1. For each patient with a Uniform Bill (UB), measures of resource use shall be calculated to distribute costs among the UB. Measures of resource use represent services provided to patients associated with each cost center. Patient days are associated with routine service cost, emergency room admissions with emergency service cost, and ancillary and therapeutic charges with ancillary and therapeutic service cost. The measures of resource use is a ratio of admissions reported on the hospital's cost report over the hospital's UB billing data. Costs are derived from the Actual Reporting Forms and are associated with admissions. Therefore, an adjustment is made to align the measures of resource use to the inpatient cost. The adjustment is the ratio of total admissions to total UB records. This results in a total adjusted measure of resource use. The hospitals shall make reasonable efforts to correct data unacceptable to the Division or Department of Health.

	Center	Measure of Resource Use	Calculation of Inpatients
	ROUTINE SERVICES		
MSA &	Medical–Surgical Acute Care Units	Patient Days	Total LOS less ICU, CCU, NBN and OBS LOS ACU
PED & PSA &	Pediatrics Psychiatric Acute Care Units		
PSY &	Psychiatric/Psychological Services		
OBS	Obstetrics		
BCU	Burn Care Unit		BCU LOS
ICU & CCU	Intensive Care Unit Coronary Care Unit	Patient Days	ICU + CCU LOS
NNI	Neonatal Intensive Care Unit	NNI Patient Days	Total ICU LOS for Newborn DRGs
NBN	Newborn Nursery	NBN Patient Days	Total LOS for Newborn DRGs less ICU LOS
	AMBULATORY SERVICES		
EMR	Emergency Service	EMR Charges (Inpatient EMR	EMR Admissions Revenue EMR Admissions)
CLN	Clinics	CLN Charges	None
HHA	Home Health Agency	OHS Charges	None
	ANCILLARY SERVICES		
ANS	Anesthesiology	ANS Charges	Direct
CCA	Cardiac Catheterization	CCA Charges	Direct
DEL	Delivery and Labor Room	DEL Charges	Direct
DIA	Dialysis	DIA Charges	Direct
DRU	Drugs Sold to Patients	PHM Charges (DRU)	Direct
EKG	Electrocardiology and Diagnostic	EDG Charges	Direct
NEU	Neurology		
LAB	Laboratory	BBK Charges and LAB Charges	Direct
MSS	Medical–Surgical Supplies Sold to Patients	CSS Charges (MSS)	Direct
NMD	Nuclear Medicine	NMD Charges	Direct
OCC	Occupational and Recreational	OPM Charges	Direct
SPA	Therapy and Speech Pathology and Audiology		
ORG	Organ Acquisition and	ORR Charges	Direct
ORR	Operating and Recovery Rooms		
PHT	Physical Therapy	PHT Charges	Direct
RAD	Diagnostic Radiology	RAD Charges	Direct
RSP	Respiratory Therapy	RSP Charges	Direct
THR	Therapeutic Radiology	THR Charges	Direct

(c) Cost per case allocation:

1. The Direct Patient Care Costs of each center (after the allocation of patient care general services in N.J.A.C. 10:52–5.11 and 5.12) are separated between inpatient, outpatient, and Skilled Nursing Facility (SNF) costs. Outpatient and SNF costs are excluded from the inpatient rates based on gross revenue reported to the Division. The total inpatient costs from each cost center are then divided by the hospital's corresponding total adjusted measure of resource use. This calculation produces ratios, including cost per patient day, cost per EMR admission, or a cost ratio per ancillary or therapeutic charge for each cost center. Each ratio is then multiplied by the corresponding cost center's measure of resource use of each DRG to calculate a cost per case for the hospital's case mix.

i. Patient days will be employed as the Measures of Resource Use to allocate MSA, PED, PSA, and OBS nursing costs. While patient days are used, the MSA, PED, PSA, OBS centers will be combined into ACU and ICU, and CCU will be combined into ICU. All other routine centers will remain as above.

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

10:52–5.13 Reasonable cost of services related to patient care

(a) The Reasonable Cost of Services related to Patient Care includes:

1. Current non-physician direct patient care costs per case as adjusted by standard costs per case for Medicaid inpatients;

2. Current physician patient service costs, as modified for physician compensation arrangements pursuant to N.J.A.C. 10:52–5.12;

3. Indirect cost pursuant to N.J.A.C. 10:52–5.11 and 5.16;

4. Less a reduction for income not related to patient care, from those sources specified in N.J.A.C. 10:52–6.27 through 6.33 except all items reported as expense recovery to the Division, shall be so treated; and

5. Current major moveable equipment amount pursuant to N.J.A.C. 10:52–6.9.

(b) The Reasonable Cost of Services Related to Medicaid Patient Care will be adjusted by the application of economic factors pursuant to N.J.A.C. 10:52–5.17.

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

10:52–5.14 Standard costs per case

(a) The standard to be used in the calculation of the proposed rates for each inpatient DRG is determined as the median plus five percent non-physician patient care costs per Medicaid case in all hospitals whose costs are included in the data base, adjusted for labor market differentials, and amount and type of Graduate Medical Education. Standards shall be calculated across all hospitals for which current cost bases were derived from a common reporting period.

(b) For determination of teaching costs, the following criteria shall be followed:

1. All residents initially employed as first-year residents (PGY1) by hospitals on July 1, 1987 or later must meet either criteria in (b)1i and ii, or (b)1i and iii listed below, in order to be included among those residents on which payment is based. To be similarly included, second-year residents (PGY2) must meet these same minimum requirements by July 1, 1988; third-year residents (PGY3), by July 1, 1989; fourth-year residents (PGY4), by July 1, 1990; fifth-year residents (PGY5), by July 1, 1991; and all residents by July 1, 1992.

i. Meet all the minimum criteria established by the New Jersey State Board of Medical Examiners required for a New Jersey medical license, with the exceptions of specific requirements for graduate medical education and that, if necessary, foreign medical graduates will be allowed to take the National Boards at the end of their first postgraduate year. The National Boards must be passed before the beginning of PGY3 in order to be counted in such graduates' PGY3.

ii. Graduation from a medical, dental or osteopathic school accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) or in the case of dental residents, the American Dental Association (ADA) or in the case of podiatric residents, the Council on Podiatric Medical Education (CPME).

iii. Graduation from a foreign medical school and passage of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) within three attempts. For residents beginning PGY1 in the State of New Jersey in July 1987 only, an Educational Commission for Foreign Medical Graduates (ECFMG) certificate may be substituted for FMGEMS, and passage of FMGEMS, mandatory before January 1, 1989, shall not be limited to three attempts.

2. For all graduate medical education programs which are subject to accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or, in the case of dental residents, the American Dental Association (ADA), or, in the case of podiatric residents, the Council on Podiatric Medical Education (CPME), accreditation must be maintained for residents in these programs to be used in determining the hospital's payment. Residents in unaccredited programs shall not be recognized in the teaching methodology for determining direct and indirect patient care costs.

3. The transfer of residents and associated costs between hospitals is permitted under the following conditions:

i. The number of positions transferred does not exceed the number relinquished;

ii. Both parties to the transfer must submit a letter of agreement to the Department of Health; and

iii. The Advisory Graduate Medical Education Council of New Jersey (AGMEC) must have recommended the transfer as being consistent with maintenance or improvement of program quality.

4. The approved costs associated with a transferred resident position shall not increase solely as a result of the transfer.

5. Beginning in rate year 1992, the changes in number of residents and associated costs due to transfers shall be reflected in each hospital's rates for the following rate year if the Division is so advised on or before April 15.

(c) Methodology for determining hospital-specific patient care rate adjustments for graduate medical education (GME) shall be as follows:

1. In order to be eligible for GME reimbursement, hospitals must submit each year, before the issuance of rates, documentation that attests to current accreditation for all programs for which accrediting bodies exist.

2. For all programs which have maintained the appropriate accreditation, and have a minimum number of residents equal to the years in that program necessary for it to receive accreditation, direct and indirect patient care costs associated with Graduate Medical Education plus the hospital current costs must be calculated for each patient DRG as follows:

i. All DRGs shall be assigned to one of four mutually-exclusive residency categories: Medicine, Surgery, Pediatrics and OB/GYN. Assignment will be determined by the specialty of the resident who would, in most New Jersey teaching hospitals, have principal responsibility for care of a patient in a given DRG.

ii. Regarding medicine, the following shall apply:

(1) For teaching reimbursement purposes, a medical teaching hospital is defined as having an accredited program, with at least one Full Time Equivalent (F.T.E.) resident per year of the program, in Internal Medicine; Transitional/Flexible First Year; a medical specialty/subspecialty; and/or Radiology.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.I.

iii. Regarding surgery, the following shall apply:

(1) For teaching reimbursement, a surgical teaching hospital is defined as having an accredited program, with at least one F.T.E. resident per year of the program, in General Surgery; surgical specialty or subspecialty Anesthesiology; and/or Pathology.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.II, incorporated herein by reference.

iv. Regarding Obstetrics/Gynecology, the following shall apply:

(1) For teaching reimbursement, an Obstetrics/Gynecology teaching hospital is defined as having an Obstetrics/Gynecology program with at least one F.T.E. resident per year of the program.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.III, incorporated herein by reference.

v. Regarding pediatrics, the following shall apply:

(1) For teaching reimbursement, a pediatric teaching hospital is defined as having an accredited pediatric program, with at least one F.T.E. resident per year of the program.

(2) Reimbursement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI B.IV, incorporated herein by reference.

vi. Regarding Family Practice, the following shall apply:

(1) For teaching reimbursement, a Family Practice hospital is defined as having an accredited Family Practice Teaching Program and shall not be considered in neutralizing costs for standard setting.

(2) For payment purposes, a Family Practice supplement shall be based on an increase in rates using the methodology described in N.J.A.C. 8:31B, Appendix XI vii, incorporated herein by reference. A teaching adjustment factor shall be applied in calculating the rates for hospitals experiencing changes in accreditation status or changes in number of residents since the base year, and to reflect any differences between actual and cap resident counts.

(3) Direct and indirect costs, including resident salaries and other educationally related costs, shall be recognized in rates in accordance with the GME reimbursement methodology which neutralizes the costs of teaching within medical, surgical, OB/GYN and pediatric DRG categories and deneutralizes these costs for setting payment rates.

(4) For purposes of payment, all deneutralization factors shall be considered to be equal to one or greater.

(d) Determination of the labor equalization factor to calculate Statewide standard costs per case shall be as follows:

1. An equalization factor shall be calculated for the non-physician direct patient care costs of each hospital (excluding ambulatory care centers) to account for differing hospital pay scales in the calculation of standards. Each hospital's equalization factor is determined as non-physician direct patient care costs (prior to allocation of costs from patient care general services) at average pay scales for all New Jersey hospitals (excluding those hospitals classified as Rehabilitation Facilities) divided by Labor Market Area non-physician direct patient care costs.

2. The Labor Market Areas recognized in 1990 rate setting at N.J.A.C. 8:31B–3.22(d)3 will be used for rate setting in subsequent years.

3. Labor Market Areas are:

		Counties or Municipalities
i.	Paterson—Clifton—Passaic	Passaic
ii.	Hackensack	Bergen
iii.	Newton—Phillipsburg	Sussex, Warren
iv.	Trenton—Flemington	Mercer, Hunterdon
v.	Newark, Suburban	Union, Essex, Somerset, Morris, except cities of Elizabeth, Belleville, East Orange, Irvington and Newark
vi.	Jersey City	Hudson

vii.	New Brunswick—Perth Amboy	Middlesex
viii.	Long Branch—Toms River	Monmouth, Ocean
ix.	Atlantic City—Cape May	Atlantic, Cape May
x.	Vineland—Millville Camden—Salem	Burlington, Gloucester Cumberland
xi.	Newark, Central City (not included in v. above)	Newark, Elizabeth, Belleville, East Orange, Orange, and Irvington

4. This factor is multiplied by the hospital's actual cost per case for all DRGs.

5. Labor costs shall be adjusted to Statewide averages by first grouping all non-physician direct patient care labor costs (after fringe benefit costs have been distributed) into eight labor categories as follows:

i. Registered Nursing: Includes non-physician salaries reported in Routine, CCA, DEL, DIA or ORR cost centers.

ii. Licensed Practical Nursing: Includes non-physician salaries reported in Routine cost centers.

iii. Attendants: Includes non-physician salaries reported in Routine and CSS cost centers.

iv. Clerical: Includes non-physician salaries reported in Routine cost centers.

v. Health Technical: Includes non-physician salaries reported in BBK, EDG, LAB, RAD, NMD, and THR cost centers.

vi. Therapists/Technical: Includes non-physician salaries reported in OPM, PHM, PHT, and RSP cost centers.

vii. General Services: Includes non-physician salaries reported in DTY, HKP, and L & L cost centers.

viii. Administrative and Clerical: Includes non-physician salaries reported in the MRD, A & G/FIS, PLT, and PCC cost centers.

6. The portion of the routine cost centers that shall be attributed to each of the four types of nursing skill levels is based on the distribution of costs as reported to the Division.

7. By dividing non-physician direct patient care costs by the non-physician hours in each category, the average hourly rates for the eight labor categories are computed for each hospital. The sum of all of the hospital's non-physician direct patient care costs for the eight labor categories divided by the total non-physician hours is equal to the Statewide average. To determine each hospital's labor equalization factor, the Statewide average cost per hour for each labor category is multiplied by the hospital's number of non-physician labor hours for that category and is added to all other non-physician costs (that is, supplies and other costs). This amount is divided by the result of the same calculation using the Labor Market Area cost per hour, rather than Statewide average, resulting in the hospital's equalization factor.

8. Whenever the number of hospitals in a given labor market area decreases to a number less than four, the Division shall calculate and compare the mean equalization factors of the Labor Market Area, both before and after the decrease. If they differ by plus or minus one percent or more, that Labor Market Area shall be merged with the geographically contiguous Labor Market Area having the most similar hourly wage rate, averaged for all salaried employees and based on the most recent data available; the factors of all Labor Market Areas shall be recalculated and effective in the following rate year.

(e) Calculation of standards shall be as follows:

1. The calculation of standards shall be based on an appropriate sample of hospitals. The cost per case of each hospital's Medicaid patients with UB records categorized by inpatient DRGs is multiplied by each hospital's equalization factor and for the appropriate DRGs and hospitals, reduced by a rate expressing the amount and type of graduate medical education for the hospital pertaining to each DRG. The median plus five percent equalized cost of all such records in all hospitals calculated after teaching costs have been removed from hospitals' Preliminary Cost Bases is the incentive standard for each DRG.

2. 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.

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

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.

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.

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.

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. The incentive standard multiplied by the unequalization factor, the physician mark-up, the deneutralization factor, and Residents adjustment factor.

(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).

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 calculated by the Department of Health is the measure of the change in the prices of goods and services used by New Jersey hospitals. After the 1993 rate year, the economic factor will be the factor recognized under the TEFRA target limitations.

(b) The technology factor calculated by the Department of Health 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. Commission and Health Planning fees;

3. Capital facilities allowance;

4. Physician fee for service;

5. Child psychiatric hospital direct and indirect;

6. Resident count correction;

7. Special perinatal expense adjustment;

8. Trauma center adjustment;

9. GME reversal;

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).

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. Capital Cash Requirements are all current payments, excluding cash purchases, made for Capital Facilities utilized for Services Related to Patient Care during a reporting period, including reasonable interest as defined in (a)1i(1) below on long term debt, but excluding the expenditure of specific purpose grants for capital projects.

(1) Reasonable Interest Expense for Capital Facilities for any rate year is defined as the lower of the hospital's actual interest expense for that year or the interest expense the hospital would have incurred had it refinanced or advance refunded its long-term debt at the average interest rate available during that year on bonds of comparable credit quality and Federal income tax status issued by the New Jersey Health Care Facilities Financing Authority, provided that such a refinancing or advance refunding would result in significant present value savings to consumers and is feasible considering issuance costs and tax laws. If either of these provisions is not met, Reasonable Interest Expense shall equal the hospital's actual interest expense.

ii. The yearly Capital Facilities Allowance is computed using information provided by the Uniform Cost Reports. For hospitals on a calendar year basis, this amount will be the 1992 depreciation and reasonable 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 reasonable 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.

(1) Requests for exceptions to this methodology may be accepted and evaluated only when a major capital project has resulted in a significant change in depreciation and reasonable interest from the most current actual reporting year to the rate year.

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:

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).

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. Any hospital seeking a rate increase must demonstrate the cost it must incur in providing services to Medicaid recipients 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. 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 or 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).

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.

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.