CHAPTER 52

HOSPITAL SERVICES MANUAL

Authority

N.J.S.A. 30:4D-6a(1), 30:4D-7, 7a, b, c, and e; 30:4D-12, P.L. 1992, c.160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 447.251, 253.

Source and Effective Date

R.1995 d.123, effective February 3, 1995.
See: 26 N.J.R. 4551(a), 27 N.J.R. 1660(a).

Executive Order No. 66(1978) Expiration Date

Chapter 52, Hospital Services Manual, expires on February 3, 2000.

Chapter Historical Note

Chapter 52, originally Manual for Hospital Services, became effective with Subchapter 1, Coverage, and Subchapter 2, Admission and Billing Procedures, adopted as R.1971 d.30, effective March 5, 1971. See: 3 N.J.R. 24(b), 3 N.J.R. 62(c). Subchapter 3, Teleprocessing Procedures, was adopted as R.1975 d.230, effective August 1, 1975. See: 7 N.J.R. 316(b), 7 N.J.R. 431(b).

Pursuant to Executive Order No. 66(1978), Subchapter 1 was readopted as R.1984 d.47, effective February 9, 1984. See: 15 N.J.R. 2125(a), 16 N.J.R. 424(b). Pursuant to Executive Order No. 66(1978), Subchapter 2 was readopted as R.1985 d.56, effective January 28, 1985. See: 16 N.J.R. 3159(a), 17 N.J.R. 451(a). Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1990 d.157, effective February 8, 1990. See: 21 N.J.R. 3911(a), 22 N.J.R. 799(b).

Subchapter 4, HCFA Common Procedure Coding System (HCPCS), was adopted as R.1993 d.327, effective August 17, 1992, but operative September 1, 1992. See: 24 N.J.R. 917(a), 24 N.J.R. 2898(a). Pursuant to P.L. 1992, c. 160; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a; 42 C.F.R. 447.251, 253 and the authority cited above Subchapter 5, Procedural and Methodological Regulations; Subchapter 6, Financial Reporting Principles and Concepts; Subchapter 7, Diagnosis Related Groups (DRG); Subchapter 8, Basis of Specific Payment for Disproportionate Share Hospitals, and Subchapter 9, Review and Appeal of Rates, were adopted as Emergency New Rules R.1993 d.154, effective March 11, 1993 (to expire May 10, 1993). See: 25 N.J.R. 1582(a). The provisions of R.1993 d.154 were readopted as R.1993 d.263, effective May 10, 1993, with changes effective June 7, 1993. See: 25 N.J.R. 2560(a).

Pursuant to Executive Order No. 66(1978), Chapter 52 was readopted as R.1995 d.123. See: Source and Effective Date. As a part of R.1995 d.123, Chapter 52 was retitled Hospital Services Manual; existing Subchapters 1 through 4 were repealed, and new Subchapters 1 through 4 were adopted, effective April 17, 1995; and Subchapter 10 was adopted as new rules, effective April 17, 1995. See, also, section annotations.

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APPENDIX

SUBCHAPTER 1. GENERAL PROVISIONS

10:52–1.1 Purpose and scope

This chapter of the Hospital Services Manual outlines the policies and procedures of the Division for the provision of inpatient and outpatient (including emergency room) hospital services to Medicaid recipients. The hospitals that are included in these policies and procedures are general hospitals, special hospitals, rehabilitation hospitals and private psychiatric hospitals, unless specifically indicated otherwise.

Petition for Rulemaking.
See: 27 N.J.R. 1818(b), 27 N.J.R. 2014(c).

10:52–1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Adjusted admissions" means inpatient admissions increased to reflect outpatient activity, which is calculated by admissions multiplied by total gross revenue divided by inpatient gross revenue.

"Base year" means the year from which historical cost data are utilized to establish prospective reimbursement in the rate year.

"Bundled drug service" means a drug that is marketed or distributed by the manufacturer or distributor as a combined package which includes in the cost of the drug, the drug product and ancillary services, such as, but not limited to, case management and laboratory services.

"Current Cost Base" means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period for the purposes of rate setting.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications, and consumption of a similar amount of resources.

"Division" means the New Jersey Division of Medical Assistance and Health Services within the New Jersey Department of Human Services.

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid recipients under 21 years of age for the purpose of assessing a recipient's health needs through initial and periodic examinations, health education and guidance, and identification, diagnosis, and treatment of health problems.

"Entity," as used in N.J.A.C. 10:52–1.2A, means an outpatient department not contiguous to a main inpatient hospital for which that hospital is attempting to seek recognition and reimbursement as an outpatient hospital service.

"Equalization Factor" means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs in setting Statewide standard costs per case.

"Financial Elements" means the reasonable cost of items approved as reimbursable under Medicaid (see N.J.A.C. 10:52–5.10).

"Grouper" means the logic that assigns cases into the appropriate Diagnosis Related Groups in accordance with the clinical and statistical information supplied.

"Hospital" means an institution which is primarily engaged in providing the following services to inpatients, by or under the supervision of physicians:

1. Diagnostic services and therapeutic services for the prevention, medical diagnosis, treatment, and care of injured, disabled or sick persons, including obstetrical services and services to the normal newborn; or,

2. Rehabilitative services for the rehabilitation of injured, disabled, or sick persons; and that

3. Maintains clinical records on all patients;

4. Has by-laws in effect with respect to its staff of physicians;

5. Requires every patient to be under the care of a physician;

6. Provides 24–hour nursing services rendered or supervised by a registered professional nurse, and has a registered professional nurse or licensed practical nurse on duty at all times;

7. Has in effect a hospital utilization review plan that meets the requirement of the law (Sec. 1861(K) of the Social Security Act); and has in place a discharge planning process that meets the requirements of the law (Sec. 1861(ee)) of the Social Security Act;

8. Is licensed as a hospital in the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located, or approved by the agency of the state or locality responsible for licensing hospitals meeting the standards established for such licensing;

9. Meets any other requirements that the U.S. Secretary of Health and Human Services finds necessary in the interest of health and safety of individuals who furnished services in the institution; and

10. For the purposes of N.J.A.C. 10:52–1.2A only, is where the main inpatient hospital services are located.

"Hospital (Approved General)" means an institution which is approved to participate as a provider in the Division if it:

1. Is licensed as a general hospital by the State of New Jersey, or licensed as a hospital by the appropriate agency under the laws of the respective state in which the hospital is located; (NOTE: When only a specific identifiable part of a multi-service institution is licensed, only the section licensed is considered a Medicaid provider);

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act);

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

4. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

"Hospital (Approved Private Psychiatric)" means an institution which is approved to participate as a provider in the Division and:

1. Is licensed by the State of New Jersey as a psychiatric (mental-non-governmental) hospital or licensed as a private psychiatric hospital (non-governmental) by the appropriate agency under the laws of the respective state in which the hospital is located;

2. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a psychiatric hospital;

3. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX);

4. Meets the special Medicare standards relative to staffing requirements and clinical medical records; and,

5. Has signed a provider agreement to participate in and abide by the rules of the Division and applicable Federal regulations.

"Hospital (Approved Private Psychiatric) facility that provides inpatient services to children under 21 years of age" means an institution that shall meet the requirements of 1., 2., 3., 4. and 5. above, listed in the definition of "Hospital (Approved Private Psychiatric): or in addition to 1. and 5. above, has facility accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO).

"Hospital (Approved Special)" means an institution which is approved by the New Jersey State Department of Health as a special hospital (for definition of special hospital, see N.J.A.C. 8:43G–1.3(b)2) and which includes any hospital which assures the provision of comprehensive specialized diagnosis, care, treatment and rehabilitation, where applicable, on an inpatient basis for one or more specific categories of patients; and approved to participate as a provider in the Division if it meets the appropriate standards of participation for one of the following classifications:

(a) Special (Acute care or short term) or Comprehensive Rehabilitation Hospital:

1. Licensed as a special or comprehensive rehabilitation hospital by the New Jersey Department of Health;

2. Accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or the Commission on Accreditation as a hospital or rehabilitation facility; and/or

3. Meets the requirements for participation and certification under Medicare (Title XVIII of the Social Security Act) as a hospital;

4. Has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Medicaid (Title XIX); and,

5. Has signed a provider agreement to participate in and abide by the rules of the Division and all applicable Federal regulations.

"Informed Consent" means the voluntary knowing assent from the individual on whom any sterilization is to be performed after he or she has been given (as evidenced by a document executed by such individual) and has been given:

1. A fair explanation of procedures to be followed;
2. A description of attendant discomforts and risks;
3. A description of benefits to be expected;

3. Determination of Labor Unequalization Factor to Calculate Standard Cost Per Case of Each Labor Market Area.

i. An unequalization factor shall be calculated for the non-physician direct patient care costs of each hospital to account for differing prevailing compensation patterns across New Jersey's Labor Market Areas in the comparison of hospital and standard costs per case. The Statewide standard times the unequalization factor is the unequalized standard in terms of the hospital's Labor Market Area.

ii. The reciprocal of the hospital's equalization factor is the hospital's unequalization factor and is applied to non-physician costs only.

(f) Effective for services provided on or after October 1, 1996, GME and IME shall no longer be reimbursed through the Medicaid hospital inpatient DRG rates. After all indirect costs have been fully allocated to the using cost centers, GME and IME costs shall be removed from the cost base before calculating the standards and Medicaid hospital inpatient rates. GME and IME shall be reimbursed in accordance with N.J.A.C. 10:52–12.

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).
Substantially amended section.

Law Review and Journal Commentaries

Hospitals. Steven P. Bann, 138 N.J.L.J. No. 9, 52 (1994).

Case Notes

Burden was on hospitals to show that regulations governing hospital rates for Medicaid patients were invalid. 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.

Division of Medical Assistance and Health Services, was not obligated to use components of Medicare rate methodology with respect to Medicaid program. 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.

Regulations governing hospital rates for Medicaid patients were valid. 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.

10:52–5.15 Reasonable direct cost per case

(a) Inpatient direct cost per case shall be determined as follows:

1. The reasonable direct cost per Medicaid case for those hospitals receiving rates in accordance with this subchapter for every DRG shall include incentives and disincentives, as appropriate, which shall be termed the boundaries of payment and are calculated as follows:

i. Effective for services provided prior to October 1, 1996, the incentive standard is multiplied by the unequalization factor, the physician mark-up, the deneutralization factor, and Residents adjustment factor.

ii. Effective for services provided on or after October 1, 1996, the incentive standard is multiplied by the unequalization factor and the physician mark-up.

(b) Inpatient outliers: The costs of low length of stay outliers shall be divided by the low length of stay days to arrive at a low per diem. The costs of high length of stay outliers shall be divided between both high outlier cost and the inlier rate. The high outlier cost net of the inlier rate times the high outlier cases shall be divided by the acute days of the patient's total stay (admission to discharge) to arrive at a high outlier per diem. High outlier cases shall be reimbursed the inlier rate plus the high per diem multiplied by the acute days of the stay.

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).
In (a)1i, inserted text "Effective for services provided prior to October 1, 1996"; and added (a)1ii.

10:52–5.16 Net income from other sources

(a) The net gain (loss) from Other Operating and Non–Operating Revenues (as defined in N.J.A.C. 10:52–6.27 through 6.34) and expenses of the reporting period which are items considered as recoveries of or increases to the Costs Related to Patient Care (see N.J.A.C. 10:52–6.27 through 6.34) as reported to the Division is subtracted from (added to) indirect costs of the Preliminary Costs Base.

(b) Such revenue shall include all Other Operating and Non–Operating Revenues and Expenses reported per Standard Hospital Accounting and Rate Evaluation (SHARE) cost center costs and "expense recoveries" as Case B and all other items reported as to their case specified in N.J.A.C. 10:52–6.27 through 6.34.

10:52–5.17 Update factors

(a) The economic factor is the measure of the change in prices of goods and services used by New Jersey hospitals. The economic factor will be the factor recognized under the TEFRA target limitations.

(b) The technology factor takes into account the costs of adopting quality enhancing technologies.

1. The hospital-specific economic factor is the weighted average of the recorded and projected change in the value of its components. The weight given to each component is its share of that hospital's total expenditure. The projection of individual components shall be based, where appropriate, on legal or regulatory changes which fix the future value of a proxy. Components which are of particular importance may be projected through the use of time series analysis on other relevant indicators.

(c) Base-year direct patient care and indirect rates shall be multiplied in succeeding years by a technology factor to provide prospective funds to support hospital adoption of quality-enhancing technologies. The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost-increasing technologies, and ProPAC's allowance for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC.

(d) In addition, the following payment rates will be in effect for these special procedures:

1. Liver Transplants: payment for DRG 480 will be $72,139 in 1988 dollars.

2. Heart Transplants: payment for DRG 103 will be $72,438 in 1988 dollars.

3. Cochlear Implants: payment for DRG 759 will be $21,608 in 1988 dollars.

4. Bone Marrow Transplants: payment for DRG 481 will be $46,599 in 1988 dollars.

5. Neonate rates: payment for neonatal DRGs as defined by New Jersey Grouper 8.0 will be based on 1989 actual New Jersey patient volume.

(e) For determination of the payment rates, direct patient care is increased for the following components:

1. Indirect patient care for items other than listed in N.J.A.C. 10:52–5.11;

2. Health Planning fees;

3. Capital facilities allowance;

4. Physician fee for service;

5. Child psychiatric hospital direct and indirect;

6. Resident count correction (only for services provided prior to October 1, 1996).

7. Special perinatal expense adjustment;

8. Trauma center adjustment;

9. GME reversal (only for services provided prior to October 1, 1996);

10. Hemophilia adjustment;

11. Regional perinatal adjustment;

12. Personnel health allowance;

13. Pediatric rate adjustment;

14. Sickle cell adjustment;

15. Continuous adjustments;

16. Outlier reversal adjustment; and

17. Poison Control Costs.

(f) No Statewide transition adjustment not otherwise specified in this chapter will be included in the rate.

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).
In (a)6 and (a)9, added text "(only for services provided prior to October 1, 1996)".

10:52–5.18 Capital facilities

(a) Capital Facilities, as defined in N.J.A.C. 10:52–6.18, shall be included in the rate in the following manner:

1. Building and fixed equipment:

i. The yearly Capital Facilities Allowance is computed using information provided by the Share Cost Reports. For hospitals on a calendar year basis, this amount will be its 1992 depreciation and interest expense, excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery. For those hospitals on a fiscal year basis, actual year's depreciation and interest applicable to rate year 1992 shall be used excluding any portion associated with major moveable equipment and any interest income reported as an expense recovery.

ii. Effective for services provided on or after October 1, 1996, all building and fixed depreciation and interest capital costs as defined in N.J.A.C. 10:52–6.18 related to GME programs shall be determined based on the 1992 audited Medicare Cost Report (HCFA–2552) and shall be excluded from the base year cost used to calculate the Medicaid DRG inpatient rates.

2. Major Moveable Equipment: For the purpose of calculating the Price Level Depreciation Allowance, Major Moveable Equipment is grouped into four categories based on the cost center function where the equipment is utilized: Beds and nursing equipment; Diagnostic and therapeutic equipment; General service equipment; and Business service equipment.

i. The following rules shall apply in calculating the Price Level Allowance for a given year:

(1) Only equipment which has not been fully depreciated at the start of the fiscal year is to be used in the calculation of the Price Level Allowance.

(2) The depreciation recorded and reported on all equipment subject to the Price Level Allowance must be calculated by the straight-line method, using at the time of the cost filing the most recent approved American Hospital Association (AHA) Recommended Useful Life (that is, 1978 revision) or Asset Depreciation Range (ADR).

(3) Only capitalized equipment and related capitalized costs can be used in the calculation of the Price Level Allowance.

(4) The price level factors for each of the four categories will be developed by the Division. For years prior to current cost base year, the factors to be used for price leveling depreciation are as follows:

Category	Proxy
Beds and Nursing Equipment	Marshall and Swift Hospital Equipment Cost Index
Diagnostic and Therapeutic Equipment	Marshall and Swift Hospital Equipment Cost Index
General Service Equipment	Producer Price Index (PPI) 1161, Food Products Machinery (41.18%), PPI 1241.02, Laundry Equipment (23.53%). PPI 113 less 1134 and 1136, Metalworking Machinery less Industrial Furnaces and Abrasive Products (35.29%).
Business Service Equipment	PPI 1193 less 1193.06, Business and Store equipment (less Coin Operated Vending Machines) and PPI 122, Commercial Furniture.

(5) Assets retired before the close of the fiscal year are not to be used in the calculation of the Price Level Allowance.

(6) The amount of the Price Level Allowance shall be calculated as follows:

(A) Current year straight-line depreciation of each asset being depreciated is multiplied by the price level factor corresponding to the year the asset was acquired to determine price level depreciation. Straight-line depreciation is then subtracted from price level depreciation and the result totaled to determine the amount of the Price Level Allowance provided by the following calculation: Algebraically the calculation is as follows:

D ... (equals) Current year depreciation, ordered by the year of acquisition of the asset being depreciated.
F ... (equals) Price level factor for the year the asset was acquired.
PLA ... (equals) Price Level Allowance.
PLA ... (equals) $(D \times F) - D$.

(7) The interest component of cash disbursements relative to capitalized Major Moveable Equipment leases is to be classified as interest expense, in accordance with GAAP, and not used as a basis for calculating the price level depreciation premium.

(8) The total Price Level Allowance will be allocated to cost centers based upon the accumulated depreciation of all Major Moveable Equipment not fully depreciated.

(b) Any new capital facilities construction with a valid certificate of need from the New Jersey Department of Health and Senior Services may request a capital facilities adjustment in rates through the review and appeal process as described in N.J.A.C. 10:52–9 except that a hospital which meets the requirements of (b)1 below may request a capital facilities adjustment in accordance with (b)2 below.

1. A hospital may submit an appeal specific to its CFA without going through the full rate review process, if:

i. The appeal is for a single capital project in excess of $20 million which is for replacement beds which reduce the number of hospital beds available in the State and as of September 15, 1997, the hospital has an approved certificate of need for this project;

ii. The hospital receives no direct State appropriation; and

iii. The hospital has a 1995 percentage of low income revenue greater than 50 percent. The low income revenue percentage shall be based on revenue data as reported on the submitted 1995 New Jersey Hospital Cost Report, after desk audit. The low income revenue percentage shall be based on the sum of the Medicaid revenue as reported on Forms E–5 and E–6, line 1, column E, plus the Charity Care revenue as reported on Forms E–5 and E–6, line 1, column J, divided by the sum of the total revenue as reported on Forms E–5 and E–6, line, column M.

2. If all of the conditions in (b)1 above are met, the hospital shall submit all supporting documentation to the Department of Human Services, Division of Medical Assistance and Health Services, Administrative and Financial Services, PO Box 712, Mail Code #42, Trenton, New Jersey 08625–0712. The Division shall issue a written determination once the supporting documentation is reviewed and the hospital may appeal the determination pursuant to N.J.A.C. 10:52–9.1(d).

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).
Deleted (a)1i, relating to capital cash requirements; recodified former (a)1ii as (a)1i and deleted subparagraph 1 of that paragraph; and inserted new (a)1ii.
Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).
In (b), added the exception; and added (b)1 and (b)2.

10:52–5.19 Division adjustments and approvals

(a) Any modifications including any statutory or regulatory changes or changes in patient care physician compensation arrangements shall be classified as direct or indirect, and as to the financial elements affected and each element adjusted proportionately.

(b) The Division shall also approve adjustments to hospitals' Schedules of Rates for 1993 and subsequent years as necessary to subtract approved costs associated with residents not meeting the minimum requirements as defined in

N.J.A.C. 10:52–5.14(b); for any costs associated with residents in programs which have lost accreditation as defined in N.J.A.C. 10:52–5.14(b); and for any costs associated with previously approved but now vacant residency positions which are unfilled as a result of a hospital's inability to recruit residents meeting these minimum standards. These costs shall include, but are not limited to, resident salaries and fringes, faculty salaries, malpractice and supplies.

(c) The Division may approve hospital appeals to transfer Division approved resident positions and associated costs between hospitals. A hospital may appeal under any option to reduce or increase the number of resident positions by transfer. An addition of resident positions by transfer may not result in a change to a higher teaching status peer group. A reduction of resident positions by transfer may result in a change to a lower teacher status peer group. The approved costs associated with a transferred resident position may not increase solely as a result of the transfer.

(d) The Division shall decide to which hospitals the approved resident positions and associated costs may be transferred.

(e) Subsections (a) through (d) above apply for dates of services provided prior to October 1, 1996. Effective for services provided on or after October 1, 1996, this section is no longer applicable.

Amended by R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).
Added (e).

10:52–5.20 Derivation from Preliminary Cost Base

(a) Apportionment of Financial Elements based on direct costs shall be as follows:

1. All other Financial Elements are added to direct Medicaid patient care costs as percentages of direct costs per Medicaid case. The Schedule of Rates is set such that all Medicaid patients' rates are based on the cost of services received by Medicaid recipients, including a proportionate share of indirect financial elements requirements of operating hospital facilities.

2. In the event that a hospital is self-insured for employee health benefits, the percentage of personnel health allowance recognized in the rates shall be proportioned to the number of Medicaid recipients serviced by the facility to financial elements from payers for such costs.

3. Each hospital shall receive from the Division a base rate order detailing the Schedule of Rates.

Amended by R.1995 d.141, effective March 6, 1995.
See: 27 N.J.R. 34(a), 27 N.J.R. 908(a).

10:52–5.21 Schedule of rates—effective date

All rates pursuant to this subchapter, as approved or modified, shall be effective as of October 1, 1996, of the rate year and then January 1 for subsequent rate years except for fiscal year hospitals whose rates shall be effective as of the first day of the "fiscal" rate year.

Amended by R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).
Amended effective date.

SUBCHAPTER 6. FINANCIAL REPORTING PRINCIPLES AND CONCEPTS

10:52–6.1 Reporting period

(a) The basic reporting period is the 12 consecutive calendar months utilized for Medicare reporting in the year prior to the hospital's first Medicaid rate.

(b) New hospitals beginning operations on any day other than January 1 must select an initial reporting period beginning on the first day of operation, through the last month preceding the hospital's fiscal year.

(c) Each calendar year's Financial Elements Reporting Forms are due on May 31 of the following year. Each year's Audited Financial Statement is due on May 31 of the following year.

10:52–6.2 Objective evidence

(a) Information produced by the accounting process should be based, to the extent possible, upon objectively determined facts. Transactions should be supported by properly executed documents such as charge slips, purchase orders, suppliers' invoices, cancelled checks, etc. Such documents serve as objective evidence of transactions and should be retained as a source of verification of the data in the accounting records.

(b) Certain determinations that enter into accounting records are based on estimates. Such estimates should be based on past experience modified by expected future considerations. Items of Other Operating Expenses, if not directly classified by the hospital, if large in amount, must be identified through a cost study, and if small in amount, costs may be deemed equal to revenue and such costs apportioned among the appropriate natural classifications of expense based on the hospital's estimate or the classifications of the center where the costs originated. Worksheets are provided along with Reporting Schedules to aid the hospital in making all appropriate reclassifications. All such reclassifications should be consistent with the concept of materiality, as defined in N.J.A.C. 10:52–6.5.

(c) Books, papers, records, or other data relevant to matters of hospital ownership, organization, and operation must be maintained. The data must be maintained in an ongoing recordkeeping system which allows the data to be readily verified by qualified auditors.

10:52–6.3 Consistency

(a) Consistency refers to continued uniformity during a period and from one period to another in methods of accounting, mainly in valuation bases and methods of accrual, as reflected in the financial statements of an accounting entity. Consistency is very important to the development and analysis of trends on a year to year basis and as a means of forecasting. However, consistency does not require continued adherence to a suboptimal method or procedure. Any change of accounting procedure, consistent with the materiality principle, must be brought to the attention of the Division by way of a cover letter which will accompany the hospital's Financial Elements Report to include both a description and analysis of reporting impact of such accounting procedure changes.

1. As an example, the accounting principle of accrual reporting may cause some hospitals who currently account for vacation on a cash basis to incur a one time reporting of expenses related to vacation time earned by employees but not yet taken. Such one time costs must be included in a cover letter and the Financial Elements Report shall identify only those vacations costs accrued in the current reporting period.

(b) Any accounting and reporting changes due to subsequent revisions of this plan or the documents referred to herein shall be reported in accordance with the instructions which accompany those revisions.

10:52–6.4 Full disclosure

The concept of full disclosure requires that all significant data be clearly and completely reflected in accounting reports. For example, if a hospital were to change its method of accounting for certain transactions, and if the change was a material effect on the reported financial position the nature of the change in method and its effect must be disclosed when reporting costs. No fact that would influence the decisions of management, the governing board, or other users of financial statements shall be omitted from or concealed in accounting reports.

10:52–6.5 Materiality

An amount is material if its exclusion from the financial statements would cause misleading or incorrect conclusions to be drawn by users of the statements.

10:52–6.6 Basis of valuation

(a) Historical cost is the basis used in accounting for the valuation of all assets and in recording all expenses (except fair market value in the case of donated non-cash goods and services). Historical cost, simply defined, is the amount of cash or cash equivalents given in exchange for properties or services at the time of acquisition. It is the basis for the valuation of assets and for the recording of most expenses. Cost ordinarily has been the basis of accounting for assets and expenses because it is a permanent and objective measurement that reflects the accountability of management for the utilization of hospital funds.

(b) Although the basis for developing capital-related financial elements shall be Division approved replacement costs of plant and equipment, where appropriate, hospitals shall be required to maintain records and report assets and related depreciation according to both historical values and price leveled values as prescribed in this plan.

(c) Long-term investments shall be reported at current market value as with corresponding income or loss reported as realized or unrealized.

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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.

(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 hospital as eligible for additional disproportionate share payments if it is determined that the hospital provides a high percentage of care (as defined in N.J.A.C. 10:52–8.2(a)4i(1)) in proportion to total operating revenue to patients with HIV, mental illness, tuberculosis, substance abuse and addiction or neonatal complexity. In addition, to be designated as eligible for this additional disproportionate share payment, the facility shall have a high Charity Care plus Medicaid utilization rate (as defined in N.J.A.C. 10:52–8.2(a)4i(1)). A facility shall further demonstrate a commitment to the establishment and operation of a managed care program for the uninsured and other low income persons.

Amended by R.1997 d.92, effective February 18, 1997.
See: 28 N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).
Substantially amended (d).
Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).
In (a), deleted the third sentence.

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 of the Department of Health and Senior Services in consultation with the Commissioner of the Department of Human Services and, as to (a)4 through 6 below, by the Commissioner, Department of Human Services based upon a determination regarding payments for charity care. The annual DSH payments shall be calculated and distributed in accordance with all applicable Federal laws and regulations.

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 Department of Health and Senior Services (DHSS) 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.

(6) For periods in which the data source excludes Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) in the Medicaid rate, the Medicaid rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. These GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid rate adjustment. For the purpose of pricing charity care claims under this section, unless otherwise indicated, the Medicaid rate shall be defined as the Medicaid rate in effect on the date of discharge. The add-ons shall be calculated as follows:

(A) The GME add-on shall be calculated as follows:

(I) For charity care payments made in calendar year 1998, the charity care GME add-on shall be calculated based on charity care's share of the teaching hospital's aggregate approved GME amount from Worksheet E–3 Part IV as reported on the 1996 submitted Medicare cost report. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, divided by the sum of the hospital's total gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, after desk audit. The resulting charity care GME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996, and shall be based on the percentage of charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

(II) For charity care payments made in calendar years after 1998, the charity care GME add-on shall be calculated based on the charity care share of the teaching hospital's aggregate approved GME amount from Worksheet E–3 Part IV as reported on the most recent submitted Medicare cost report. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, divided by the sum of the hospital's total gross charges from the New Jersey Hospital Cost Report as reported on Forms E–5 and E–6, after desk audit.

(B) The IME add-on shall be calculated as follows:

(I) For charity care payments made in calendar year 1998, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the 1996 Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the 1996 Medicare submitted cost report. This charity care IME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996. (Charity care claims are priced at the Medicaid rate in effect when the services are rendered.) This adjustment shall be based on the percentage of inpatient charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

(II) For charity care payments made in calendar years after 1998, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

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 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 HIV, mental health, tuberculosis, substance abuse and addiction and complex neonates.

i. Payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the most recent calendar year hospital expenditure data available as of October 1 of each year preceding the distribution year. For the purpose of pricing the problem billed cases listed at (a)4i(2)(A) below, the Medicaid rate shall be defined as the rate in effect as of October 1 of each year preceding the distribution year.

(1) For purposes of determining which hospitals are eligible for payment from the HRSF, a hospital shall satisfy both of the two following independent criteria:

(A) The hospital's cases for the seven categories listed at (a)4i(2)(A) below, priced at the Medicaid rate, divided by the hospital's Total Operating Revenue, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey hospitals receiving Medicaid payments. For periods in which the data source excludes GME and IME in the rate, the Medicaid rate shall be adjusted by hospital-specific GME and IME add-ons. The hospital-specific GME and IME add-ons shall be calculated as defined in (a)4i(4) below; and

(B) The hospital's Charity Care days plus the hospital's Medicaid days, divided by the hospital's total days, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey hospitals receiving Medicaid payments.

(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) as of October 1 of each year preceding the distribution year:

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);

Mothers with substance abuse (MDC 14 with the following codes: ICD–9–CM; 6483, 6555, 304, 305); and

HIV as a secondary diagnosis (excluding MDC 24; including ICD–9–CM; 0420 through 0422, 0429 through 0433, 0439, 0440, 0449).

(3) The funding for the subsidy shall be distributed among eligible facilities based upon the hospital's percentage of payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)4i(4) below, for patients with the categories in (a)4i(2)(A) above as a percentage of all payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)4i(4) below, for patients in these categories in eligible hospitals.

(4) For periods in which the data source excludes GME and IME costs in the Medicaid rate, the Medicaid rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified in this section, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid rate. The add-ons shall be calculated as follows:

(A) A hospital-specific GME add-on shall be calculated based on the hospital-specific GME per discharge multiplied by the number of cases of the categories defined in (a)4i(2)(A) above. The hospital-specific GME per discharge shall be calculated based on the inpatient share of the aggregate approved GME amount from Worksheet E–3 Part IV of the Medicare submitted cost report divided by the hospital-specific total hospital discharges from Worksheet S–3 Part I of the Medicare submitted cost report.

(B) The hospital-specific IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the number of cases of the categories defined in (a)4i(2)(A) above, priced at the current available Medicaid inpatient rates. The components of the IME formula, IME intern and resident FTEs, and maintained beds shall be taken from the Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the Medicare submitted cost report used in the calculation.

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.

6. Disproportionate share hospitals which implement capital projects may be eligible to receive increased disproportionate share hospital payments in accordance with this section. These additional payments shall recognize the unique needs of certain disproportionate share hospitals serving a high portion of low income persons for capital funds for the replacement of existing aged facilities. Payments to eligible hospitals shall begin the calendar year following project completion and facility operation.

i. The Hospital Subsidy Fund for Capital Projects payment shall be an amount authorized by the Commissioner of the Department of Human Services from the Hospital Health Care Fund for capital purposes for any disproportionate share hospital which, in the year prior to implementation of a capital project in excess of $20 million, has accumulated depreciation greater than 60 percent of total gross property, plant and equipment, has an approved certificate of need which are for replacement beds, thereby reducing the number of beds available in the State, and has a ratio of New Jersey Medicaid inpatient revenue plus uninsured inpatient hospital charges to total inpatient charges in excess of 45 percent of total net inpatient revenues, using the most recent data available as of October 1 for the year preceding the distribution year, and receives no other direct State appropriation.

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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).
Amended by R.1997 d.92, effective February 18, 1997.
See: 28 N.J.R. 4698(a), 29 N.J.R. 80(a), 29 N.J.R. 600(b).
In (a), amended subsection reference, substituted "charity care" for "charity and uncompensated care from the Health Care Subsidy Fund", and added reference to calculation and distribution of DSH; substantially amended (a)4; and added (a)6.
Amended by R.1997 d.541, effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).
Inserted (a)2i(6), and (a)4i(4); and rewrote (a)6i.

10:52–8.3 Calculation and distribution of disproportionate share hospital (DSH) payments as a result of hospital closure; purpose and procedure

(a) The purpose of this rule is to provide guidance to allocate and redistribute disproportionate share hospital (DSH) payments to provide for the patients who were served by the closed hospital. When a hospital closes, the DSH payments that would have gone to that hospital had that hospital not closed shall be reallocated and distributed to eligible hospitals, in accordance with Federal and State laws, rules and regulations. The eligible hospitals that are serving or are expected to serve the patients that would have gone to the closed hospital will receive the closed hospital's allocation. In the event of any future hospital closings, DSH payments to the closed hospital will cease and State laws and/or rules will be enacted or promulgated, respectively, to specify the eligible hospitals and the calculation and distribution of the closed hospital's(s') DSH payment(s).

1. In (b) and (c) below, the reimbursement methodology for DSH applies exclusively to the closure of UHMC.

(b) For the 1998 Charity Care allocation, the Division shall exclude all data pertaining to United Hospitals Medical Center (UHMC).

(c) In calendar year 1998, and each year thereafter, when the source hospital data precedes calendar year 1997, an HRSF allocation that would have gone to UHMC shall be initially calculated. Then the reallocation of UHMC's calculated HRSF allocation shall be calculated and distributed to eligible disproportionate share hospitals using the same data as was used for the original allocation, with the exception of market share admission data, which shall be taken from the most recent available UB-PS hospital data in the following manner:

1. DSHs eligible to receive a portion of UHMC's calculated HRSF allocation shall satisfy both of the two following independent criteria:

i. An eligible hospital shall draw its patients from the same neighborhoods, identified by zip codes, that UHMC served. Zip codes are included in the definition of UHMC's market area if they represent areas from which UHMC drew one percent or more of its adult admission or 2.5 percent or more of its pediatric admissions; or if UHMC's admissions represented five percent or more of admissions to all hospitals from that zip code.

ii. An eligible hospital shall have a market share of five percent or more of problem-billed admissions. The market share problem-billed admissions shall be based on the number of admissions from the same neighborhoods, identified by zip code that UHMC served as defined above in (c)1i above for the problem-billed categories specified in N.J.A.C. 10:52–8.2(a)4i(2)(A).

2. The available Hospital Relief Subsidy Funds (HRSFs) to be reallocated shall be distributed among eligible hospitals based upon an eligible hospital's percentage of market share problem-billed admissions as a percentage of all market share problem-billed admissions of eligible hospitals. The reallocated funds shall be distributed on a monthly basis.

New Rule, R.1998 d.60, effective January 20, 1998.
See: 29 N.J.R. 4376(a), 30 N.J.R. 388(a).

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, Administrative and Financial Services, PO Box 712, Mail Code #42, 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.
Amended by R.1997 d.541 effective December 15, 1997 (operative January 1, 1998).
See: 29 N.J.R. 3227(a), 29 N.J.R. 5325(a).

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.

Acid—Phosphatase
Albumin
Alkaline Phosphatase
(ALT, SGPT) Aspartate Aminotranferase
(AST, SGOT) Aspartate Aminotranferase
Amylase
Bilirubin, Total
Bilirubin, Direct
Blood Urea Nitrogen (BUN)
Calcium
Carbon Dioxide (CO2)
Chlorides (Cl)
Cholesterol
Creatine Kinase (CK, CPK)
Creatinine
Gamma Glutamyl Transpeptidase (GGTP)
Glucose (Sugar)
Iron
Iron Binding Capacity
Lactic Dehydrogenase (LD)
Lipoprotein (HDL Cholesterol)
Magnesium
Phosphorus
Potassium (K)
Protein, Total
Sodium (NA)
Triglycerides
Uric Acid

NOTE 1: If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded $5.00, the maximum reimbursement will not be more than $5.00: 82040, 82150, 82250, 82251, 82310, 82374, 82435, 82465, 82550, 82565, 82947, 82977, 83540, 83550, 83615, 83718, 83735, 84060, 84075, 84100, 84132, 84155, 84295, 84450, 84460, 84478, 84520, 84550.

NOTE 2: The following calculations and ratios are not eligible for separate or additional reimbursement. Mathematical calculations listed below are not reimbursable:

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

NOTE 3: Any additional automated multichannel chemistry tests performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019 will not be reimbursed at the current allowable fee for each added test when performed on automated multichannel equipment.

NOTE 4: Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional $2.00.

2. Codes 80050, 80055, 80058, 80059, 80061, 80072, 80090, 80091, 80092—The panels listed must include the laboratory tests assigned by the CPT–4 as the components of the panel. The tests listed with each of the panels identify the defined components of that panel. If any laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

NOTE 1: Code 80091—Thyroid panel

Reimbursement not eligible for 84439 when billed in conjunction with 80091 on same day.

NOTE 2: Code 80092—Thyroid panel with TSH

Code 8443—TSH will not be paid a separate reimbursement when performed in conjunction with 80091 or 80092.

3. Codes 82487, 82488, and 82489—Chromatography—must list substance (compound) tested for in block 34 (REMARKS) of the claim form.

4. Code 82728—Ferritin

When the procedure for ferritin is performed in combination with Vitamin B12 or Folate or any of the chemistry analytes listed on codes 80002–80019 the maximum reimbursable fee for code 82728 is $5.00.

5. Code 84081—Phosphatidylglycerol—test done on newborn or amniotic fluid to determine fetal lung maturity.

6. Code 84202—Protoporphyrin, RBC; quantitative—Utilize only for testing of anemia. Utilize code 84203—Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will no longer be reimbursed when billed in conjunction with code 83655—Blood lead determination (quantitative).

7. Code 84620—Xylose absorption tests, blood and/or urine (D-xylose tolerance test), includes serum & urine levels, up to 5 hourly specimens.

8. Codes 85023 and 85025—Hematology

NOTE: For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a hematocrit, hemoglobin determination, RBC count, RBC indices, WBC count and differential WBC count (See codes 85021 and 85022), for a platelet count with a CBC (see codes 85023–85025).

Hematology codes 85014, 85018, 85041 and 85048 may not be billed in conjunction with codes for blood count with hemogram (85021, 85022, 85023, 85024, 85025, and 85027).

The code for manual differential WBC count (85007) may not be billed in conjunction with codes 85021, 85022, 85023, 85024, 85025, and 85027.

Codes for platelet count (85590 and 85595) may not be billed in conjunction with codes 985023–85027.

Code 85044 may be billed in conjunction with codes 85023 and 85025, when a complete hemogram is ordered.

9. Codes 87040, 87045, 87060, 87070, 87184—Cultures

NOTE: These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture; (87081 and 87082).

10. Code 88155—pap smear

NOTE: Obtaining specimen not a separate eligible service.

11. Code 88348 and 89349—Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

NOTE: For reimbursement purposes, Medicaid will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, i.e., gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

12. Code 89360—Sweat (without iontophoresis) test

NOTE: Reimbursement not eligible for qualitative tests. For reimbursement purposes, 84295 will not be reimbursed at any additional charge. Do not bill 84295 in conjunction 89360.

13. Code 36415—Utilize this code only for finger/heel/ear stick for collection of specimen(s). This service is reimbursable in the physician office laboratory (POL) when the specimen is referred out to an independent clinical laboratory for testing. Finger/heel/ear stick is not reimbursable when billed by the independent clinical laboratory.

NOTE: This service is reimbursable at a fixed rate or at the amount of the hospital charge (whichever is less) per specimen type, per patient encounter, regardless of the number of patient encounters per day.

10:52–11.5 Pathology and Laboratory HCPCS Codes—Modifiers

(a) Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid program's recognized modifier codes are:

Modifier Code	Description
22	Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '22' to the usual procedure number. A report may also be appropriate.
26	Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier '26' to the usual procedure number.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier '52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
90	Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier '90' to the usual procedure number.

SUBCHAPTER 12. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION

Authority

N.J.S.A. 30:4D–6a(1); 7, 7a, b, and c, 30:4D–12; 42 C.F.R. 447.200 through 205, 250 and 252; and P.L. 1996, c.42.

Source and Effective Date

R.1997 d.43, effective January 21, 1997.
See: 28 N.J.R. 4022(a), 29 N.J.R. 350(b).

10:52–12.1 Calculation of the amount of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement to be distributed

(a) Effective for services on or after October 1, 1996, the amount of hospital reimbursement for GME and IME to be distributed shall be calculated based on Medicare principles of reimbursement to major teaching hospitals. Major teaching hospitals are defined as those hospitals which had a minimum of 45 intern and resident full-time equivalents (FTEs) in all approved and accredited residencies from the 1993 Medicare first finalized audited cost report.

(b) Medicare principles of reimbursement for GME and IME are as follows:

1. Direct GME is calculated based on Medicaid's share of the major teaching hospitals' intern and resident FTEs multiplied by their specific per resident amounts as reported on the Medicare audited cost report (including subsequent amendments) in Worksheet E–3 Part IV for the year in which payment is being made.

2. IME is calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference. The major teaching hospitals' IME factor, as calculated by the Medicare IME formula, is multiplied by their hospital specific Medicaid inpatient DRG payments (net of GME and IME) to arrive at the Medicaid IME payment. The components of Medicare's IME formula, IME intern and resident FTEs and maintained beds, are from the audited Medicare cost report (including subsequent amendments) in Worksheet S–3 for the year in which payment is being made.

10:52–12.2 Distribution of Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement

Effective for services on or after October 1, 1996, hospital reimbursement for GME and IME as calculated in N.J.A.C. 10:52–12.1 shall be distributed to all teaching hospitals based on the hospital-specific percentage of total weighted GME FTEs, where weighted GME FTEs equals the hospital-specific current GME FTEs times the hospital-specific Medicaid fee-for-service days divided by the total Medicaid fee-for-services days for all teaching hospitals. The source for the GME FTEs and the Medicaid fee-for-service days is the Medicare audited cost report including subsequent amendments for the year in which payment is being made.

10:52–12.3 Establishment of GME and IME interim method of reimbursement

Effective for services provided on or after January 21, 1997, all teaching hospitals are required to submit, for the year in which payment shall be made, their estimated average intern and resident GME and IME FTE count and maintained beds by November 1 of the preceding year to Blue Cross and Blue Shield of New Jersey (BCBSNJ), the Division's settlement agent. BCBSNJ shall review the submitted information for reasonableness and consistency and forward the information to the Division. Effective for services on or after October 1, 1996, the Division shall calculate Medicaid's GME and IME payment based on the major teaching hospitals' submitted data and their Medicaid inpatient DRG payments (net of IME and GME) from their most current fiscal year Unisys settlement data report with 24 months of paid data. Once the Medicaid GME and IME payment is calculated, it shall be distributed to all teaching hospitals in accordance with N.J.A.C. 10:52–12.2 utilizing the submitted FTE count and the Medicaid days from the teaching hospitals' most current fiscal year Unisys settlement data report with 24 months of paid data. The payment shall be made in equal monthly installments and reconciled in accordance with N.J.A.C. 10:52–12.4.

10:52–12.4 Establishment of GME and IME final method of reimbursement

Effective for services on or after October 1, 1996, the Medicaid GME and IME final payment shall be calculated in accordance with N.J.A.C. 10:52–12.1 and distributed to all teaching hospitals in accordance with N.J.A.C. 10:52–12.2. A reconciliation of the final GME and IME distribution of payment to the interim GME and IME distribution of payment shall be made and additional disbursement or recoupment shall be made in accordance with N.J.A.C. 10:52–4.71(a)1 through 5.

APPENDIX

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

UNISYS
PO Box 4801
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or contact:

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Quakerbridge Plaza, Building 9
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