CHAPTER 54

AN ACT concerning assessments on certain health care facilities and amending P.L.1992, c.160 and P.L.1971, c.136.

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

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

C.26:2H-18.57 Assessment of per adjusted admission charge.

7. a. Effective January 1, 1994, the Department of Health and Senior Services shall assess each hospital a per adjusted admission charge of $10.00.

Of the revenues raised by the hospital per adjusted admission charge, $5.00 per adjusted admission shall be used by the department to carry out its duties pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) and $5.00 per adjusted admission shall be used by the department for administrative costs related to health planning.

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

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

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

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

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

The commissioner shall provide notice no later than August 15, 2004 to all facilities that are subject to the assessment that the first payment of the assessment is due October 1, 2004 and that proof of gross receipts for the facility's tax year ending in calendar year 2003 shall be provided by the facility to the commissioner no later than September 15, 2004. If a facility fails to provide proof of gross receipts by September 15, 2004, the facility shall be assessed the maximum rate of $200,000 for Fiscal Year 2005.

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

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

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

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

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

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

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

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

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

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

2. Section 12 of P.L.1992, c.160 (C.26:2H-18.62) is amended to read as follows:

C.26:2H-18.62 Use of hospital, other health care initiatives monies.

12. a. The monies in the hospital and other health care initiatives account are appropriated for the establishment of a program which will assist hospitals and other health care facilities in the underwriting of innovative and necessary health care services and provide funding for public or private health care programs, which may include any program funded pursuant to section 25 of P.L.1991, c.187 (C.26:2H-18.47), managed care regulation and oversight pursuant to P.L.1997, c.192 (C.26:2S-1 et al.), administration and enforcement of health care facility licensing requirements pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), and for such other programs that the commissioner deems necessary or appropriate to carry out the provisions of section 5 of P.L.1992, c.160 (C.26:2H-18.55).

The commissioner shall develop equitable regulations regarding eligibility for and access to the financial assistance, within six months of the effective date of this act.

b. Such funds as may be necessary shall be transferred by the department from the fund to the Division of Medical Assistance and Health Services in the Department of Human Services for payment to disproportionate share hospitals.

c. Notwithstanding any law to the contrary, each general hospital and each specialty heart hospital shall pay.53% of its total operating revenue to the department for deposit in the Health Care Subsidy Fund, except that the amount to be paid by a hospital in a given year shall be prorated by the department so as not to exceed the $40 million limit set forth in this subsection. The hospital shall make monthly payments to the department beginning July 1, 1993, except that the total amount paid into the Health Care Subsidy Fund plus interest shall not exceed $40 million per year. The commissioner shall determine the manner in which the payments shall be made.

For the purposes of this subsection, "total operating revenue" shall be defined by the department in accordance with financial reporting requirements established pursuant to N.J.A.C.8:31B-3.3 and shall include revenue from any ambulatory care facility that is licensed to a general hospital as an off-site ambulatory care service facility.

d. The monies paid by the hospitals shall be credited to the hospital and other health care initiatives account.

3. Section 2 of P.L.1971, c.136 (C.26:2H-2) is amended to read as follows:

C.26:2H-2 Definitions.

2. The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, dispensary, home health care agency, residential health care facility and bioanalytical laboratory (except as specifically excluded hereunder) or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer and excluding such bioanalytical laboratories as are independently owned and operated, and are not owned, operated, managed or controlled, in whole or in part, directly or indirectly by any one or more health care facilities, and the predominant source of business of which is not by contract with health care facilities within the State of New Jersey and which solicit or accept specimens and operate predominantly in interstate commerce.

b. "Health care service" means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice, except as provided in sections 7 and 12 of P.L.1971, c.136 (C.26:2H-7 and 26:2H-12), or by practitioners of healing solely by prayer, and services provided by first aid, rescue and ambulance squads as defined in the "New Jersey Highway Safety Act of 1971," P.L.1971, c.351 (C.27:5F-1 et seq.).

c. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including its equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

d. "Board" means the Health Care Administration Board established pursuant to this act.

e. (Deleted by amendment, P.L.1998, c.43).

f. "Government agency" means a department, board, bureau, division, office, agency, public benefit or other corporation, or any other unit, however described, of the State or political subdivision thereof.

g. (Deleted by amendment, P.L.1991, c.187).

h. (Deleted by amendment, P.L.1991, c.187).

I. "Department" means the State Department of Health and Senior Services.

j. "Commissioner" means the State Commissioner of Health and Senior Services.

k. "Preliminary cost base" means that proportion of a hospital's current cost which may reasonably be required to be reimbursed to a properly utilized hospital for the efficient and effective delivery of appropriate and necessary health care services of high quality required by such hospital's mix of patients. The preliminary cost base initially may include costs identified by the commissioner and approved or adjusted by the commission as being in excess of that proportion of a hospital's current costs identified above, which excess costs shall be eliminated in a timely and reasonable manner prior to certification of the revenue base. The preliminary cost base shall be established in accordance with regulations proposed by the commissioner and approved by the board.

l. (Deleted by amendment, P.L.1992, c.160).

m. "Provider of health care" means an individual (1) who is a direct provider of health care service in that the individual's primary activity is the provision of health care services to

individuals or the administration of health care facilities in which such care is provided and, when required by State law, the individual has received professional training in the provision of such services or in such administration and is licensed or certified for such provision or administration; or (2) who is an indirect provider of health care in that the individual (a) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph b(ii) or subparagraph b(iv); provided, however, that a member of the governing body of a county or any elected official shall not be deemed to be a provider of health care unless he is a member of the board of trustees of a health care facility or a member of a board, committee or body with authority similar to that of a board of trustees, or unless he participates in the direct administration of a health care facility; or (b) received, either directly or through his spouse, more than one-tenth of his gross annual income for any one or more of the following:

(I) Fees or other compensation for research into or instruction in the provision of health care services;

(ii) Entities engaged in the provision of health care services or in research or instruction in the provision of health care services;

(iii) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care services;

(iv) Entities engaged in producing drugs or such other articles.

n. "Private long-term health care facility" means a nursing home, skilled nursing home or intermediate care facility presently in operation and licensed as such prior to the adoption of the 1967 Life Safety Code by the State Department of Health and Senior Services in 1972 and which has a maximum 50-bed capacity and which does not accommodate Medicare or Medicaid patients.

o. (Deleted by amendment, P.L.1998, c.43).

p. "State Health Planning Board" means the board established pursuant to section 33 of P.L.1991, c.187 (C.26:2H-5.7) to conduct certificate of need review activities.

4. Section 12 of P.L.1971, c.136 (C.26:2H-12) is amended to read as follows:

C.26:2H-12 Operation requirements for health care service, facility; application for license; fee.

12. a. No health care service or health care facility shall be operated unless it shall: (1) possess a valid license issued pursuant to this act, which license shall specify the kind or kinds of health care services the facility is authorized to provide; (2) establish and maintain a uniform system of cost accounting approved by the commissioner; (3) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner; (4) prepare and review annually a long range plan for the provision of health care services; and (5) establish and maintain a centralized, coordinated system of discharge planning which assures every patient a planned program of continuing care and which meets the requirements of the commissioner which requirements shall, where feasible, equal or exceed those standards and regulations established by the federal government for all federally-funded health care facilities but shall not require any person who is not in receipt of State or federal assistance to be discharged against his will.

b. (1) Application for a license for a health care service or health care facility shall be made upon forms prescribed by the department. The department shall charge a single, nonrefundable fee for the filing of an application for and issuance of a license and a single, nonrefundable fee for any renewal thereof, and a single, nonrefundable fee for a biennial inspection of the facility, as it shall from time to time fix in rules or regulations; provided, however, that no such licensing fee shall exceed $10,000 in the case of a hospital and $4,000 in the case of any other health care facility for all services provided by the hospital or other health care facility, and no such inspection fee shall exceed $5,000 in the case of a hospital and $2,000 in the case of any other health care facility for all services provided by the hospital or other health care facility. No inspection fee shall be charged for inspections other than biennial inspections. The application shall contain the name of the health care facility, the kind or kinds of health care service to be provided, the location and physical description of the institution, and such other information as the department may require. (2) A license shall be issued by the department upon its findings that

the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.

c. (Deleted by amendment, P.L.1998, c.43).

d. The commissioner may amend a facility's license to reduce that facility's licensed bed capacity to reflect actual utilization at the facility if the commissioner determines that 10 or more licensed beds in the health care facility have not been used for at least the last two succeeding years. For the purposes of this subsection, the commissioner may retroactively review utilization at a facility for a two-year period beginning on January 1, 1990.

e. If a prospective applicant for licensure for a health care service or facility that is not subject to certificate of need review pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) so requests, the department shall provide the prospective applicant with a pre-licensure consultation. The purpose of the consultation is to provide the prospective applicant with information and guidance on rules, regulations, standards and procedures appropriate and applicable to the licensure process. The department shall conduct the consultation within 60 days of the request of the prospective applicant.

f. Notwithstanding the provisions of any other law to the contrary, an entity that provides magnetic resonance imaging or computerized axial tomography services shall be required to obtain a license from the department to operate those services prior to commencement of services, except that a physician who is operating such services on the effective date of P.L.2004, c.54 shall have one year from the effective date of P.L.2004, c.54 to obtain the license.

5. This act shall take effect July 1, 2004.

Approved June 29, 2004.