(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.

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.
Amended by R.1998 d.340, effective July 6, 1998.
See: 30 N.J.R. 1260(a), 30 N.J.R. 2486(b).
In (a), rewrote 2 and 4, and deleted a former 6.

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).

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(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.