3. w CC: Patients with a substantial complication or comorbidity.

4. wO CC: Patients without a substantial complication or comorbidity.

5. O.R. Procedures: therapeutic or diagnostic procedures generally performed in a fully equipped operating room (O.R.).

6. URI: Upper Respiratory Infection.

7. AMI: Acute Myocardial Infarction.

8. CHF: Congestive Heart Failure.

9. D & C: Dilation and Curettage.

10. FUO: Fever of Unknown Origin.

11. NEC: Not Elsewhere Classifiable.

SUBCHAPTER 8. BASIS OF SPECIFIC PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

10:52–8.1 Disproportionate Share Adjustment

(a) A disproportionate share hospital shall be a hospital designated by the Commissioner of Human Services. At a minimum, each hospital with a Medicaid inpatient hospital utilization rate that is one standard deviation above the mean Medicaid utilization rate for hospitals receiving Medicaid payments in the State, and every hospital with a low income utilization rate above 25 percent will be treated as a disproportionate share hospital. A hospital shall be designated as a disproportionate share hospital eligible for a charity care subsidy pursuant to P.L. 1992, c.160, Section 9 if upon establishing a rank order of the percentage of uncompensated care for all hospitals, the hospital is determined by the Commissioner of Health to be at or above the 80th percentile of hospitals with the highest percentage of uncompensated care, or if the hospital is eligible for other uncompensated fund subsidy pursuant to P.L. 1992, c.160, Section 11, if upon establishing a rank order of other uncompensated care for hospitals, has other uncompensated care which is at or above the 45th percentile of all hospitals' other uncompensated care levels.

(b) The Commissioner of the Department of Human Services may designate additional hospitals as disproportionate share hospitals if it is determined they serve a large number of low income mentally ill or developmentally disabled clients.

(c) The Commissioner of the Department of Human Services may make additional disproportionate share payments to facilities operating under N.J.S.A. 18A:64G–1 et seq. providing a high level of charity and uncompensated care to low income persons and persons with special needs.

(d) The Commissioner of the Department of Human Services may also designate a facility as eligible for additional disproportionate share payments if its uncompensated care as a percentage of payments from non-governmental payers is equal to or greater than 30 percent. In addition, to be designated as eligible for this additional disproportionate share payment, the facility must demonstrate a commitment to the establishment and operation of a managed care program for the uninsured and other low income persons, case management programs for persons with AIDS, tuberculosis or substance abuse and addiction or a program for children at risk of health problems resulting from lack of immunizations, lead poisoning, abuse or birth defects. In addition, a facility must demonstrate a commitment to continuing service to mentally ill clients.

10:52–8.2 Method of payment

(a) The disproportionate share adjustment shall include an adjustment amount annually determined, as to (a)1 through 3 below, by the Commissioner, Department of Health and Senior Services in consultation with the Commissioner, Department of Human Services and, as to (a)4 and 5 below, by the Commissioner, Department of Human Services based upon a determination regarding payments for charity and uncompensated care from the Health Care Subsidy Fund.

1. For facilities operating under N.J.S.A. 18A:64G–1 et seq., the disproportionate share adjustment determined by the Essential Health Services Commission may be increased by an amount recommended by the Office of Management and Budget which will consider the total operating cost of the facility less any third party payments, including all other Medicaid payments, as well as payments from non-State sources for services provided by the hospital during the hospital's fiscal year.

2. The recommendation from the Essential Health Services Commission shall be calculated in the following manner pursuant to P.L. 1992, c.160 (N.J.S.A. 26:2H–18).

i. The determination of the Charity Care Component Costs of the Health Care Subsidy Fund shall be calculated in the following manner:

(1) The Essential Health Services Commission shall use the results of the charity care audit conducted as its definition of charity care incurred by all hospitals.

(2) The New Jersey Department of Health shall report to the Essential Health Services Commission, the results of its audit of New Jersey acute care hospital's charity care provided in the year per N.J.A.C. 8:31B–4.41 through 4.41N.

(A) For purposes of determining annual charity care costs, hospitals shall submit their audit lists per N.J.A.C. 8:31B–4.41A but may list their accounts by charges rather than the Medicaid rate.

(B) For purposes of determining annual charity care costs, the criteria in N.J.A.C. 8:31B–4.41D through 4.41L shall not apply to a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction pursuant to N.J.S.A. 30:4. A patient so found shall qualify for 100 percent charity care coverage. Hospitals with patients who qualify under this provision shall include the appropriate documentation from the court in the patient's file for audit.

(C) For purposes of determining annual charity care costs, hospitals may document New Jersey residency for patients in either of the following two ways: hospitals must document that the applicant was a New Jersey resident at the time he or she received services and had the intent to remain in the State. An out-of-State resident may apply for charity care if his or her services resulted from a situation requiring immediate medical care pursuant to N.J.A.C. 8:31B–4.41F.

(3) All charity care accounts shall be valued at the Medicaid rate as follows:

(A) For inpatient accounts, the New Jersey Department of Health and the New Jersey Department of Human Services shall value each account at the rate Medicaid would have reimbursed hospitals for the service(s).

(B) For outpatient accounts, outpatient charity care accounts written-off during the calendar year will be valued as follows: annual outpatient charity care charges multiplied by the ratio of the annual outpatient Medicaid payments to the annual outpatient Medicaid charges associated with paid claims. This Medicaid outpatient payment-to-charge ratio excludes billings for HealthStart and dental services.

(C) Disproportionate share adjustments and final rate settlements for the service period shall not be taken into account for the recognition of charity care costs.

(4) If a hospital's percentage of charity care costs in relation to their revenue cap is among the 80 percent of hospitals with the highest percentage of charity care, it is eligible to receive a Health Care Subsidy Fund Charity Care adjustment.

(5) For eligible hospitals, charity care subsidy amounts are determined as follows:

(A) Eligible hospitals annual charity care subsidy amount is equal to charity care costs as determined by the audit and valued at Medicaid rates.

(B) The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase used to set Medicaid hospital rates will be used to inflate charity care costs in the current year.

(C) In no instances shall payments made during a calendar year exceed the preceding years audited and Medicaid rate valued amounts inflated by TEFRA rates used in the hospital rate setting system.

(D) Any overpayments which result from interim payments exceeding the audited payment levels shall be recovered by offsetting all Medicaid payments.

3. A hospital's eligibility for the Other Uncompensated Care Hospital Subsidy Fund payment shall be calculated using the following formula:

i. Hospital Specific Other Uncompensated Care for Year/Hospital Specific Revenue for Year = Hospital Specific Percentage of Other Uncompensated Care (% OUC). A hospital is eligible for a subsidy if, upon establishing rank order of the % OUC for all hospitals:

(1) In 1993, the hospital is among the 45 percent of hospitals with the highest % OUC;

(2) In 1994, the hospital is among the 30 percent of hospitals with the highest % OUC; and

(3) In 1995, the hospital is among the 15 percent of hospitals with the highest % OUC.

ii. The amount of the subsidy an eligible hospital shall receive shall be based on the following:

Hospital Specific Other Uncompensated Care for Year/Total Other Uncompensated Care for all Eligible Hospitals for Year multiplied by Total Amount of Subsidy Allocated for the Year = Hospital Specific Subsidy for the Year.

The monies in the Other Uncompensated Care component of the disproportionate share hospital subsidy account shall be distributed to eligible hospitals in accordance with the formulas provided in this section. In 1993, the fund shall distribute $100 million in subsidies to eligible hospitals; in 1994, the fund shall distribute $67 million to eligible hospitals; and in 1995, the fund shall distribute $33 million to eligible hospitals. For 1993, the formulas shall use 1991 Hospital Specific Other Uncompensated Care and Total Uncompensated Care for eligible hospitals and the hospital's PCB for "Hospital Specific Revenue for Year." In 1994 and 1995, the formulas shall use 1992 Other Uncompensated Care and Total Other Uncompensated Care for all eligible hospitals and the hospital's 1993 revenue cap established pursuant to P.L. 1992, c.160, section 3. (N.J.S.A. 26:2H–18).

iii. Other Uncompensated Care (OUC) shall be distributed to hospitals to meet the requirements of Chapter 160, Section 1d (N.J.S.A. 26:2H–18). OUC is defined as all costs not reimbursed by hospital payers excluding charity care, graduate medical education, discounts, bad debt, and reduction in Medicaid payments. The Department of Health (DOH), under the direction of the Essential Health Services Commission (EHSC), will calculate the actual OUC amounts for the purpose of determining the distribution of the OUC subsidy payments.

(1) In 1993, OUC subsidies shall be based upon actual 1991 OUC amounts.

(2) In 1994 and 1995, OUC subsidies shall be based upon actual 1992 OUC amounts.

(3) In 1994, interim OUC subsidy payments shall initially be based upon the projected 1992 OUC amounts determined by the DOH under Chapter 83 (N.J.S.A. 26:2H–1) for the rate year 1992; the actual 1992 OUC amounts shall be determined after October 1, 1994, when final 1992 data for all acute hospitals is available from the fiscal intermediary. After the actual 1992 OUC amounts are calculated by the DOH and approved by the EHSC, the 1994 OUC subsidy payments or other Medicaid payments shall be adjusted by making adjustments to the OUC or other DSH or Medicaid payments made by the Division of Medical Assistance and Health Services (DMAHS).

iv. The Chapter 83 (N.J.S.A. 26:2H–1) inpatient payments referenced in (a)3iii above, shall be based upon Diagnosis Related Groups (DRG) payments from the applicable rate year's uniform bill (UB) data submitted to the DOH under the former N.J.A.C. 8:31B–3.45.

(1) For 1993, total indirect costs from the 1991 pro forma final reconciliation shall be first apportioned to inpatients through application of the inpatient direct patient care cost (DPC) percentage, then apportioned to Medicare inpatients based upon the Medicare percentage of total DRG payments using UB data. The inpatient DPC percentage shall be derived by dividing total inpatient DRG payments into the sum of the following: total inpatient DRG payments plus patients with rates approved cost from the 1991 pro forma final reconciliation plus outpatients without rates approved cost from the 1991 pro forma final reconciliations by total inpatient DRG payments.

(2) For 1994, most 1992 indirect costs were volume variable and included in the DRG rates. For those 1992 indirect costs not allocated through the establishment of inpatient and outpatient rates, those "other" indirect costs will be considered fixed and will be allocated to inpatients through the inpatient DPC percentage, and apportioned to Medicare inpatients based upon the Medicare percentage of total DRG payments. The source of the 1992 "other" indirect costs shall be the 1992 Report 5, which expresses 1988 base year costs in 1992 dollars. Total 1992 DPC shall be established as follows: 1992 total inpatient DRG rates plus 1992 outpatient DPC. 1992 outpatient DPC shall be derived by running 1992 actual costs through the 1992 rate setting methodology, which allocates most indirect costs to both inpatient and outpatient rates.

(3) Inpatient Part B physician costs shall be removed since no comparable Medicare data on Medicare payments is available.

v. The DOH will apply the Federal Prospective Payment System (PPS) GROUPER and Pricer programs to determine DRG payments for the Medicare patients identified in (a)3iv above.

(1) The DOH will include "excluded unit" Medicare reimbursement in Medicare inpatient payments for the applicable rate year for those Medicare cases reimbursed under Chapter 83 (N.J.S.A. 26:2H–1) but not under PPS.

(2) The DOH will include the following data from the applicable rate year Medicare cost reports in order to determine the other components of Medicare inpatient payments:

(A) Excluded unit reimbursement;

(B) Pass-through payments; and

(C) Inpatient Part B physician costs.

vi. Chapter 83 (N.J.S.A. 26:2H–1) Medicare outpatient payments shall be based upon:

(1) For 1993, total Chapter 83 outpatient payments will be derived by adding total 1993 approved cost for outpatients with rates to total 1991 approved cost for all patients without rates. The source of this data shall be the 1991 pro forma final reconciliations. 1991 Chapter 83 outpatient payments for Medicare patients shall be derived by multiplying the 1991 Medicare outpatient revenue percentage by the total Chapter 83 payments.

(2) For 1994, 1992 actual outpatient DPC costs shall be used to determine Chapter 83 outpatient payments. These DPC costs shall include indirect costs allocated to outpatients, and shall be apportioned to Medicare patients by applying the actual 1992 cost-to-charge ratio to Medicare outpatient charges from the 1992 Medicare cost reports.

(3) For 1994, most 1992 indirect costs were volume variable and included in the outpatient rates. For those 1992 indirect costs not allocated through the establishment of inpatient and outpatient rates,

those "other" indirect costs will be considered fixed and will be allocated to outpatients through the outpatient DPC percentage, and apportioned to Medicare outpatients based upon the Medicare percentage of total outpatient revenue. The source of the 1992 "other" indirect costs shall be 1992 Report 5, which expresses 1988 base year costs in 1992 dollars. The outpatient DPC shall be derived by allocating indirect costs to the inpatient and outpatient rates in accordance with the 1992 rate setting methodology. The outpatient DPC percentage shall be derived by dividing 1992 outpatient DPC into 1992 total DPC as defined in (a)3iv(2) above.

(4) Outpatient Part B physician costs shall be removed since no comparable Medicare data on payments is available.

vii. The DOH will use the following Medicare outpatient data from the applicable rate year Medicare cost reports:

(1) Medicare outpatient payments;

(2) Medicare outpatient revenue which shall be used to determine the Medicare outpatient percentages to apportion Chapter 83 (N.J.S.A. 26:2H–1) outpatient indirect costs; and

(3) Medicare outpatient Part B physician costs.

viii. The OUC formula is as follows: The sum of Chapter 83 (N.J.S.A. 26:2H–1) inpatient and outpatient payments as defined in (a)3iv and vi above, minus inpatient and outpatient payments as defined in (a)3v and vii above.

ix. The DOH will calculate the OUC subsidy payments based upon the formula in P.L. 1992, c.160, section 11 (N.J.S.A. 26:2H–18), as follows:

(1) In 1993, each hospital's actual 1991 OUC amount divided by its 1992 preliminary cost base shall yield a percentage called the OUC percentage. Forty-five percent of the hospitals with the highest OUC percentages will receive $100 million in OUC subsidy payments. For those hospitals qualifying for a share of the subsidy payments, in accordance with (a)3ix(2) below, each hospital's payment is determined by the hospital's OUC as a percentage of the sum of all eligible hospitals' OUC amounts; this hospital-specific percentage is multiplied by the Statewide subsidy amount to derive the hospital's subsidy payment.

(2) In 1994, each hospital's actual 1992 OUC amount divided by its 1993 revenue cap shall yield the OUC percentage. Thirty percent of the hospitals with the highest OUC percentage will receive $67 million in OUC subsidy payments. For those hospitals qualifying for a share of the subsidy payments, each hospital's payment is determined by the hospital's OUC as a percentage of the sum of all eligible hospitals' OUC amounts; this hospital-specific percentage is multiplied by the Statewide subsidy amount to derive the hospital's subsidy payment.

(3) In 1995, each hospital's actual 1992 OUC amount divided by its 1993 revenue cap shall yield the OUC percentage. Fifteen percent of the hospitals with the highest OUC percentages will receive $33 million in OUC subsidy payments. For those hospitals qualifying for a share of the subsidy payments, each hospital's payments is determined by the hospital's OUC as a percentage of the sum of all eligible hospitals' OUC amounts; this hospital-specific percentage is multiplied by the Statewide subsidy amount to derive the hospital's subsidy payment.

4. Hospitals eligible for additional disproportionate share payments may receive an additional payment adjustment determined by the Commissioner of the Department of Human Services from the Hospital Relief Subsidy Fund. This additional payment shall be based upon the facility's percentage of clients with AIDS, tuberculosis, substance abuse and addiction and complex births. Eligibility for such additional disproportionate share payments will be determined by the proportion of low income clients served by the hospital.

i. Effective for payments made on or after July 1, 1996, payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using hospital expenditure data for the most recent calendar year available in the following manner.

(1) Hospitals with a Hospital Relief Subsidy Eligibility Factor (HRSEF) above 30 percent, or which received a HRSF payment in the prior reimbursement period, shall continue to be eligible for a HRSF payment. A facility's annual HRSEF is equal to the sum of the facility's Charity Care Charges and the facility's Bad Debt Charges divided by the facility's revenue from private payers. The hospital-specific revenue from private payers shall be equal to the sum of the gross revenues, as reported to the Department of Health and Senior Services (DHSS), for all non-governmental third party payers including, but not limited to, Blue Cross and Blue Shield plans, commercial insurers and health maintenance organizations.

(2) The subsidy shall be an amount allocated by the Commissioner during the fiscal year for this purpose and shall be distributed in the following manner:

(A) The payments for admissions for the following categories are taken from the most recent hospital expenditure data maintained by the New Jersey Department of Health and Senior Services (DHSS):

HIV (MDC 24);

Mental Health (MDC 19);

Substance Abuse (MDC 20):

Complex Neonates (DRG 600 through 618, 622, 623, 626 or 627;

Tuberculosis as a major or minor diagnosis (ICD–9–CM; 010.0 through 018.9).

(3) The funding for the subsidy shall be distributed among eligible facilities based upon the following methodology:

(A) The Division will calculate an initial allocation for hospitals with an HRSEF at or above 30 percent. The initial allocation will be based upon the facility's percentage of payments for clients with the above five categories as a percentage of all payments for clients in these categories in hospitals with an HRSEF above 30 percent. All hospitals with an HRSEF below 30 percent will have an initial allocation of zero. The initial allocations will be modified as below:

(I) Final annualized allocations for hospitals with a HRSEF below 30 percent which had received an HRSF allocation in the prior year, will be established at 85 percent of the prior year's annualized allocation.

(B) Final annualized allocations for hospitals with a HRSEF at or above 30 percent will be established in the following manner:

(I) Initial annualized allocations which are greater than 85 percent of the prior year's annualized allocation but less than the prior year's annualized allocation shall be established at the initial annualized allocation;

(II) Initial annualized allocations which are less than 85 percent of the prior year's annualized allocation shall be established at 85 percent of the prior year's annualized allocation;

(III) Once the steps in (a)4i(3)(B)(I) and (II) above have been completed, this third and final step shall be calculated. Initial annualized allocations which are greater than the prior year's annualized allocation shall be established at the sum of the prior year's annualized allocation plus the remaining funds distributed proportionately according to the amount the initial annualized allocation is over the prior year's annualized allocation.

(4) Payments shall be distributed based on the final allocations as established in (a)4i(3) above.

5. Disproportionate Share Hospitals which service a large number of low income mentally ill or developmentally disabled clients may also be eligible to receive increased disproportionate share payment. The amount of payments to be made to facilities which serve a large number of mentally ill low income clients will be based upon recommendation by the Division of Mental Health and Hospitals within the Department of Human Services to the Commissioner of the Department of Human Services. This recommendation will identify hospitals essential to preserve the fragile network of mental health providers in the State. The Division of Developmental Disabilities may also recommend an additional payment to facilities who serve a large number of developmentally disabled clients. These additional payments will assure that these low income and special needs clients continue to have access to critical care.

i. The Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients shall be an amount allocated by the Commissioner during the fiscal year for this purpose. It shall be distributed in the following manner:

(1) Hospitals who receive funding from the Hospital Relief Subsidy Fund shall only be eligible for a payment from this fund if recognized by the Division of Mental Health and Hospitals and a Short Term Care Facility (STCF) or a Child Community Inpatient Service (CCIS). Payments to STCF and CCIS shall be based upon its distribution of beds for these services times a projection of the cost of providing the service in a state facility. Any hospital adding these beds will be eligible for payments from this fund. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year.

(2) Hospitals who are not STCF or CCIS, but which are under contract with the Division of Mental Health and Hospitals shall receive an allocation of funds based upon the percentage of services provided by the hospital as a percentage of all services provided by all hospitals. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year.

Amended by R.1994 d.432, effective August 15, 1994.
See: 26 N.J.R. 2241(a), 26 N.J.R. 3473(a).
Emergency Amendment, R.1994 d.440, effective August 1, 1994 (expired September 30, 1994).
See: 26 N.J.R. 3485(a).
Petition for Rulemaking.
See: 26 N.J.R. 3756(a).
Adopted Concurrent Proposal, R.1994 d.536, effective September 29, 1994.
See: 26 N.J.R. 3485(a), 26 N.J.R. 4392(a).
Amended by R.1995 d.13, effective January 3, 1995.
See: 26 N.J.R. 2239(a), 27 N.J.R. 152(a).
Petition for Rulemaking.
See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).
Emergency amendment R.1996 d.425, effective August 13, 1996 (to expire October 12, 1996).
See: 28 N.J.R. 4115(a).
Adopted concurrent amendment, R.1996 d.520, effective October 11, 1996.
See: 28 N.J.R. 4115(a), 28 N.J.R. 4805(c).

SUBCHAPTER 9. REVIEW AND APPEAL OF RATES

10:52–9.1 Review and appeal of rates

(a) All hospitals, within 15 working days of receipt of the Proposed Schedule of Rates shall notify the Division of any calculation errors in the rate schedule. If upon review it is determined by the Division that the error is of substantial value, a revised rate will be issued to the hospital within 10 working days. If the discrepancy is determined to be substantial and a revised Schedule of Rates is not issued by the Division within 10 working days, notification time frames above will not become effective until the hospital received a revised Schedule of Rates.

(b) Any hospital which seeks an adjustment to its rates must agree to an operational review at the discretion of the Department of Human Services.

1. A request for a rate review must be submitted by a hospital in writing to the Department of Human Services, Division of Medical Assistance and Health Services, Office of Budget, Fiscal Affairs and Information Systems, CN 712, Mail Code # 23, Trenton, New Jersey 08625–0712 within 20 calendar days after publication of the rates by the Department of Human Services (DHS).

i. A hospital shall identify its rate review issues and submit supporting documentation in writing to the Division within 80 calendar days after publication of the rates by the DHS.

2. The Division will not approve an increase in a hospital's rates unless the hospital demonstrates that it would sustain a marginal loss in providing inpatient services to Medicaid recipients at the rates under appeal even if it were an economically and efficiently operated hospital. Marginal loss is the amount by which a hospital's rate year's Medicaid reimbursement for inpatient services is expected to fall short of the incremental costs, defined as the variable or additional out-of-pocket costs, that the hospital expects to incur providing inpatient hospital services to Medicaid patients during the rate year. These incremental costs are over and above the inpatient costs the hospitals would expect to incur during the rate year even if it did not provide service to Medicaid patients. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid beneficiaries and the extent to which it has taken all reasonable steps to contain or reduce the costs of providing inpatient hospital services. The hospital may be required at a minimum to submit to the Department of Human Services, the following information:

i. Operational reviews;

ii. Efficiency studies and reports identifying opportunities for cost savings;

iii. Minutes of the meeting of the hospital's board of directors and board's finance committee;

iv. Reports of the Joint Commission on the Accreditation of Health Care Organizations;

v. Management letters;

vi. The hospital's strategic plans, long range plans, facilities plans and marketing plans;

vii. The hospital's annual report;

viii. Any analyses of the hospital's marginal cost in providing services to Medicaid or other categories of patients;

ix. Cost accounting documentation or reports pertaining to the hospital's cost incurred in treating Medicaid recipients or the comparative cost of treating Medicaid and other patients;

x. A copy of the hospital's most recent Medicare cost report with all supporting schedules;

xi. Contracts with other payors providing for negotiated rates or discounts from billed charges; and

xii. Evidence that the appealed rates jeopardize the long term financial viability of the hospital (that is, that the hospital is sustaining a marginal loss in treating Medicaid recipients) and that the hospital is necessary to provide access to care for Medicaid recipients.

(c) The Division shall review the documentation and determine if an adjustment is warranted.

(d) The Division shall issue a written determination with an explanation as to each request for a rate adjustment. If a hospital is not satisfied with the Division's determination, they may request an administrative hearing pursuant to N.J.A.C. 10:49–10. If a hospital elects to request an administrative hearing, the request must be made within 20 calendar days from the date the Division's determination was received by the hospital. The Administrative Law Judge will review the reasonableness of the Division's reason for denying the requested rate adjustment based on the documentation that was presented to the Division. Additional evidence and documentation shall not be considered. The Director of the Division of Medical Assistance and Health Services shall thereafter issue the final agency decision either adopting, modifying or rejecting the Administrative Law Judge's initial Office of Administrative Law decision. Thereafter, review may be had in the Appellate Division.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).
Amended by R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).
Added (b)2, inserted provisions defining marginal loss and incremental costs; and in (d), inserted provision providing time period for an administrative hearing request.

Case Notes

Existence of state's administrative process did not preempt hospital association's action to enjoin state from using its revised rate setting methodology for general inpatient hospital services. New Jersey Hosp. Ass'n v. Waldman, C.A.3 (N.J.)1995, 73 F.3d 509.

Regulations promulgated by state department of human services regarding hospital rates for Medicaid patients were valid where they allowed hospitals to challenge impact of designation of labor market areas as part of rate adjudication process. Matter of Adoption of N.J.A.C. 10:52–5.14(d)2 and 3, 276 N.J.Super. 568, 648 A.2d 509 (A.D.1994), certification denied 142 N.J. 448, 663 A.2d 1355.

SUBCHAPTER 10. CHARITY CARE

Authority

N.J.S.A. 30:4D–6a(1), 30:4D–7, 7a, b, and c; 30:4D–12, P.L.1992, c. 160; N.J.S.A. 26:2H–5 and 13.

Source and Effective Date

R.1995 d. 258, effective May 15, 1995.
See: 27 N.J.R. 656(a), 27 N.J.R. 1995(a).

10:52–10.1 Charity care audit functions

(a) The Department of Health shall conduct an audit of acute care hospitals' charity care reported as written-off each calendar year. The Department of Health shall audit charity care at least once, but no more than six times each calendar year.

(b) The Department of Health shall make a monthly report to the Essential Health Services Commission on charity care. This report shall include any adjustments made pursuant to N.J.A.C. 10:52–10.14 or approvals made pursuant to N.J.A.C. 10:52–10.8(c) and (d).

10:52–10.2 Sampling methodology

(a) The Department of Health shall audit charity care claims based on a sample which will be developed in the following way:

1. Hospitals shall maintain their charity care list in a way that will allow the Department of Health to select unduplicated accounts for unit dollar sampling on a quarterly basis. The unit dollar sampling method used to select the accounts for audit is explained in the "Handbook of Sampling for Audit and Accounting" (3d edition), by Herbert Arkin. The list shall include patient name, account number, write-off date, and write-off amount. Hospitals shall rank all charity care accounts from the smallest to the largest, based on the rate that Medicaid would have paid for each account, and run a cumulative dollar balance on the list. For 1995, a hospital may report accounts either at the Medicaid rate or gross charges provided that the reporting is done consistently throughout the year.

2. Once the selection of sample dollars has been completed and the associated patient accounts have been identified, hospitals will be required to retrieve the patient account files according to the following schedule:

Number of files to be retrieved	Time to retrieve
0–500 files	One week
501–1100 files	Two weeks
1101–1800 files	Three weeks
1801 files and above	Four weeks

(b) The Department of Health shall require hospitals to make a small number of additional charity care accounts available upon audit.

(c) The hospital shall provide the audit list to the Department of Health no later than 30 days from the request date. If the hospital does not submit its audit list to the Department by the 30 day deadline, the Department shall assess a penalty of $2,500 per day for each day after the deadline.

10:52–10.3 Charity care write off amount

(a) The Department of Health shall value charity care claims at the Medicaid rate by multiplying the hospital's actual charity care service charges by the hospital-specific ratio of Medicaid payments to hospital charges. For write-off and billing purposes, the hospital shall use the following procedures:

1. Charity Care Write Off Amount equals Charity Care Eligibility Percentage, as determined by N.J.A.C. 10:52–10.7(b)–(c), multiplied by the Medicaid payment rate.