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SENATE, No. 2759

STATE OF NEW JERSEY

218th LEGISLATURE

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Sponsored by:
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District 29 (Essex)
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SYNOPSIS

Expands per adjusted admission charge on hospitals to create supplemental funding pool for State's graduate medical education subsidy; appropriates $24,285,714.

CURRENT VERSION OF TEXT

As amended by the Senate on June 21, 2018.

(Sponsorship Updated As Of: 6/22/2018)

AN ACT concerning the assessment of a per adjusted admission charge on hospitals [1]**[**and**]** ,[1] amending P.L.1992, c.160 [1], and making an appropriation[1].

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 7 of P.L.1992, c.160 (C.26:2H-18.57) is amended to read as follows:

7. a. Effective January 1, 1994, the Department of Health shall assess each hospital a per adjusted admission charge of $10.

Of the revenues raised by the hospital per adjusted admission charge, $5 per adjusted admission shall be used by the department to carry out its duties pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) and $5 per adjusted admission shall be used by the department for administrative costs related to health planning.

Effective July 1, 2018, the assessment shall apply to all general acute care hospitals, rehabilitation hospitals, and long term acute care hospitals. Any General Fund savings resulting from the assessment meeting the permissibility standards set forth in 42 C.F.R. s.433.68 shall be used to create a supplemental funding pool, known as Safety Net Graduate Medical Education, for the State's graduate medical education subsidy.

[1]Notwithstanding the provisions of any law or regulation to the contrary, and except as otherwise provided and subject to such modifications as may be required by the Centers for Medicare and Medicaid Services in order to achieve any required federal approval and full federal financial participation, $24,285,714 is appropriated from the General Fund for Safety Net Graduate Medical Education, and conditioned upon the following:

Funds from the Safety Net Graduate Medical Education pool shall be available to eligible hospitals that meet the following eligibility criteria: An eligible hospital has a Relative Medicaid Percentage (RMP) that is in the top third of all acute care hospitals that have a residency program. The RMP is a ratio calculated using the 2016 Audited C.160 SHARE Cost Reports. The numerator of the RMP equals a hospital's gross revenue from patient care for Medicaid and Medicaid HMO as reported on Line 1, Col. D & Col. H of Forms E5 and E6. The denominator of the RMP equals a hospital's gross revenue from patient care as reported on Line 1, Col. E of Form E4. For instances where hospitals that have a single Medicare identification number submit a separate cost report for each campus, the values referenced above shall be consolidated.

Payments to eligible hospitals shall be made in the following manner:

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate floor amendments adopted June 21, 2018.

(1) the subsidy payment shall be split into a Direct Medical Education (DME) allocation, which is calculated by multiplying the total subsidy amount by the ratio of 2016 total median Medicaid managed care DME costs--to--total 2016 median Medicaid managed care GME costs; and an Indirect Medical Education (IME) allocation, which is calculated by multiplying the total subsidy amount by the ratio of 2016 total Medicaid managed care IME costs--to--total 2016 Medicaid managed care GME costs.

(2) Each hospital's percentage of total 2016 Medicaid managed care DME costs shall be multiplied by the DME allocation to calculate its DME payment. Each hospital's percentage of total 2016 Medicaid managed care IME costs shall be multiplied by the IME allocation to calculate its IME payment.

(3) Source data used shall come from the Medicaid cost report for calendar year (CY) 2016 submitted by each acute care hospital by November 30, 2017 and Medicaid Managed Care encounter payments for Medicaid and NJ FamilyCare clients as reported by insurers to the State for the following reporting period: services dates between January 1, 2016 and December 31, 2016; payment dates between January 1, 2016 and December 31, 2017; and a run--date of not later than January 31, 2018.

(4) In the event that a hospital reported less than 12 months of 2016 Medicaid costs, the number of reported months of data regarding days, costs, or payments shall be annualized. In the event the hospital completed a merger, acquisition, or business combination or a supplemental cost report for the calendar year 2016 submitted by the affected acute care hospital by November 30, 2017 shall be used. In the event that a hospital did not report its Medicaid managed care days on the cost report utilized in this calculation, the Department of Health (DOH) shall ascertain Medicaid managed care encounter days for Medicaid and NJ FamilyCare clients as reported by insurers to the State.

(5) Medicaid managed care DME cost is defined as the approved intern and residency program costs using the 2016 Medicaid cost report total residency costs, reported on Worksheet B Pt I Column 21 line 21 plus Worksheet B Pt I Column 22 Line 22 divided by 2016 resident full time equivalent employees (FTE), reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop an average cost per FTE for each hospital used to calculate the overall median cost per FTE.

(6) The median cost per FTE is multiplied by the 2016 resident FTEs reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop approved total residency program costs.

(7) The approved residency costs are multiplied by the quotient of Medicaid managed care days, reported on Worksheet S--3 Column 7 line 2, divided by the quantity of total days, on Worksheet S--3 Column 8 line 14, less nursery days, on Worksheet S--3 Column 8 line 13.

(8) Medicaid managed care IME cost is defined as the Medicare IME factor multiplied by Medicaid managed care encounter payments for Medicaid and NJ FamilyCare clients as reported by insurers to the State.

(9) The IME factor is calculated using the Medicare IME formula as follows: 1.35 * [(1 + x) ^0.405 – 1], in which "x" is the quotient of submitted IME resident full--time equivalencies reported on Worksheet S--3 Pt 1 Column 9 line 14 divided by the quantity of total available beds less nursery beds reported on Worksheet S--3 Column 2 line 14.

(10) In the event that a hospital believes that there are mathematical errors in the calculations, or data not matching the actual source documents used to calculate the subsidy as defined above, hospitals shall be permitted to file calculation appeals within 15 working days of receipt of the subsidy allocation letter. If upon review it is determined by the department that the error has occurred and would constitute at least a five percent change in the hospital's allocation amount, a revised industry--wide allocation shall be issued.[1]

b. Effective July 1, 2004, the department shall assess each licensed ambulatory care facility that is licensed to provide one or more of the following ambulatory care services: ambulatory surgery, computerized axial tomography, comprehensive outpatient rehabilitation, extracorporeal shock wave lithotripsy, magnetic resonance imaging, megavoltage radiation oncology, positron emission tomography, orthotripsy, and sleep disorder services. The Commissioner of Health may, by regulation, add additional categories of ambulatory care services that shall be subject to the assessment if such services are added to the list of services provided in N.J.A.C.8:43A-2.2(b) after the effective date of P.L.2004, c.54.

The assessment established in this subsection shall not apply to an ambulatory care facility that is licensed to a hospital in this State as an off-site ambulatory care service facility.

(1) For Fiscal Year 2005, the assessment on an ambulatory care facility providing one or more of the services listed in this subsection shall be based on gross receipts for the 2003 tax year as follows:

(a) a facility with less than $300,000 in gross receipts shall not pay an assessment; and

(b) a facility with at least $300,000 in gross receipts shall pay an assessment equal to 3.5**[**%**]** percent of its gross receipts or $200,000, whichever amount is less.

The commissioner shall provide notice no later than August 15, 2004 to all facilities that are subject to the assessment that the first payment of the assessment is due October 1, 2004 and that proof of gross receipts for the facility's tax year ending in calendar year 2003 shall be provided by the facility to the commissioner no later than September 15, 2004. If a facility fails to provide proof of gross receipts by September 15, 2004, the facility shall be assessed the maximum rate of $200,000 for Fiscal Year 2005.

The Fiscal Year 2005 assessment shall be payable to the department in four installments, with payments due October 1, 2004, January 1, 2005, March 15, 2005, and June 15, 2005.

(2) For Fiscal Year 2006, the commissioner shall use the calendar year 2004 data submitted in accordance with subsection c. of this section to calculate a uniform gross receipts assessment rate for each facility with gross receipts over $300,000 that is subject to the assessment, except that no facility shall pay an assessment greater than $200,000. The rate shall be calculated so as to raise the same amount in the aggregate as was assessed in Fiscal Year 2005. A facility shall pay its assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

(3) Beginning in Fiscal Year 2007 and for each fiscal year thereafter through Fiscal Year 2010, the uniform gross receipts assessment rate calculated in accordance with paragraph (2) of this subsection shall be applied to each facility subject to the assessment with gross receipts over $300,000, as those gross receipts are documented in the facility's most recent annual report to the department, except that no facility shall pay an assessment greater than $200,000. A facility shall pay its annual assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

(4) Beginning in Fiscal Year 2011 and for each fiscal year thereafter, the uniform gross receipts assessment shall be applied at the rate of 2.95**[**%**]** percent to each facility subject to the assessment with gross receipts over $300,000, as those gross receipts are documented in the facility's most recent annual report submitted to the department pursuant to subsection c. of this section, except that no facility shall pay an assessment greater than $350,000. A facility shall pay its annual assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

c. Each ambulatory care facility that is subject to the assessment provided in subsection b. of this section shall submit an annual report including, at a minimum, data on volume of patient visits, charges, and gross revenues, by payer type, for patient services, beginning with calendar year 2004 data. The annual report shall be submitted to the department according to a timetable and in a form and manner prescribed by the commissioner.

The department may audit selected annual reports in order to determine their accuracy.

d. (1) If, upon audit as provided for in subsection c. of this section, it is determined that an ambulatory care facility understated its gross receipts in its annual report to the department, the facility's assessment for the fiscal year that was based on the defective report shall be retroactively increased to the appropriate amount and the facility shall be liable for a penalty in the amount of the difference between the original and corrected assessment.

(2) A facility that fails to provide the information required pursuant to subsection c. of this section shall be liable for a civil penalty not to exceed $500 for each day in which the facility is not in compliance.

(3) A facility that is operating one or more of the ambulatory care services listed in subsection b. of this section without a license from the department, on or after July 1, 2004, shall be liable for double the amount of the assessment provided for in subsection b. of this section, in addition to such other penalties as the department may impose for operating an ambulatory care facility without a license.

(4) The commissioner shall recover any penalties provided for in this subsection in an administrative proceeding in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

e. The revenues raised by the ambulatory care facility assessment pursuant to this section shall be deposited in the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

(cf: P.L.2012, c.17, s.222)

2. This act shall take effect immediately.