ASSEMBLY, No. 5605

STATE OF NEW JERSEY

218th LEGISLATURE

INTRODUCED JUNE 17, 2019

Sponsored by:
Assemblyman DANIEL R. BENSON
District 14 (Mercer and Middlesex)

SYNOPSIS

Revises assessments on ambulatory care facilities.

CURRENT VERSION OF TEXT

As introduced.

AN ACT revising assessments on ambulatory care facilities and amending P.L.1971, c.136 and P.L.1992, c.160.

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

1. Section 12 of P.L.1971, c.136 (C.26:2H-12) is amended to read as follows:

12. a. No health care service or health care facility shall be operated unless it shall: (1) possess a valid license issued pursuant to this act, which license shall specify the kind or kinds of health care services the facility is authorized to provide; (2) establish and maintain a uniform system of cost accounting approved by the commissioner; (3) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner; (4) prepare and review annually a long range plan for the provision of health care services; and (5) establish and maintain a centralized, coordinated system of discharge planning which assures every patient a planned program of continuing care and which meets the requirements of the commissioner which requirements shall, where feasible, equal or exceed those standards and regulations established by the federal government for all federally-funded health care facilities but shall not require any person who is not in receipt of State or federal assistance to be discharged against his will.

b. (1) Application for a license for a health care service or health care facility shall be made upon forms prescribed by the department. The department shall charge a single, nonrefundable fee for the filing of an application for and issuance of a license and a single, nonrefundable fee for any renewal thereof, and a single, nonrefundable fee for a biennial inspection of the facility, as it shall from time to time fix in rules or regulations; provided, however, that no such licensing fee shall exceed $10,000 in the case of a hospital and $4,000 in the case of any other health care facility for all services provided by the hospital or other health care facility, and no such inspection fee shall exceed $5,000 in the case of a hospital and $2,000 in the case of any other health care facility for all services provided by the hospital or other health care facility. No inspection fee shall be charged for inspections other than biennial inspections. Any surgical practice required to apply for licensure by the department as an ambulatory care facility pursuant to P.L.2017, c.283 shall be exempt from the initial and renewal license fees required by this section. The application shall contain the name of the health care facility, the kind or kinds of health care service to be provided, the location and physical description of the

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 <u>thus</u> is new matter.

institution, and such other information as the department may require.

(2) A license shall be issued by the department upon its findings that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.

(3) The department shall post on its Internet website each inspection report prepared following an inspection of a residential health care facility, as defined in section 1 of P.L.1953, c.212 (C.30:11A-1) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), that is performed pursuant to this subsection, along with any other inspection report prepared by or on behalf of the department for such facility.

If an inspection reveals a serious health and safety violation at a residential health care facility, the department shall post the inspection report, including the name of the facility and the owner of the facility, on its website no later than 72 hours following the inspection. If a license of a residential health care facility is suspended, the department shall post the suspension on its website no later than 72 hours following the suspension. The department shall update its website to reflect the correction of a serious health and safety violation, and the lifting of a suspension.

The department shall notify, as soon as possible, the Commissioner of Human Services, or the commissioner's designee, and the director of the county board of social services or county welfare agency, as appropriate, in the county in which a residential health care facility is located, of a serious health and safety violation at the facility and of any suspension of a license to operate such facility.

If the inspection responsibilities under this subsection with respect to such facility are transferred or otherwise assigned to another department, that other department shall post on its Internet website each inspection report prepared following an inspection of such facility performed pursuant to this subsection, along with any other inspection report prepared by or on behalf of that department for such facility, and shall comply with the other requirements specified in this subsection.

c. (Deleted by amendment, P.L.1998, c.43)

d. The commissioner may amend a facility's license to reduce that facility's licensed bed capacity to reflect actual utilization at the facility if the commissioner determines that 10 or more licensed beds in the health care facility have not been used for at least the last two succeeding years. For the purposes of this subsection, the commissioner may retroactively review utilization at a facility for a two-year period beginning on January 1, 1990.

e. If a prospective applicant for licensure for a health care service or facility that is not subject to certificate of need review pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) so requests, the department shall provide the prospective applicant with a pre-licensure consultation. The purpose of the consultation is to provide the prospective applicant with information and guidance on rules, regulations, standards and procedures appropriate and applicable to the licensure process. The department shall conduct the consultation within 60 days of the request of the prospective applicant.

f. Notwithstanding the provisions of any other law to the contrary, an entity that provides magnetic resonance imaging or computerized axial tomography services shall be required to obtain a license from the department to operate those services prior to commencement of services, except that a physician who is operating such services on the effective date of P.L.2004, c.54 shall have one year from the effective date of P.L.2004, c.54 to obtain the license.

g. (1) (Deleted by amendment, P.L.2017, c.283)

(2) (Deleted by amendment, P.L.2017, c.283)

(3) (Deleted by amendment, P.L.2017, c.283)

(4) A surgical practice in operation on the date of enactment of P.L.2017, c.283 shall be required to apply to the department for licensure as an ambulatory care facility licensed to provide surgical and related services within one year of the date of enactment of P.L.2017, c.283.

A surgical practice that is certified by the Centers for Medicare and Medicaid Services (CMS) shall not be required to meet the physical plant and functional requirements specified in N.J.A.C.8:43A-19.1 et seq. A surgical practice that is not Medicare certified, either by CMS or by any deeming authority recognized by CMS, but which has obtained accreditation from the American Association of Ambulatory Surgery Facilities or any accrediting body recognized by CMS and is in operation on the date of enactment of P.L.2017, c.283, shall not be required to meet the physical plant and functional requirements specified in N.J.A.C.8:43A-19.1 et seq. A surgical practice not in operation on the date of enactment of P.L.2017, c.283, if it is certified by CMS as an ambulatory surgery center provider, shall also be exempt from these requirements. A surgical practice required by this subsection to meet the physical plant and functional requirements specified in N.J.A.C.8:43A-19.1 et seq. may apply for a waiver of any such requirement in accordance with N.J.A.C.8:43A-2.9. The commissioner shall grant a waiver of those physical plant and functional requirements, as the commissioner deems appropriate, if the waiver does not endanger the life, safety, or health of patients or the public.

[A**]** Beginning is Fiscal Year 2020 and in each fiscal year thereafter, a surgical practice required to be licensed pursuant to this subsection shall be **[**exempt from**]** subject to the ambulatory care facility assessment pursuant to section 7 of P.L.1992, c.160 (C.26:2H-18.57)**[**; except that, if the entity expands to include any additional room dedicated for use as an operating room, the entity shall be subject to the assessment**]**.

(5) As used in this subsection and subsection i. of this section, "surgical practice" means a structure or suite of rooms that has the following characteristics:

(a) has no more than one room dedicated for use as an operating room which is specifically equipped to perform surgery, and is designed and constructed to accommodate invasive diagnostic and surgical procedures;

(b) has one or more post-anesthesia care units or a dedicated recovery area where the patient may be closely monitored and observed until discharged; and

(c) is established by a physician, physician professional association surgical practice, or other professional practice form specified by the State Board of Medical Examiners pursuant to regulation solely for the physician's, association's, or other professional entity's private medical practice.

(6) Nothing in this subsection shall be construed to limit the State Board of Medical Examiners from establishing standards of care with respect to the practice of medicine.

h. An ambulatory care facility licensed to provide surgical and related services shall be required to obtain ambulatory care accreditation from an accrediting body recognized by the Centers for Medicare and Medicaid Services as a condition of licensure by the department.

An ambulatory care facility that is licensed to provide surgical and related services on the effective date of this section of P.L.2009, c.24 shall have one year from the effective date of this section of P.L.2009, c.24 to obtain ambulatory care accreditation.

i. Beginning on the effective date of this section of P.L.2009, c.24, and as provided in P.L.2017, c.283, the department shall not issue a new license to an ambulatory care facility to provide surgical and related services unless:

(1) in the case of a licensed facility in which a transfer of ownership of the facility is proposed, the commissioner reviews the qualifications of the new owner or owners and approves the transfer;

(2) (a) except as provided in subparagraph (b) of this paragraph, in the case of a licensed facility for which a relocation of the facility is proposed, the relocation is within 20 miles of the facility's current location or the relocation is to a "Health Enterprise Zone" designated pursuant to section 1 of P.L.2004, c.139 (C.54A:3-7), there is no expansion in the number of operating rooms provided at

the new location from that of the current location, and the commissioner reviews and approves the relocation prior to its occurrence; or

(b) in the case of a licensed facility described in paragraph (5) or (6) of this subsection for which a relocation of the facility is proposed, the commissioner reviews and approves the relocation prior to its occurrence;

(3) the entity is a surgical practice required to be licensed pursuant to subsection g. of this section and meets the requirements of that subsection;

(4) the entity has filed its plans, specifications, and required documents with the Health Care Plan Review Unit of the Department of Community Affairs or the municipality in which the surgical practice or facility will be located, as applicable, on or before the 180th day following the effective date of this section of P.L.2009, c.24;

(5) the facility is owned jointly by a general hospital in this State and one or more other parties;

(6) the facility is owned by a hospital or medical school in this State, or the facility is owned by any hospital approved on or before the effective date of P.L.2015, c.305 to provide ambulatory surgery services in this State, or the facility is owned by a hospital which applied on or before the effective date of P.L.2015, c.305 to provide ambulatory surgery services in this State so long as the hospital is later approved to provide ambulatory surgery services at the facility, or the facility is owned by any hospital approved to provide ambulatory surgery services at another facility in this State; or

(7) (a) the facility is a newly licensed ambulatory surgical facility that was created by combining two or more registered surgical practices, provided that the number of operating rooms at the newly licensed facility is not greater than the total number of operating rooms prior to the establishment of the newly licensed facility;

(b) the facility is a licensed ambulatory surgical facility that has expanded by combining with one or more registered surgical practices, provided that the number of operating rooms at the newly expanded facility is not greater than the total number of operating rooms prior to the combination of the practices and facility; or

(c) the facility is a licensed ambulatory surgical facility that has expanded through the combination of two or more licensed ambulatory surgical facilities, provided that the number of operating rooms at the newly expanded facility is not greater than the total number of operating rooms prior to the combining of the facilities.

Beginning on the effective date of P.L.2017, c.283, the department shall not issue a new registration to a surgical practice. Any surgical practice in operation on the effective date of P.L.2017, c.283 that proposes to relocate on or after the effective date of

P.L.2017, c.283 shall be required to be licensed by the department as an ambulatory care facility providing surgical and related services pursuant to subsection g. of this section.

j. (Deleted by amendment, P.L.2017, c.283)

k. An ambulatory care facility licensed to provide surgical and related services and a surgical practice shall:

(1) report to the department any change in ownership of the facility within 30 days of the change in ownership; and

(2) annually report to the department the name of the facility's medical director, physician director, and physician director of anesthesia, as applicable, and the director of nursing services. The facility shall notify the department if there is any change in a named director within 30 days of the change of the director.

(cf: P.L.2017, c.283, s.1)

2. 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. 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:

(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.

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 <u>through Fiscal Year 2019</u>, 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.

<u>(5) Beginning in Fiscal Year 2020 and for each fiscal year thereafter, the uniform gross receipts assessment shall be applied to each facility subject to the assessment at the rate of 2.95 percent of gross receipts documented in the facility’s most recent annual report submitted to the department pursuant to subsection c. of this section. A facility shall pay its annual assessment to the department</u>

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.2018, c.116, s.1)

3. This act shall take effect immediately.

STATEMENT

This bill revises the Ambulatory Care Facility (ACF) Assessment, and levies this fee on additional types of health care facilities beginning in Fiscal Year 2020. Currently, the State imposes an annual ACF Assessment fee of 2.95 percent of gross

receipts over $300,000, as documented in the facility's most recent annual report. An ACF's annual assessment is currently capped at $350,000. The ACF Assessment fee is levied upon all Department of Health (DOH) licensed ACFs, with the exception of surgical practices that have only one operating room. However, surgical practices that have more than one operating room are required to pay the fee.

This bill would, starting in Fiscal Year 2020, apply the 2.95 percent Assessment to all of an ACF's annual gross receipts, and remove the assessment cap of $350,000. Additionally, the ACF Assessment fee would now be levied uniformly on all DOH-licensed ACFs, including surgical practices that have only one operating room. This expansion of the scope and application of the ACF Assessment will increase State revenues collected through this fee. Revenues collected through the ACF Assessment are budgeted in the Health Care Subsidy Fund, which supports various health care initiatives throughout the State.