

SENATE, No. 2541

STATE OF NEW JERSEY 219th LEGISLATURE

INTRODUCED JUNE 8, 2020

Sponsored by:

Senator PAUL A. SARLO

District 36 (Bergen and Passaic)

SYNOPSIS

Defers ambulatory care facility gross receipts assessment payment due on June 15, 2020 by nine months.

CURRENT VERSION OF TEXT

As introduced.



1 **AN ACT** concerning the ambulatory care facility gross receipts
2 assessment and amending P.L.1992, c.160.

3

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

6

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

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

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

16 Effective July 1, 2018, the assessment shall apply to all general
17 acute care hospitals, rehabilitation hospitals, and long term acute
18 care hospitals. Any General Fund savings resulting from the
19 assessment meeting the permissibility standards set forth in 42
20 C.F.R. s.433.68 shall be used to create a supplemental funding pool,
21 known as Safety Net Graduate Medical Education, for the State's
22 graduate medical education subsidy. Notwithstanding the
23 provisions of any law or regulation to the contrary, and except as
24 otherwise provided and subject to such modifications as may be
25 required by the Centers for Medicare and Medicaid Services in
26 order to achieve any required federal approval and full federal
27 financial participation, \$24,285,714 is appropriated from the
28 General Fund for Safety Net Graduate Medical Education, and
29 conditioned upon the following:

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

43 Payments to eligible hospitals shall be made in the following
44 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.

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

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

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

22 (4) In the event that a hospital reported less than 12 months of
23 2016 Medicaid costs, the number of reported months of data
24 regarding days, costs, or payments shall be annualized. In the event
25 the hospital completed a merger, acquisition, or business
26 combination or a supplemental cost report for the calendar year
27 2016 submitted by the affected acute care hospital by November 30,
28 2017 shall be used. In the event that a hospital did not report its
29 Medicaid managed care days on the cost report utilized in this
30 calculation, the Department of Health (DOH) shall ascertain
31 Medicaid managed care encounter days for Medicaid and NJ
32 FamilyCare clients as reported by insurers to the State.

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

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

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

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

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

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

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

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

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

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

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

43 The commissioner shall provide notice no later than August 15,
44 2004 to all facilities that are subject to the assessment that the first
45 payment of the assessment is due October 1, 2004 and that proof of
46 gross receipts for the facility's tax year ending in calendar year 2003
47 shall be provided by the facility to the commissioner no later than

1 September 15, 2004. If a facility fails to provide proof of gross
2 receipts by September 15, 2004, the facility shall be assessed the
3 maximum rate of \$200,000 for Fiscal Year 2005.

4 The Fiscal Year 2005 assessment shall be payable to the
5 department in four installments, with payments due October 1,
6 2004, January 1, 2005, March 15, 2005, and June 15, 2005.

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

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

27 (4) Beginning in Fiscal Year 2011 and for each fiscal year
28 thereafter, the uniform gross receipts assessment shall be applied at
29 the rate of 2.95 percent to each facility subject to the assessment
30 with gross receipts over \$300,000, as those gross receipts are
31 documented in the facility's most recent annual report submitted to
32 the department pursuant to subsection c. of this section, except that
33 no facility shall pay an assessment greater than \$350,000. A
34 facility shall pay its annual assessment to the department in four
35 payments in accordance with a timetable prescribed by the
36 commissioner, except that the payment due on June 15, 2020,
37 pursuant to N.J.A.C. 8:31A-2.2, shall be deferred for nine months
38 and paid in full on March 15, 2021, along with the payment due on
39 that date pursuant to regulation.

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

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

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

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

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

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

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

27 (cf: P.L.2018, c.116, s.1)

28
29 2. This act shall take effect immediately.
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31

32 STATEMENT

33
34 This bill defers the ambulatory care facility (ACFs) gross
35 receipts assessment payment due on June 15, 2020 by nine months.
36 Since March of 2020, ACFs have experienced a significant drop in
37 patient volume, and hence revenue, due to the coronavirus 2019
38 (COVID-19) pandemic. It is the sponsor's goal that this bill will
39 provide relief to ACFs in the wake of the current public health crisis
40 by delaying the next quarterly payment until March 15, 2021;
41 thereby, allowing these facilities the time to stabilize financially
42 before the payment is due.

43 Currently, Section 7 of P.L.1992, c.160 (C.26:2H-18.57) provides
44 for an assessment on the gross receipts of certain ACFs at a rate of
45 2.95 percent to each facility subject to the assessment, with a per
46 facility assessment cap of \$350,000. ACFs that are subject to the

1 assessment include facilities with gross receipts over \$300,000 that
2 provide the following ambulatory care services: ambulatory surgery,
3 computerized axial tomography, comprehensive outpatient
4 rehabilitation, extracorporeal shock wave lithotripsy, magnetic
5 resonance imaging, megavoltage radiation oncology, positron emission
6 tomography, orthotripsy, and sleep disorder services.
7 Pursuant to State regulations at N.J.A.C.8:31A-1.1 et seq. each
8 covered facility is required to pay the annual assessment, based on an
9 annual report submitted by the ACF for the previous State fiscal year,
10 in four equal installments on October 1, January 1, March 15, and June
11 15. This bill defers the payment due on June 15, 2020 by nine months.
12 This June payment is based on gross receipts from the previous fiscal
13 year and it would be a hardship to impose such an assessment on
14 ACFs at a time when revenues are significantly less. As a result of
15 delaying the June payment, ACFs will be required to make two
16 installments on March 15, 2021 – one for that date, and one for the
17 deferred June 15, 2020 payment.