK blood bank	.07				.07
CSS central sterile supply	5.29			5.29	
DEL delivery & labor	.24				.24
EDG electrodiagnosis	1.36				1.36
LAB laboratory	7.63				7.63
ORR operating & recovery	6.09				6.09
PHM pharmacy	4.05				4.05
PHT physical therapy	.21				.21
RAD radiological diagnosis	4.01				4.01
RSP respiratory therapy	1.15				1.15
PHY physicians coverage	4.05			4.05	
RSD residents	.62			.62	
A&G admin. & general	5.78			5.78	
DTY dietary	7.03	7.03			
FIS fiscal	5.27			5.27	
HKP housekeeping	3.00	3.00			
L&L laundry & linen	2.34	2.34			
MAL malpractice insurance	1.62			1.62	
MRD medical records	2.38			2.38	
NAD nursing admin.	1.18		1.18		
PCC patient care coord.	1.81		1.81		
PLT plant	5.08	5.08			
UTC utilities cost	1.69	1.69			
OGS other general services	.60			.60	
EDR education & research	1.43			1.43	
LFB legal fringe benefits	4.63	.76	2.19	.62	1.06
PFB policy fringe benefits	1.09	.18	.52	.14	.25
PEN pensions	2.50	.41	1.18	.33	.58
INT interest	2.77	.45	1.31	.37	.64
MOH misc. overhead recov.	(.26)			(.26)	
Adjustments					
Emergency room	.32				.32
Minimum base period	(2.29)			(2.29)	
Sub-total	$108.12	$20.94	$32.67	$26.44	$28.07
Per diem adj. (Net)					
Rider J	.18			.18	
Radiology fee for serv.	1.13				1.13
Outside collection costs	.50			.50	
Medicare carve-out	1.25				1.25
TOTAL	$111.18	$20.94	$32.67	$27.12	$30.45

UNITED HOSPITALS MEDICAL CENTER - #62
(in thousands)[1]
Appendix I

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 4,186	$ 4,186	$	$ 664	$ 3,522
ICU intensive care	1,039	1,039		169	870
NBN newborn nursery	31	31		2	29
EMR emergency room	869		869		
CLN clinics	593		593		
ANS anesthesiology	265	265		42	223
BBK blood bank	166	166			166
CSS central sterile supply	1,336	1,307	29	472	835
DEL delivery & labor	111	111		23	88
EDG electrodiagnosis	137	121	16	8	113
LAB laboratory	1,755	1,525	230	257	1,268
NMD nuclear medicine	177		177		
ORR operating & recov.	853	844	9	85	759
OPM other physical medicine	137	13	124		13
PHM pharmacy	531	513	18	(41)	554
PHT physical therapy	101	81	20	44	37
RAD radiological diagnosis	925	580	345	8	572
RSP respiratory therapy	337	337		119	218
THR therapeutic radiology	341		341		
OAS other ancillary services	160	132	28	25	107
PHY physicians coverage	520	397	123	78	319
RSD residents	1,069	816	253	27	789
A&G admin. & general	1,352	1,099	253	72	1,027
DTY dietary	1,255	1,255		(33)	1,288
FIS fiscal	1,378	1,182	196	424	758
HKP housekeeping	792	675	117	96	579
L&L laundry & linen	573	551	22	138	413
MAL malpractice insurance	500	407	93		407
MRD medical records	335	316	19	102	214
NAD nursing admin.	149	127	22	24	103
PCC patient care coord.	268	182	86	10	172
PLT plant	1,582	1,368	214	70	1,298
UTC utilities cost	606	524	82		524
OGS other general services	406	330	76	63	267
EDR education & research	213	199	14	10	189
LFB legal fringe benefits	1,106	926	180		926
PFB policy fringe benefits	304	254	50		254
PEN pensions	774	648	126		648
INT interest	457	395	62		395
MOH misc. overhead recov.		(48)	48	(48)	
Adjustments					
Emergency room		169	(169)		169
Ancillary cluster				(533)	533
General services cluster				(444)	444
Minimum base period				409	(409)
Malpractice insurance				54	(54)
TOTAL	$27,689	$23,023	$4,666	$2,396	$20,627

UNITED HOSPITALS MEDICAL CENTER - #62

Appendix I

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 26.09	$	$25.75	$ .34	$
ICU intensive care	6.44		6.20	.24	
NBN newborn nursery	.21		.21		
ANS anesthesiology	1.65				1.65
BBK blood bank	1.23				1.23
CSS central sterile supply	6.19			6.19	
DEL delivery & labor	.65				.65
EDG electrodiagnosis	.84				.84
LAB laboratory	9.39				9.39
ORR operating & recov.	5.62				5.62
OPM other physical medicine	.10				.10
PHM pharmacy	4.10				4.10
PHT physical therapy	.27				.27
RAD radiological diagnosis	4.24				4.24
RSP respiratory therapy	1.61				1.61
OAS other ancillary services	.79				.79
PHY physicians coverage	2.36			2.36	
RSD residents	5.84			5.84	
A&G admin. & general	7.61			7.61	
DTY dietary	9.54	9.54			
FIS fiscal	5.61			5.61	
HKP housekeeping	4.29	4.29			
L&L laundry & linen	3.06	3.06			
MAL malpractice insurance	3.01			3.01	
MRD medical records	1.59			1.59	
NAD nursing admin.	.76		.76		
PCC patient care coord.	1.27		1.27		
PLT plant	9.61	9.61			
UTC utilities cost	3.88	3.88			
OGS other general services	1.98			1.98	
EDR education & research	1.40			1.40	
LFB legal fringe benefits	6.86	1.56	2.46	.80	2.04
PFB policy fringe benefits	1.88	.43	.67	.22	.56
PEN pensions	4.80	1.09	1.72	.56	1.43
INT interest	2.93	.67	1.05	.34	.87
Adjustments					
Emergency room	1.25				1.25
Ancillary cluster	3.95				3.95
General services cluster	3.29	.89		2.40	
Minimum base period	(3.03)	(.34)		(.94)	(1.75)
Malpractice insurance	(.40)			(.40)	
Sub-total	$152.76	$34.68	$40.09	$39.15	$38.84
Per diem adj. (Net)					
Self insurance	1.90			1.90	
Rider J	.22			.22	
Outside collection costs	.12			.12	
Medicare carve-out	6.02				6.02
Fringe benefits 3/19	.83	.19	.29	.10	.25
TOTAL	$161.85	$34.87	$40.38	$41.49	$45.11

HOSPITAL CENTER AT ORANGE - #78
(in thousands)[1]
Appendix J

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 3,341	$ 3,341	$	$ 564	$ 2,777
ICU intensive care	498	498		124	374
NBN newborn nursery	102	102		9	93
EMR emergency room	689	276	413		276
CLN clinics	265		265		
BBK blood bank	80		80		
CSS central sterile supply	403	399	4	79	320
DEL delivery & labor	143	143		40	103
EDG electrodiagnosis	317	209	108	111	98
LAB laboratory	1,095	832	263	169	663
NMD nuclear medicine	219	109	110	20	89
ORR operating & recovery	853	853		76	777
OPM other physical medicine	72	39	33	10	29
PHM pharmacy	776	706	70	254	452
PHT physical therapy	256	138	118	44	94
RAD radiological diagnosis	885	487	398	73	414
RSP respiratory therapy	304	301	3	177	124
THR therapeutic radiology	95	6	89	2	4
OAS other ancillary services	51	24	27	5	19
PHY physicians coverage	241	241		102	139
RSD residents	100	82	18	(5)	87
A&G admin. & general	1,211	962	249	390	572
DTY dietary	1,324	1,324		139	1,185
FIS fiscal	1,008	807	201	274	533
HKP housekeeping	733	636	97	90	546
L&L laundry & linen	351	326	25	44	282
MAL malpractice insurance	300	238	62	72	166
MRD medical records	255	224	31	49	175
NAD nursing admin.	339	302	37	84	218
PCC patient care coord.	94	94		14	80
PLT plant	1,147	995	152	54	941
UTC utilities cost	518	450	68		450
OGS other general services	316	251	65	33	218
EDR education & research	323	297	26	62	235
LFB legal fringe benefits	890	713	177		713
PFB policy fringe benefits	900	721	179		721
PEN pensions	656	525	131		525
MOH misc. overhead recov.		(76)	76	(76)	
Adjustments					
Emergency room		594	(594)	406	188
Patient care cluster				(25)	25
General services cluster				(58)	58
Minimum base period				379	(379)
TOTAL	$21,150	$18,169	$2,981	$3,785	$14,384

HOSPITAL CENTER AT ORANGE - #78

Appendix J

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 26.45	$	$25.63	$ .82	$
ICU intensive care	3.56		3.35	.21	
NBN newborn nursery	.89		.89		
EMR emergency room	2.63				2.63
CSS central sterile supply	3.05			3.05	
DEL delivery & labor	.99				.99
EDG electrodiagnosis	.93				.93
LAB laboratory	6.31				6.31
NMD nuclear medicine	.85				.85
ORR operating & recovery	7.40				7.40
OPM other physical medicine	.28				.28
PHM pharmacy	4.30				4.30
PHT physical therapy	.90				.90
RAD radiological diagnosis	3.94				3.94
RSP respiratory therapy	1.18				1.18
THR therapeutic radiology	.04				.04
OAS other ancillary services	.18				.18
PHY physicians coverage	1.32			1.32	
RSD residents	.83			.83	
A&G admin. & general	5.45			5.45	
DTY dietary	11.29	11.29			
FIS fiscal	5.07			5.07	
HKP housekeeping	5.20	5.20			
L&L laundry & linen	2.68	2.68			
MAL malpractice insurance	1.58			1.58	
MRD medical records	1.67			1.67	
NAD nursing admin.	2.07		2.07		
PCC patient care coord.	.76		.76		
PLT plant	8.96	8.96			
UTC utilities cost	4.28	4.28			
OGS other general services	2.08			2.08	
EDR education & research	2.24			2.24	
LFB legal fringe benefits	6.79	1.62	2.42	.89	1.86
PFB policy fringe benefits	6.86	1.64	2.44	.90	1.88
PEN pensions	5.00	1.19	1.78	.66	1.37
Adjustments					
Emergency room	1.79				1.79
Patient care cluster	.24			.24	
General services cluster	.55			.55	
Minimum base period	(3.61)		(.65)	(1.71)	(1.25)
Sub-total	$136.98	$36.86	$38.69	$25.85	$35.58
Per diem adj. (Net)					
Rider J	.95			.95	
Outside collection costs	.50			.50	
Medicare carve-out	4.50				4.50
TOTAL	$142.93	$36.86	$38.69	$27.30	$40.08

SAINT JOSEPH'S HOSPITAL - #19
(in thousands)[1]
Appendix K

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 4,695	$ 4,695	$	$ 739	$ 3,956
ICU intensive care	1,389	1,389		373	1,016
NBN newborn nursery	217	217		25	192
EMR emergency room	563	68	495		68
CLN clinics	148		148		
ANS anesthesiology	53	53			53
BBK blood bank	97	97		4	93
CSS central sterile supply	807	662	145	93	569
DEL delivery & labor	349	349		30	319
DIA dialysis	576	86	490	12	74
EDG electrodiagnosis	149	128	21	16	112
LAB laboratory	1,600	1,392	208	189	1,203
NMD nuclear medicine	136	63	73	10	53
ORR operating & recovery	1,304	1,265	39	119	1,146
OPM other physical medicine	143	69	74	23	46
PHM pharmacy	844	802	42	155	647
PHT physical therapy	118	57	61	8	49
RAD radiological diagnosis	1,197	718	479	78	640
RSP respiratory therapy	337	334	3	104	230
THR therapeutic radiology	114		114		
OAS other ancillary services	609	469	140	129	340
PHY physicians coverage	977	921	56	188	733
RSD residents	1,168	1,010	158	132	878
A&G admin. & general	1,281	1,065	216	202	863
DTY dietary	1,631	1,615	16	146	1,469
FIS fiscal	1,502	1,340	162	157	1,183
HKP housekeeping	827	736	91	163	573
L&L laundry & linen	431	395	36	16	379
MAL malpractice insurance	600	499	101	497	2
MRD medical records	248	246	2	41	205
NAD nursing admin.	247	229	18	25	204
PCC patient care coord.	423	406	17	45	361
PLT plant	2,121	1,867	254	194	1,673
UTC utilities cost	700	616	84		616
OGS other general services	579	493	86	164	329
EDR education & research	184	159	25	16	143
LFB legal fringe benefits	1,050	894	156		894
PFB policy fringe benefits	425	362	63		362
PEN pensions	450	383	67		383
INT interest	565	497	68		497
MOH misc. overhead recov.		(13)	13	(13)	
Adjustments					
Depreciation				206	(206)
Emergency room		831	(831)	174	657
Minimum base period-Phy.				134	(134)
TOTAL	$30,854	$27,464	$3,390	$4,594	$22,870

SAINT JOSEPH'S HOSPITAL - #19

Appendix K

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 25.16	$	$24.68	$ .48	$
ICU intensive care	6.46		5.90	.56	
NBN newborn nursery	1.22		1.22		
EMR emergency room	.43				.43
ANS anesthesiology	.34				.34
BBK blood bank	.59				.59
CSS central sterile supply	3.62			3.62	
DEL delivery & labor	2.03				2.03
DIA dialysis	.47				.47
EDG electrodiagnosis	.71				.71
LAB laboratory	7.65				7.65
NMD nuclear medicine	.34				.34
ORR operating & recovery	7.29				7.29
OPM other physical medicine	.30				.30
PHM pharmacy	4.12				4.12
PHT physical therapy	.31				.31
RAD radiological diagnosis	4.07				4.07
RSP respiratory therapy	1.46				1.46
OAS other ancillary services	2.16				2.16
PHY physicians coverage	4.66			4.66	
RSD residents	5.58			5.58	
A&G admin. & general	5.49			5.49	
DTY dietary	9.34	9.34			
FIS fiscal	7.52			7.52	
HKP housekeeping	3.64	3.64			
L&L laundry & linen	2.41	2.41			
MAL malpractice insurance	.01			.01	
MRD medical records	1.30			1.30	
NAD nursing admin.	1.30		1.30		
PCC patient care coord.	2.30		2.30		
PLT plant	10.64	10.64			
UTC utilities cost	3.92	3.92			
OGS other general services	2.09			2.09	
EDR education & research	.91			.91	
LFB legal fringe benefits	5.69	1.22	2.07	.68	1.72
PFB policy fringe benefits	2.30	.49	.84	.27	.70
PEN pensions	2.44	.52	.89	.29	.74
INT interest	3.16	.68	1.15	.37	.96
Adjustments					
Depreciation	(1.31)	(1.19)			(.12)
Emergency room	4.19				4.19
Minimum base period-Phy.	(.85)			(.85)	
Sub-total	$145.46	$31.67	$40.35	$32.98	$40.46
Per diem adj. (Net)					
Rider J	.55			.55	
Self insurance	.67			.67	
Medicare carve-out	1.50				1.50
TOTAL	$148.18	$31.67	$40.35	$34.20	$41.96

EAST ORANGE GENERAL HOSPITAL - #83
(in thousands)[1]
Appendix L

Cost Center	Total Costs	Covered Inpatient	EMR CLN&POP NON-EL[2]	Less Costs[3]	Base
ACU acute care	$ 1,968	$ 1,968	$	$ 90	$ 1,878
ICU intensive care	234	234		4	230
NBN newborn nursery	117	117		20	97
EMR emergency room	381	36	345		36
CLN clinics	307		307		
ANS anesthesiology	122	122		20	102
BBK blood bank	42	39	3		39
CSS central sterile supply	262	238	24	(8)	246
DEL delivery & labor	119	119		(1)	120
DIA dialysis	297	36	261	2	34
EDG electrodiagnosis	99	89	10	4	85
LAB laboratory	573	468	105	18	450
NMD nuclear medicine	56		56		
ORR operating & recovery	308	308			308
PHM pharmacy	423	389	34	57	332
PHT physical therapy	53	40	13	7	33
RAD radiological diagnosis	511	316	195	4	312
RSP respiratory therapy	149	147	2	2	145
OAS other ancillary services	18	2	16		2
PHY physicians coverage	365	365		14	351
A&G admin. & general	707	541	166	64	477
DTY dietary	911	807	104	69	738
FIS fiscal	675	598	77	141	457
HKP housekeeping	395	369	26	(28)	397
L&L laundry & linen	339	307	32	114	193
MAL malpractice	260	199	61	51	148
MRD medical records	128	118	10	8	110
NAD nursing admin.	225	200	25	18	182
PCC patient care coord.	569	504	65	42	462
PLT plant	1,065	944	121	122	822
UTC utilities cost	357	316	41		316
OGS other general services	199	153	46	16	137
EDR education & research	211	194	17	54	140
LFB legal fringe benefits	608	505	103		505
PFB policy fringe benefits	220	183	37		183
PEN pensions	258	214	44		214
INT interest	351	311	40		311
MOH misc. overhead recov.		(70)	70		(70)
Adjustments					
Emergency room		418	(418)	27	391
General services cluster				(143)	143
TOTAL	$13,882	$11,844	$2,038	$ 788	$11,056

EAST ORANGE GENERAL HOSPITAL - #83

Appendix L

Cost Center	Totals per diem	Hotel	Nursing	General Patient Care	Ancillary Patient Care
ACU acute care	$ 24.20	$	$22.92	$ 1.28	$
ICU intensive care	2.96		2.64	.32	
NBN newborn nursery	1.25		1.25		
EMR emergency room	.46				.46
ANS anesthesiology	1.31				1.31
BBK blood bank	.50				.50
CSS central sterile supply	3.17			3.17	
DEL delivery & labor	1.55				1.55
DIA dialysis	.44				.44
EDG electrodiagnosis	1.10				1.10
LAB laboratory	5.80				5.80
ORR operating & recovery	3.97				3.97
PHM pharmacy	4.28				4.28
PHT physical therapy	.43				.43
RAD radiological diagnosis	4.02				4.02
RSP respiratory therapy	1.87				1.87
OAS other ancillary services	.03				.03
PHY physicians coverage	4.52			4.52	
A&G admin. & general	6.15			6.15	
DTY dietary	9.51	9.51			
FIS fiscal	5.89			5.89	
HKP housekeeping	5.12	5.12			
L&L laundry & linen	2.49	2.49			
MAL malpractice insurance	1.91			1.91	
MRD medical records	1.42			1.42	
NAD nursing admin.	2.35		2.35		
PCC patient care coord.	5.95		5.95		
PLT plant	10.59	10.59			
UTC utilities cost	4.07	4.07			
OGS other general services	1.76			1.76	
EDR education & research	1.80			1.80	
LFB legal fringe benefits	6.51	1.37	2.16	1.46	1.52
PFB policy fringe benefits	2.36	.50	.78	.53	.55
PEN pensions	2.76	.58	.92	.62	.64
INT interest	4.00	.84	1.33	.90	.93
MOH misc. overhead recov.	(.90)			(.90)	
Adjustments					
Emergency room	5.04				5.04
General services cluster	1.84	1.37		.47	
Sub-total	$142.48	$36.44	$40.30	$31.30	$34.44
Per diem adj. (Net)					
Self insurance	.68			.68	
Rider J	1.20			1.20	
Outside collection costs	.51			.51	
Medicare carve-out	7.73				7.73
TOTAL	$152.60	$36.44	$40.30	$33.69	$42.17