

COMMITTEE STATEMENT:	ASSEMBLY:	No
	SENATE:	Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT:	No
-----------------------------------	----

LEGISLATIVE FISCAL ESTIMATE:	Yes
-------------------------------------	-----

VETO MESSAGE:	No
----------------------	----

GOVERNOR'S PRESS RELEASE ON SIGNING:	Yes
---	-----

LEGISLATOR STATEMENT:	No
------------------------------	----

FOLLOWING WERE PRINTED:

To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or <mailto:refdesk@njstatelib.org>

REPORTS:	No
-----------------	----

HEARINGS:	No
------------------	----

NEWSPAPER ARTICLES:	No
----------------------------	----

CL/MMcB

P.L. 2025, CHAPTER 70, *approved June 30, 2025*
Assembly, No. 5809

1 AN ACT concerning ambulatory care facility assessments and
2 hospital admission charges, and amending P.L.1971, c.136 and
3 P.L.1992, c.160.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. Section 12 of P.L.1971, c.136 (C.26:2H-12) is amended to read
9 as follows:

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

26 b. (1) Application for a license for a health care service or health
27 care facility shall be made upon forms prescribed by the department.
28 The department shall charge a single, nonrefundable fee for the filing
29 of an application for and issuance of a license and a single,
30 nonrefundable fee for any renewal thereof, and a single,
31 nonrefundable fee for a biennial inspection of the facility, as it shall
32 from time to time fix in rules or regulations; provided, however, that
33 no such licensing fee shall exceed \$10,000 in the case of a hospital
34 and \$4,000 in the case of any other health care facility for all services
35 provided by the hospital or other health care facility, and no such
36 inspection fee shall exceed \$5,000 in the case of a hospital and \$2,000
37 in the case of any other health care facility for all services provided
38 by the hospital or other health care facility. No inspection fee shall
39 be charged for inspections other than biennial inspections. Any
40 surgical practice required to apply for licensure by the department as
41 an ambulatory care facility pursuant to P.L.2017, c.283 shall be

EXPLANATION – Matter enclosed in bold-faced brackets **[thus]** in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 exempt from the initial and renewal license fees required by this
2 section. The application shall contain the name of the health care
3 facility, the kind or kinds of health care service to be provided, the
4 location and physical description of the institution, and such other
5 information as the department may require.

6 (2) A license shall be issued by the department upon its findings
7 that the premises, equipment, personnel, including principals and
8 management, finances, rules and bylaws, and standards of health care
9 service are fit and adequate and there is reasonable assurance the
10 health care facility will be operated in the manner required by this act
11 and rules and regulations thereunder.

12 (3) The department shall post on its Internet website each
13 inspection report prepared following an inspection of a residential
14 health care facility, as defined in section 1 of P.L.1953, c.212
15 (C.30:11A-1) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
16 seq.), that is performed pursuant to this subsection, along with any
17 other inspection report prepared by or on behalf of the department for
18 such facility.

19 If an inspection reveals a serious health and safety violation at a
20 residential health care facility, the department shall post the
21 inspection report, including the name of the facility and the owner of
22 the facility, on its website no later than 72 hours following the
23 inspection. If a license of a residential health care facility is
24 suspended, the department shall post the suspension on its website no
25 later than 72 hours following the suspension. The department shall
26 update its website to reflect the correction of a serious health and
27 safety violation, and the lifting of a suspension.

28 The department shall notify, as soon as possible, the
29 Commissioner of Human Services, or the commissioner's designee,
30 and the director of the county board of social services or county
31 welfare agency, as appropriate, in the county in which a residential
32 health care facility is located, of a serious health and safety violation
33 at the facility and of any suspension of a license to operate such
34 facility.

35 If the inspection responsibilities under this subsection with respect
36 to such facility are transferred or otherwise assigned to another
37 department, that other department shall post on its Internet website
38 each inspection report prepared following an inspection of such
39 facility performed pursuant to this subsection, along with any other
40 inspection report prepared by or on behalf of that department for such
41 facility, and shall comply with the other requirements specified in
42 this subsection.

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

44 d. The commissioner may amend a facility's license to reduce
45 that facility's licensed bed capacity to reflect actual utilization at the
46 facility if the commissioner determines that 10 or more licensed beds
47 in the health care facility have not been used for at least the last two
48 succeeding years. For the purposes of this subsection, the

1 commissioner may retroactively review utilization at a facility for a
2 two-year period beginning on January 1, 1990.

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

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

19 g. (1) (Deleted by amendment, P.L.2017, c.283)

20 (2) (Deleted by amendment, P.L.2017, c.283)

21 (3) (Deleted by amendment, P.L.2017, c.283)

22 (4) A surgical practice in operation on the date of enactment of
23 P.L.2017, c.283 shall be required to apply to the department for
24 licensure as an ambulatory care facility licensed to provide surgical
25 and related services within one year of the date of enactment of
26 P.L.2017, c.283.

27 A surgical practice that is certified by the Centers for Medicare
28 and Medicaid Services (CMS) shall not be required to meet the
29 physical plant and functional requirements specified in
30 N.J.A.C.8:43A-19.1 et seq. A surgical practice that is not Medicare
31 certified, either by CMS or by any deeming authority recognized by
32 CMS, but which has obtained accreditation from the American
33 Association of Ambulatory Surgery Facilities or any accrediting
34 body recognized by CMS and is in operation on the date of enactment
35 of P.L.2017, c.283, shall not be required to meet the physical plant
36 and functional requirements specified in N.J.A.C.8:43A-19.1 et seq.
37 A surgical practice not in operation on the date of enactment of
38 P.L.2017, c.283, if it is certified by CMS as an ambulatory surgery
39 center provider, shall also be exempt from these requirements. A
40 surgical practice required by this subsection to meet the physical
41 plant and functional requirements specified in N.J.A.C.8:43A-19.1 et
42 seq. may apply for a waiver of any such requirement in accordance
43 with N.J.A.C.8:43A-2.9. The commissioner shall grant a waiver of
44 those physical plant and functional requirements, as the
45 commissioner deems appropriate, if the waiver does not endanger the
46 life, safety, or health of patients or the public.

47 **[A]** Through State Fiscal Year 2025, a surgical practice required
48 to be licensed pursuant to this subsection shall be exempt from the

1 ambulatory care facility assessment pursuant to section 7 of
2 P.L.1992, c.160 (C.26:2H-18.57); except that, if the entity expands
3 to include any additional room dedicated for use as an operating
4 room, the entity shall be subject to the assessment. Beginning in
5 State Fiscal Year 2026, a surgical practice required to be licensed
6 pursuant to this subsection shall no longer be exempt from the
7 ambulatory care facility assessment.

8 (5) As used in this subsection and subsection i. of this section,
9 "surgical practice" means a structure or suite of rooms that has the
10 following characteristics:

11 (a) has no more than one room dedicated for use as an operating
12 room which is specifically equipped to perform surgery, and is
13 designed and constructed to accommodate invasive diagnostic and
14 surgical procedures;

15 (b) has one or more post-anesthesia care units or a dedicated
16 recovery area where the patient may be closely monitored and
17 observed until discharged; and

18 (c) is established by a physician, physician professional
19 association surgical practice, or other professional practice form
20 specified by the State Board of Medical Examiners pursuant to
21 regulation solely for the physician's, association's, or other
22 professional entity's private medical practice.

23 (6) Nothing in this subsection shall be construed to limit the State
24 Board of Medical Examiners from establishing standards of care with
25 respect to the practice of medicine.

26 h. An ambulatory care facility licensed to provide surgical and
27 related services shall be required to obtain ambulatory care
28 accreditation from an accrediting body recognized by the Centers for
29 Medicare and Medicaid Services as a condition of licensure by the
30 department.

31 An ambulatory care facility that is licensed to provide surgical and
32 related services on the effective date of this section of P.L.2009, c.24
33 shall have one year from the effective date of this section of
34 P.L.2009, c.24 to obtain ambulatory care accreditation.

35 i. Beginning on the effective date of this section of P.L.2009,
36 c.24, and as provided in P.L.2017, c.283, the department shall not
37 issue a new license to an ambulatory care facility to provide surgical
38 and related services unless:

39 (1) in the case of a licensed facility in which a transfer of
40 ownership of the facility is proposed, the commissioner reviews the
41 qualifications of the new owner or owners and approves the transfer;

42 (2) (a) except as provided in subparagraph (b) of this paragraph,
43 in the case of a licensed facility for which a relocation of the facility
44 is proposed, the relocation is within 20 miles of the facility's current
45 location or the relocation is to a "Health Enterprise Zone" designated
46 pursuant to section 1 of P.L.2004, c.139 (C.54A:3-7), there is no
47 expansion in the number of operating rooms provided at the new

- 1 location from that of the current location, and the commissioner
2 reviews and approves the relocation prior to its occurrence; or
- 3 (b) in the case of a licensed facility described in paragraph (5) or
4 (6) of this subsection for which a relocation of the facility is
5 proposed, the commissioner reviews and approves the relocation
6 prior to its occurrence;
- 7 (3) the entity is a surgical practice required to be licensed
8 pursuant to subsection g. of this section and meets the requirements
9 of that subsection;
- 10 (4) the entity has filed its plans, specifications, and required
11 documents with the Health Care Plan Review Unit of the Department
12 of Community Affairs or the municipality in which the surgical
13 practice or facility will be located, as applicable, on or before the
14 180th day following the effective date of this section of P.L.2009,
15 c.24;
- 16 (5) the facility is owned jointly by a general hospital in this State
17 and one or more other parties;
- 18 (6) the facility is owned by a hospital or medical school in this
19 State, or the facility is owned by any hospital approved on or before
20 the effective date of P.L.2015, c.305 to provide ambulatory surgery
21 services in this State, or the facility is owned by a hospital which
22 applied on or before the effective date of P.L.2015, c.305 to provide
23 ambulatory surgery services in this State so long as the hospital is
24 later approved to provide ambulatory surgery services at the facility,
25 or the facility is owned by any hospital approved to provide
26 ambulatory surgery services at another facility in this State; or
- 27 (7) (a) the facility is a newly licensed ambulatory surgical facility
28 that was created by combining two or more registered surgical
29 practices, provided that the number of operating rooms at the newly
30 licensed facility is not greater than the total number of operating
31 rooms prior to the establishment of the newly licensed facility;
- 32 (b) the facility is a licensed ambulatory surgical facility that has
33 expanded by combining with one or more registered surgical
34 practices, provided that the number of operating rooms at the newly
35 expanded facility is not greater than the total number of operating
36 rooms prior to the combination of the practices and facility; or
- 37 (c) the facility is a licensed ambulatory surgical facility that has
38 expanded through the combination of two or more licensed
39 ambulatory surgical facilities, provided that the number of operating
40 rooms at the newly expanded facility is not greater than the total
41 number of operating rooms prior to the combining of the facilities.
- 42 Beginning on the effective date of P.L.2017, c.283, the department
43 shall not issue a new registration to a surgical practice. Any surgical
44 practice in operation on the effective date of P.L.2017, c.283 that
45 proposes to relocate on or after the effective date of P.L.2017, c.283
46 shall be required to be licensed by the department as an ambulatory
47 care facility providing surgical and related services pursuant to
48 subsection g. of this section.

1 j. (Deleted by amendment, P.L.2017, c.283)

2 k. An ambulatory care facility licensed to provide surgical and
3 related services and a surgical practice shall:

4 (1) report to the department any change in ownership of the
5 facility within 30 days of the change in ownership; and

6 (2) annually report to the department the name of the facility's
7 medical director, physician director, and physician director of
8 anesthesia, as applicable, and the director of nursing services. The
9 facility shall notify the department if there is any change in a named
10 director within 30 days of the change of the director.

11 (cf: P.L.2017, c.283, s.1)

12

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

15 7. a. Effective January 1, 1994 through June 30, 2025, the
16 Department of Health shall assess each hospital a per adjusted
17 admission charge of \$10. Effective July 1, 2025, the Department of
18 Health shall assess each hospital a per adjusted admission charge of
19 \$12.50.

20 **【Of the】** The revenues raised by the hospital per adjusted
21 admission charge **【, \$5 per adjusted admission】** shall be used by the
22 department to carry out its duties pursuant to P.L.1992, c.160
23 (C.26:2H-18.51 et al.) and **【\$5 per adjusted admission shall be used**
24 **by the department】** for administrative costs related to health
25 planning.

26 Effective July 1, 2018, the assessment shall apply to all general
27 acute care hospitals, rehabilitation hospitals, **【and】** long term acute
28 care hospitals, and non-public psychiatric hospitals. Any General
29 Fund savings resulting from the assessment meeting the
30 permissibility standards set forth in 42 C.F.R. s.433.68 shall be used
31 to create a supplemental funding pool, known as Safety Net Graduate
32 Medical Education, for the State's graduate medical education
33 subsidy.

34 Notwithstanding the provisions of any law or regulation to the
35 contrary, and except as otherwise provided and subject to such
36 modifications as may be required by the Centers for Medicare and
37 Medicaid Services in order to achieve any required federal approval
38 and full federal financial participation, \$24,285,714 is appropriated
39 from the General Fund for Safety Net Graduate Medical Education,
40 and conditioned upon the following:

41 Funds from the Safety Net Graduate Medical Education pool shall
42 be available to eligible hospitals that meet the following eligibility
43 criteria: An eligible hospital has a Relative Medicaid Percentage
44 (RMP) that is in the top third of all acute care hospitals that have a
45 residency program. The RMP is a ratio calculated using the 2016
46 Audited C.160 SHARE Cost Reports. The numerator of the RMP
47 equals a hospital's gross revenue from patient care for Medicaid and

1 Medicaid HMO as reported on Line 1, Col. D & Col. H of Forms E5
2 and E6. The denominator of the RMP equals a hospital's gross
3 revenue from patient care as reported on Line 1, Col. E of Form E4.
4 For instances where hospitals that have a single Medicare
5 identification number submit a separate cost report for each campus,
6 the values referenced above shall be consolidated.

7 Payments to eligible hospitals shall be made in the following
8 manner:

9 (1) the subsidy payment shall be split into a Direct Medical
10 Education (DME) allocation, which is calculated by multiplying the
11 total subsidy amount by the ratio of 2016 total median Medicaid
12 managed care DME costs to total 2016 median Medicaid managed
13 care GME costs; and an Indirect Medical Education (IME) allocation,
14 which is calculated by multiplying the total subsidy amount by the
15 ratio of 2016 total Medicaid managed care IME costs to total 2016
16 Medicaid managed care GME costs.

17 (2) Each hospital's percentage of total 2016 Medicaid managed
18 care DME costs shall be multiplied by the DME allocation to
19 calculate its DME payment. Each hospital's percentage of total 2016
20 Medicaid managed care IME costs shall be multiplied by the IME
21 allocation to calculate its IME payment.

22 (3) Source data used shall come from the Medicaid cost report for
23 calendar year (CY) 2016 submitted by each acute care hospital by
24 November 30, 2017 and Medicaid Managed Care encounter
25 payments for Medicaid and NJ FamilyCare clients as reported by
26 insurers to the State for the following reporting period: services dates
27 between January 1, 2016 and December 31, 2016; payment dates
28 between January 1, 2016 and December 31, 2017; and a run date of
29 not later than January 31, 2018.

30 (4) In the event that a hospital reported less than 12 months of
31 2016 Medicaid costs, the number of reported months of data
32 regarding days, costs, or payments shall be annualized. In the event
33 the hospital completed a merger, acquisition, or business
34 combination or a supplemental cost report for the calendar year 2016
35 submitted by the affected acute care hospital by November 30, 2017
36 shall be used. In the event that a hospital did not report its Medicaid
37 managed care days on the cost report utilized in this calculation, the
38 Department of Health (DOH) shall ascertain Medicaid managed care
39 encounter days for Medicaid and NJ FamilyCare clients as reported
40 by insurers to the State.

41 (5) Medicaid managed care DME cost is defined as the approved
42 intern and residency program costs using the 2016 Medicaid cost
43 report total residency costs, reported on Worksheet B Pt I Column 21
44 line 21 plus Worksheet B Pt I Column 22 Line 22 divided by 2016
45 resident full time equivalent employees (FTE), reported on
46 Worksheet S--3 Pt 1 Column 9 line 14 to develop an average cost per
47 FTE for each hospital used to calculate the overall median cost per
48 FTE.

1 (6) The median cost per FTE is multiplied by the 2016 resident
2 FTEs reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop
3 approved total residency program costs.

4 (7) The approved residency costs are multiplied by the quotient
5 of Medicaid managed care days, reported on Worksheet S--3 Column
6 7 line 2, divided by the quantity of total days, on Worksheet S--3
7 Column 8 line 14, less nursery days, on Worksheet S--3 Column 8
8 line 13.

9 (8) Medicaid managed care IME cost is defined as the Medicare
10 IME factor multiplied by Medicaid managed care encounter
11 payments for Medicaid and NJ FamilyCare clients as reported by
12 insurers to the State.

13 (9) The IME factor is calculated using the Medicare IME formula
14 as follows: $1.35 * [(1 + x)^{0.405} - 1]$, in which "x" is the quotient of
15 submitted IME resident full--time equivalencies reported on
16 Worksheet S--3 Pt 1 Column 9 line 14 divided by the quantity of total
17 available beds less nursery beds reported on Worksheet S--3 Column
18 2 line 14.

19 (10) In the event that a hospital believes that there are
20 mathematical errors in the calculations, or data not matching the
21 actual source documents used to calculate the subsidy as defined
22 above, hospitals shall be permitted to file calculation appeals within
23 15 working days of receipt of the subsidy allocation letter. If upon
24 review it is determined by the department that the error has occurred
25 and would constitute at least a five percent change in the hospital's
26 allocation amount, a revised industry--wide allocation shall be
27 issued.

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

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

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

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

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

4 The commissioner shall provide notice no later than August 15,
5 2004 to all facilities that are subject to the assessment that the first
6 payment of the assessment is due October 1, 2004 and that proof of
7 gross receipts for the facility's tax year ending in calendar year 2003
8 shall be provided by the facility to the commissioner no later than
9 September 15, 2004. If a facility fails to provide proof of gross
10 receipts by September 15, 2004, the facility shall be assessed the
11 maximum rate of \$200,000 for Fiscal Year 2005.

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

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

24 (3) Beginning in Fiscal Year 2007 and for each fiscal year
25 thereafter through Fiscal Year 2010, the uniform gross receipts
26 assessment rate calculated in accordance with paragraph (2) of this
27 subsection shall be applied to each facility subject to the assessment
28 with gross receipts over \$300,000, as those gross receipts are
29 documented in the facility's most recent annual report to the
30 department, except that no facility shall pay an assessment greater
31 than \$200,000. A facility shall pay its annual assessment to the
32 department in four payments in accordance with a timetable
33 prescribed by the commissioner.

34 (4) Beginning in Fiscal Year 2011 and for each fiscal year
35 thereafter through Fiscal Year 2025, the uniform gross receipts
36 assessment shall be applied at the rate of 2.95 percent to each facility
37 subject to the assessment with gross receipts over \$300,000, as those
38 gross receipts are documented in the facility's most recent annual
39 report submitted to the department pursuant to subsection c. of this
40 section, except that no facility shall pay an assessment greater than
41 \$350,000. A facility shall pay its annual assessment to the
42 department in four payments in accordance with a timetable
43 prescribed by the commissioner.

44 (5) Beginning in Fiscal Year 2026 and for each fiscal year
45 thereafter, the uniform gross receipts assessment shall be applied at
46 the rate of 2.5 percent to each facility subject to the assessment. A
47 facility shall pay its annual assessment to the department in four

1 payments in accordance with a timetable prescribed by the
2 commissioner.

3 (6) An ambulatory care facility that was exempt from the
4 assessment prior to Fiscal Year 2026 pursuant to section 12 of
5 P.L.1971, c.136 (C.26:2H-12) shall report in Fiscal Year 2026 the
6 facility's gross receipts from its operating room services, pursuant to
7 subsection c. of this section, and the department shall assess 2.5
8 percent of the facility's gross receipts beginning in Fiscal Year 2027.
9 As used in this subparagraph, "operating room services" shall mean
10 surgical or diagnostic procedures performed in a room specifically
11 equipped to perform surgery, and designed and constructed to
12 accommodate invasive diagnostic and surgical procedures.

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

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

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

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

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

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

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

47 (cf: P.L.2018, c.116, s.1)

1 3. This act shall take effect immediately.

2

3

4

STATEMENT

5

6 This bill establishes the “Healthcare Finance Enhancement Act.”

7 Under current law, the Department of Health imposes an

8 assessment on the gross receipts of ambulatory care facilities with

9 gross receipts over \$300,000. This assessment is imposed at a rate

10 of 2.95 percent on each facility that is subject to the assessment. The

11 assessments on ambulatory care facilities collected under this law are

12 to be deposited in the Health Care Subsidy Fund established pursuant

13 to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

14 This bill amends current law to reduce this assessment rate from

15 2.95 percent to 2.5 percent in fiscal year 2026 and to extend the

16 assessment to all ambulatory care facilities beginning in fiscal year

17 2027. The bill also eliminates the exemption from the ambulatory

18 care facility assessment for surgical practices beginning in fiscal year

19 2026.

20 The bill increases the per adjusted admission charge imposed on

21 hospitals by the Department of Health from \$10 to \$12.50 beginning

22 on July 1, 2025, and extends the imposition of this charge to non-

23 public psychiatric hospitals.

24

25

26

27

28 _____

“Healthcare Finance Enhancement Act.”

CHAPTER 70

AN ACT concerning ambulatory care facility assessments and hospital admission charges, and amending P.L.1971, c.136 and P.L.1992, c.160.

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

1. 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 certain health care facilities; 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. Any surgical practice required to apply for licensure by the department as an ambulatory care facility pursuant to P.L.2017, c.283 shall be exempt from the initial and renewal license fees required by this section. 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.

(3) The department shall post on its Internet website each inspection report prepared following an inspection of a residential health care facility, as defined in section 1 of P.L.1953, c.212 (C.30:11A-1) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), that is performed pursuant to this subsection, along with any other inspection report prepared by or on behalf of the department for such facility.

If an inspection reveals a serious health and safety violation at a residential health care facility, the department shall post the inspection report, including the name of the facility and

the owner of the facility, on its website no later than 72 hours following the inspection. If a license of a residential health care facility is suspended, the department shall post the suspension on its website no later than 72 hours following the suspension. The department shall update its website to reflect the correction of a serious health and safety violation and the lifting of a suspension.

The department shall notify, as soon as possible, the Commissioner of Human Services, or the commissioner's designee, and the director of the county board of social services or county welfare agency, as appropriate, in the county in which a residential health care facility is located, of a serious health and safety violation at the facility and of any suspension of a license to operate such facility.

If the inspection responsibilities under this subsection with respect to such facility are transferred or otherwise assigned to another department, that other department shall post on its Internet website each inspection report prepared following an inspection of such facility performed pursuant to this subsection, along with any other inspection report prepared by or on behalf of that department for such facility, and shall comply with the other requirements specified in this subsection.

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 al.) 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.

g. (1) (Deleted by amendment, P.L.2017, c.283)

(2) (Deleted by amendment, P.L.2017, c.283)

(3) (Deleted by amendment, P.L.2017, c.283)

(4) A surgical practice in operation on the date of enactment of P.L.2017, c.283 shall be required to apply to the department for licensure as an ambulatory care facility licensed to provide surgical and related services within one year of the date of enactment of P.L.2017, c.283.

A surgical practice that is certified by the Centers for Medicare and Medicaid Services (CMS) shall not be required to meet the physical plant and functional requirements specified in N.J.A.C.8:43A-19.1 et seq. A surgical practice that is not Medicare certified, either by CMS or by any deeming authority recognized by CMS, but which has obtained accreditation from the American Association of Ambulatory Surgery Facilities or any accrediting body recognized by CMS and is in operation on the date of enactment of P.L.2017, c.283, shall not be required to meet the physical plant and functional requirements specified in N.J.A.C.8:43A-19.1 et seq. A surgical practice not in operation on the date of enactment of P.L.2017, c.283,

if it is certified by CMS as an ambulatory surgery center provider, shall also be exempt from these requirements. A surgical practice required by this subsection to meet the physical plant and functional requirements specified in N.J.A.C.8:43A-19.1 et seq. may apply for a waiver of any such requirement in accordance with N.J.A.C.8:43A-2.9. The commissioner shall grant a waiver of those physical plant and functional requirements, as the commissioner deems appropriate, if the waiver does not endanger the life, safety, or health of patients or the public.

Through State Fiscal Year 2025, a surgical practice required to be licensed pursuant to this subsection shall be exempt from the ambulatory care facility assessment pursuant to section 7 of P.L.1992, c.160 (C.26:2H-18.57), except that, if the entity expands to include any additional room dedicated for use as an operating room, the entity shall be subject to the assessment. Beginning in State Fiscal Year 2026, a surgical practice required to be licensed pursuant to this subsection shall no longer be exempt from the ambulatory care facility assessment.

(5) As used in this subsection and subsection i. of this section, "surgical practice" means a structure or suite of rooms that has the following characteristics:

(a) has no more than one room dedicated for use as an operating room which is specifically equipped to perform surgery and is designed and constructed to accommodate invasive diagnostic and surgical procedures;

(b) has one or more post-anesthesia care units or a dedicated recovery area where the patient may be closely monitored and observed until discharged; and

(c) is established by a physician, physician professional association surgical practice, or other professional practice form specified by the State Board of Medical Examiners pursuant to regulation solely for the physician's, association's, or other professional entity's private medical practice.

(6) Nothing in this subsection shall be construed to limit the State Board of Medical Examiners from establishing standards of care with respect to the practice of medicine.

h. An ambulatory care facility licensed to provide surgical and related services shall be required to obtain ambulatory care accreditation from an accrediting body recognized by the Centers for Medicare and Medicaid Services as a condition of licensure by the department.

An ambulatory care facility that is licensed to provide surgical and related services on the effective date of this section of P.L.2009, c.24 shall have one year from the effective date of this section of P.L.2009, c.24 to obtain ambulatory care accreditation.

i. Beginning on the effective date of this section of P.L.2009, c.24, and as provided in P.L.2017, c.283, the department shall not issue a new license to an ambulatory care facility to provide surgical and related services unless:

(1) in the case of a licensed facility in which a transfer of ownership of the facility is proposed, the commissioner reviews the qualifications of the new owner or owners and approves the transfer;

(2) (a) except as provided in subparagraph (b) of this paragraph, in the case of a licensed facility for which a relocation of the facility is proposed, the relocation is within 20 miles of the facility's current location or the relocation is to a "Health Enterprise Zone" designated pursuant to section 1 of P.L.2004, c.139 (C.54A:3-7), there is no expansion in the number of operating rooms provided at the new location from that of the current location, and the commissioner reviews and approves the relocation prior to its occurrence; or

(b) in the case of a licensed facility described in paragraph (5) or (6) of this subsection for which a relocation of the facility is proposed, the commissioner reviews and approves the relocation prior to its occurrence;

(3) the entity is a surgical practice required to be licensed pursuant to subsection g. of this section and meets the requirements of that subsection;

(4) the entity has filed its plans, specifications, and required documents with the Health Care Plan Review Unit of the Department of Community Affairs or the municipality in which the surgical practice or facility will be located, as applicable, on or before the 180th day following the effective date of this section of P.L.2009, c.24;

(5) the facility is owned jointly by a general hospital in this State and one or more other parties;

(6) the facility is owned by a hospital or medical school in this State, or the facility is owned by any hospital approved on or before the effective date of P.L.2015, c.305 to provide ambulatory surgery services in this State, or the facility is owned by a hospital which applied on or before the effective date of P.L.2015, c.305 to provide ambulatory surgery services in this State so long as the hospital is later approved to provide ambulatory surgery services at the facility, or the facility is owned by any hospital approved to provide ambulatory surgery services at another facility in this State; or

(7) (a) the facility is a newly licensed ambulatory surgical facility that was created by combining two or more registered surgical practices, provided that the number of operating rooms at the newly licensed facility is not greater than the total number of operating rooms prior to the establishment of the newly licensed facility;

(b) the facility is a licensed ambulatory surgical facility that has expanded by combining with one or more registered surgical practices, provided that the number of operating rooms at the newly expanded facility is not greater than the total number of operating rooms prior to the combination of the practices and facility; or

(c) the facility is a licensed ambulatory surgical facility that has expanded through the combination of two or more licensed ambulatory surgical facilities, provided that the number of operating rooms at the newly expanded facility is not greater than the total number of operating rooms prior to the combining of the facilities.

Beginning on the effective date of P.L.2017, c.283, the department shall not issue a new registration to a surgical practice. Any surgical practice in operation on the effective date of P.L.2017, c.283 that proposes to relocate on or after the effective date of P.L.2017, c.283 shall be required to be licensed by the department as an ambulatory care facility providing surgical and related services pursuant to subsection g. of this section.

j. (Deleted by amendment, P.L.2017, c.283)

k. An ambulatory care facility licensed to provide surgical and related services and a surgical practice shall:

(1) report to the department any change in ownership of the facility within 30 days of the change in ownership; and

(2) annually report to the department the name of the facility's medical director, physician director, and physician director of anesthesia, as applicable, and the director of nursing services. The facility shall notify the department if there is any change in a named director within 30 days of the change of the director.

2. 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; use of funds.

7. a. Effective January 1, 1994 through June 30, 2025, the Department of Health shall assess each hospital a per adjusted admission charge of \$10. Effective July 1, 2025, the Department of Health shall assess each hospital a per adjusted admission charge of \$12.50.

The revenues raised by the hospital per adjusted admission charge 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 for administrative costs related to health planning.

Effective July 1, 2018, the assessment shall apply to all general acute care hospitals, rehabilitation hospitals, long term acute care hospitals, and non-public psychiatric hospitals. Any General Fund savings resulting from the assessment meeting the permissibility standards set forth in 42 C.F.R. s.433.68 shall be used to create a supplemental funding pool, known as Safety Net Graduate Medical Education, for the State's graduate medical education subsidy.

Notwithstanding the provisions of any law or regulation to the contrary, and except as otherwise provided and subject to such modifications as may be required by the Centers for Medicare and Medicaid Services in order to achieve any required federal approval and full federal financial participation, \$24,285,714 is appropriated from the General Fund for Safety Net Graduate Medical Education, and conditioned upon the following:

Funds from the Safety Net Graduate Medical Education pool shall be available to eligible hospitals that meet the following eligibility criteria: An eligible hospital has a Relative Medicaid Percentage (RMP) that is in the top third of all acute care hospitals that have a residency program. The RMP is a ratio calculated using the 2016 Audited C.160 SHARE Cost Reports. The numerator of the RMP equals a hospital's gross revenue from patient care for Medicaid and Medicaid HMO as reported on Line 1, Col. D & Col. H of Forms E5 and E6. The denominator of the RMP equals a hospital's gross revenue from patient care as reported on Line 1, Col. E of Form E4. For instances where hospitals that have a single Medicare identification number submit a separate cost report for each campus, the values referenced above shall be consolidated.

Payments to eligible hospitals shall be made in the following manner:

(1) the subsidy payment shall be split into a Direct Medical Education (DME) allocation, which is calculated by multiplying the total subsidy amount by the ratio of 2016 total median Medicaid managed care DME costs to total 2016 median Medicaid managed care GME costs; and an Indirect Medical Education (IME) allocation, which is calculated by multiplying the total subsidy amount by the ratio of 2016 total Medicaid managed care IME costs to total 2016 Medicaid managed care GME costs.

(2) Each hospital's percentage of total 2016 Medicaid managed care DME costs shall be multiplied by the DME allocation to calculate its DME payment. Each hospital's percentage of total 2016 Medicaid managed care IME costs shall be multiplied by the IME allocation to calculate its IME payment.

(3) Source data used shall come from the Medicaid cost report for calendar year (CY) 2016 submitted by each acute care hospital by November 30, 2017 and Medicaid Managed Care encounter payments for Medicaid and NJ FamilyCare clients as reported by insurers to the State for the following reporting period: services dates between January 1, 2016 and December 31, 2016; payment dates between January 1, 2016 and December 31, 2017; and a run date of not later than January 31, 2018.

(4) In the event that a hospital reported less than 12 months of 2016 Medicaid costs, the number of reported months of data regarding days, costs, or payments shall be annualized. In the event the hospital completed a merger, acquisition, or business combination or a supplemental cost report for the calendar year 2016 submitted by the affected acute care hospital by November 30, 2017 shall be used. In the event that a hospital did not report its Medicaid managed care days on the cost report utilized in this calculation, the Department of Health (DOH) shall ascertain Medicaid managed care encounter days for Medicaid and NJ FamilyCare clients as reported by insurers to the State.

(5) Medicaid managed care DME cost is defined as the approved intern and residency program costs using the 2016 Medicaid cost report total residency costs, reported on Worksheet B Pt I Column 21 line 21 plus Worksheet B Pt I Column 22 Line 22 divided by

2016 resident full time equivalent employees (FTE), reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop an average cost per FTE for each hospital used to calculate the overall median cost per FTE.

(6) The median cost per FTE is multiplied by the 2016 resident FTEs reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop approved total residency program costs.

(7) The approved residency costs are multiplied by the quotient of Medicaid managed care days, reported on Worksheet S--3 Column 7 line 2, divided by the quantity of total days, on Worksheet S--3 Column 8 line 14, less nursery days, on Worksheet S--3 Column 8 line 13.

(8) Medicaid managed care IME cost is defined as the Medicare IME factor multiplied by Medicaid managed care encounter payments for Medicaid and NJ FamilyCare clients as reported by insurers to the State.

(9) The IME factor is calculated using the Medicare IME formula as follows: $1.35 * [(1 + x)^{0.405} - 1]$, in which "x" is the quotient of submitted IME resident full-time equivalencies reported on Worksheet S--3 Pt 1 Column 9 line 14 divided by the quantity of total available beds less nursery beds reported on Worksheet S--3 Column 2 line 14.

(10) In the event that a hospital believes that there are mathematical errors in the calculations, or data not matching the actual source documents used to calculate the subsidy as defined above, hospitals shall be permitted to file calculation appeals within 15 working days of receipt of the subsidy allocation letter. If upon review it is determined by the department that the error has occurred and would constitute at least a five percent change in the hospital's allocation amount, a revised industry-wide allocation shall be issued.

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 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 off-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 percent 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 through Fiscal Year 2010, 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.

(4) Beginning in Fiscal Year 2011 and for each fiscal year thereafter through Fiscal Year 2025, the uniform gross receipts assessment shall be applied at the rate of 2.95 percent 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 submitted to the department pursuant to subsection c. of this section, except that no facility shall pay an assessment greater than \$350,000. A facility shall pay its annual assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

(5) Beginning in Fiscal Year 2026 and for each fiscal year thereafter, the uniform gross receipts assessment shall be applied at the rate of 2.5 percent to each facility subject to the assessment. A facility shall pay its annual assessment to the department in four payments in accordance with a timetable prescribed by the commissioner.

(6) An ambulatory care facility that was exempt from the assessment prior to Fiscal Year 2026 pursuant to section 12 of P.L.1971, c.136 (C.26:2H-12) shall report in Fiscal Year 2026 the facility's gross receipts from its operating room services, pursuant to subsection c. of this section, and the department shall assess 2.5 percent of the facility's gross receipts beginning in Fiscal Year 2027. As used in this subparagraph, "operating room services" shall mean surgical or diagnostic procedures performed in a room specifically equipped to perform surgery, and designed and constructed to accommodate invasive diagnostic and surgical procedures.

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.

P.L. 2025, CHAPTER 70

8

(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).

3. This act shall take effect immediately.

Approved June 30, 2025.

ASSEMBLY, No. 5809

STATE OF NEW JERSEY 221st LEGISLATURE

INTRODUCED JUNE 26, 2025

Sponsored by:

Assemblywoman CAROL A. MURPHY

District 7 (Burlington)

Senator JOSEPH F. VITALE

District 19 (Middlesex)

SYNOPSIS

“Healthcare Finance Enhancement Act.”

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 6/30/2025)

A5809 MURPHY

2

1 AN ACT concerning ambulatory care facility assessments and
2 hospital admission charges, and amending P.L.1971, c.136 and
3 P.L.1992, c.160.

4

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

7

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

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

26 b. (1) Application for a license for a health care service or health
27 care facility shall be made upon forms prescribed by the department.
28 The department shall charge a single, nonrefundable fee for the filing
29 of an application for and issuance of a license and a single,
30 nonrefundable fee for any renewal thereof, and a single,
31 nonrefundable fee for a biennial inspection of the facility, as it shall
32 from time to time fix in rules or regulations; provided, however, that
33 no such licensing fee shall exceed \$10,000 in the case of a hospital
34 and \$4,000 in the case of any other health care facility for all services
35 provided by the hospital or other health care facility, and no such
36 inspection fee shall exceed \$5,000 in the case of a hospital and \$2,000
37 in the case of any other health care facility for all services provided
38 by the hospital or other health care facility. No inspection fee shall
39 be charged for inspections other than biennial inspections. Any
40 surgical practice required to apply for licensure by the department as
41 an ambulatory care facility pursuant to P.L.2017, c.283 shall be
42 exempt from the initial and renewal license fees required by this
43 section. The application shall contain the name of the health care
44 facility, the kind or kinds of health care service to be provided, the
45 location and physical description of the institution, and such other
46 information as the department may require.

EXPLANATION – Matter enclosed in bold-faced brackets **[thus]** in the above bill is
not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 (2) A license shall be issued by the department upon its findings
2 that the premises, equipment, personnel, including principals and
3 management, finances, rules and bylaws, and standards of health care
4 service are fit and adequate and there is reasonable assurance the
5 health care facility will be operated in the manner required by this act
6 and rules and regulations thereunder.

7 (3) The department shall post on its Internet website each
8 inspection report prepared following an inspection of a residential
9 health care facility, as defined in section 1 of P.L.1953, c.212
10 (C.30:11A-1) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
11 seq.), that is performed pursuant to this subsection, along with any
12 other inspection report prepared by or on behalf of the department for
13 such facility.

14 If an inspection reveals a serious health and safety violation at a
15 residential health care facility, the department shall post the
16 inspection report, including the name of the facility and the owner of
17 the facility, on its website no later than 72 hours following the
18 inspection. If a license of a residential health care facility is
19 suspended, the department shall post the suspension on its website no
20 later than 72 hours following the suspension. The department shall
21 update its website to reflect the correction of a serious health and
22 safety violation, and the lifting of a suspension.

23 The department shall notify, as soon as possible, the
24 Commissioner of Human Services, or the commissioner's designee,
25 and the director of the county board of social services or county
26 welfare agency, as appropriate, in the county in which a residential
27 health care facility is located, of a serious health and safety violation
28 at the facility and of any suspension of a license to operate such
29 facility.

30 If the inspection responsibilities under this subsection with respect
31 to such facility are transferred or otherwise assigned to another
32 department, that other department shall post on its Internet website
33 each inspection report prepared following an inspection of such
34 facility performed pursuant to this subsection, along with any other
35 inspection report prepared by or on behalf of that department for such
36 facility, and shall comply with the other requirements specified in
37 this subsection.

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

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

46 e. If a prospective applicant for licensure for a health care
47 service or facility that is not subject to certificate of need review
48 pursuant to P.L.1971, c.136 (C.26:2H-1 et al.) so requests, the

1 department shall provide the prospective applicant with a pre-
2 licensure consultation. The purpose of the consultation is to provide
3 the prospective applicant with information and guidance on rules,
4 regulations, standards and procedures appropriate and applicable to
5 the licensure process. The department shall conduct the consultation
6 within 60 days of the request of the prospective applicant.

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

14 g. (1) (Deleted by amendment, P.L.2017, c.283)

15 (2) (Deleted by amendment, P.L.2017, c.283)

16 (3) (Deleted by amendment, P.L.2017, c.283)

17 (4) A surgical practice in operation on the date of enactment of
18 P.L.2017, c.283 shall be required to apply to the department for
19 licensure as an ambulatory care facility licensed to provide surgical
20 and related services within one year of the date of enactment of
21 P.L.2017, c.283.

22 A surgical practice that is certified by the Centers for Medicare
23 and Medicaid Services (CMS) shall not be required to meet the
24 physical plant and functional requirements specified in
25 N.J.A.C.8:43A-19.1 et seq. A surgical practice that is not Medicare
26 certified, either by CMS or by any deeming authority recognized by
27 CMS, but which has obtained accreditation from the American
28 Association of Ambulatory Surgery Facilities or any accrediting
29 body recognized by CMS and is in operation on the date of enactment
30 of P.L.2017, c.283, shall not be required to meet the physical plant
31 and functional requirements specified in N.J.A.C.8:43A-19.1 et seq.
32 A surgical practice not in operation on the date of enactment of
33 P.L.2017, c.283, if it is certified by CMS as an ambulatory surgery
34 center provider, shall also be exempt from these requirements. A
35 surgical practice required by this subsection to meet the physical
36 plant and functional requirements specified in N.J.A.C.8:43A-19.1 et
37 seq. may apply for a waiver of any such requirement in accordance
38 with N.J.A.C.8:43A-2.9. The commissioner shall grant a waiver of
39 those physical plant and functional requirements, as the
40 commissioner deems appropriate, if the waiver does not endanger the
41 life, safety, or health of patients or the public.

42 **[A] Through State Fiscal Year 2025, a surgical practice required**
43 **to be licensed pursuant to this subsection shall be exempt from the**
44 **ambulatory care facility assessment pursuant to section 7 of**
45 **P.L.1992, c.160 (C.26:2H-18.57); except that, if the entity expands**
46 **to include any additional room dedicated for use as an operating**
47 **room, the entity shall be subject to the assessment. Beginning in**
48 **State Fiscal Year 2026, a surgical practice required to be licensed**

1 pursuant to this subsection shall no longer be exempt from the
2 ambulatory care facility assessment.

3 (5) As used in this subsection and subsection i. of this section,
4 "surgical practice" means a structure or suite of rooms that has the
5 following characteristics:

6 (a) has no more than one room dedicated for use as an operating
7 room which is specifically equipped to perform surgery, and is
8 designed and constructed to accommodate invasive diagnostic and
9 surgical procedures;

10 (b) has one or more post-anesthesia care units or a dedicated
11 recovery area where the patient may be closely monitored and
12 observed until discharged; and

13 (c) is established by a physician, physician professional
14 association surgical practice, or other professional practice form
15 specified by the State Board of Medical Examiners pursuant to
16 regulation solely for the physician's, association's, or other
17 professional entity's private medical practice.

18 (6) Nothing in this subsection shall be construed to limit the State
19 Board of Medical Examiners from establishing standards of care with
20 respect to the practice of medicine.

21 h. An ambulatory care facility licensed to provide surgical and
22 related services shall be required to obtain ambulatory care
23 accreditation from an accrediting body recognized by the Centers for
24 Medicare and Medicaid Services as a condition of licensure by the
25 department.

26 An ambulatory care facility that is licensed to provide surgical and
27 related services on the effective date of this section of P.L.2009, c.24
28 shall have one year from the effective date of this section of
29 P.L.2009, c.24 to obtain ambulatory care accreditation.

30 i. Beginning on the effective date of this section of P.L.2009,
31 c.24, and as provided in P.L.2017, c.283, the department shall not
32 issue a new license to an ambulatory care facility to provide surgical
33 and related services unless:

34 (1) in the case of a licensed facility in which a transfer of
35 ownership of the facility is proposed, the commissioner reviews the
36 qualifications of the new owner or owners and approves the transfer;

37 (2) (a) except as provided in subparagraph (b) of this paragraph,
38 in the case of a licensed facility for which a relocation of the facility
39 is proposed, the relocation is within 20 miles of the facility's current
40 location or the relocation is to a "Health Enterprise Zone" designated
41 pursuant to section 1 of P.L.2004, c.139 (C.54A:3-7), there is no
42 expansion in the number of operating rooms provided at the new
43 location from that of the current location, and the commissioner
44 reviews and approves the relocation prior to its occurrence; or

45 (b) in the case of a licensed facility described in paragraph (5) or
46 (6) of this subsection for which a relocation of the facility is
47 proposed, the commissioner reviews and approves the relocation
48 prior to its occurrence;

1 (3) the entity is a surgical practice required to be licensed
2 pursuant to subsection g. of this section and meets the requirements
3 of that subsection;

4 (4) the entity has filed its plans, specifications, and required
5 documents with the Health Care Plan Review Unit of the Department
6 of Community Affairs or the municipality in which the surgical
7 practice or facility will be located, as applicable, on or before the
8 180th day following the effective date of this section of P.L.2009,
9 c.24;

10 (5) the facility is owned jointly by a general hospital in this State
11 and one or more other parties;

12 (6) the facility is owned by a hospital or medical school in this
13 State, or the facility is owned by any hospital approved on or before
14 the effective date of P.L.2015, c.305 to provide ambulatory surgery
15 services in this State, or the facility is owned by a hospital which
16 applied on or before the effective date of P.L.2015, c.305 to provide
17 ambulatory surgery services in this State so long as the hospital is
18 later approved to provide ambulatory surgery services at the facility,
19 or the facility is owned by any hospital approved to provide
20 ambulatory surgery services at another facility in this State; or

21 (7) (a) the facility is a newly licensed ambulatory surgical facility
22 that was created by combining two or more registered surgical
23 practices, provided that the number of operating rooms at the newly
24 licensed facility is not greater than the total number of operating
25 rooms prior to the establishment of the newly licensed facility;

26 (b) the facility is a licensed ambulatory surgical facility that has
27 expanded by combining with one or more registered surgical
28 practices, provided that the number of operating rooms at the newly
29 expanded facility is not greater than the total number of operating
30 rooms prior to the combination of the practices and facility; or

31 (c) the facility is a licensed ambulatory surgical facility that has
32 expanded through the combination of two or more licensed
33 ambulatory surgical facilities, provided that the number of operating
34 rooms at the newly expanded facility is not greater than the total
35 number of operating rooms prior to the combining of the facilities.

36 Beginning on the effective date of P.L.2017, c.283, the department
37 shall not issue a new registration to a surgical practice. Any surgical
38 practice in operation on the effective date of P.L.2017, c.283 that
39 proposes to relocate on or after the effective date of P.L.2017, c.283
40 shall be required to be licensed by the department as an ambulatory
41 care facility providing surgical and related services pursuant to
42 subsection g. of this section.

43 j. (Deleted by amendment, P.L.2017, c.283)

44 k. An ambulatory care facility licensed to provide surgical and
45 related services and a surgical practice shall:

46 (1) report to the department any change in ownership of the
47 facility within 30 days of the change in ownership; and

A5809 MURPHY

7

1 (2) annually report to the department the name of the facility's
2 medical director, physician director, and physician director of
3 anesthesia, as applicable, and the director of nursing services. The
4 facility shall notify the department if there is any change in a named
5 director within 30 days of the change of the director.

6 (cf: P.L.2017, c.283, s.1)

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

10 7. a. Effective January 1, 1994 through June 30, 2025, the
11 Department of Health shall assess each hospital a per adjusted
12 admission charge of \$10. Effective July 1, 2025, the Department of
13 Health shall assess each hospital a per adjusted admission charge of
14 \$12.50.

15 **【Of the】** The revenues raised by the hospital per adjusted
16 admission charge **【, \$5 per adjusted admission】** shall be used by the
17 department to carry out its duties pursuant to P.L.1992, c.160
18 (C.26:2H-18.51 et al.) and **【\$5 per adjusted admission shall be used**
19 **by the department】** for administrative costs related to health
20 planning.

21 Effective July 1, 2018, the assessment shall apply to all general
22 acute care hospitals, rehabilitation hospitals, **【and】** long term acute
23 care hospitals, and non-public psychiatric hospitals. Any General
24 Fund savings resulting from the assessment meeting the
25 permissibility standards set forth in 42 C.F.R. s.433.68 shall be used
26 to create a supplemental funding pool, known as Safety Net Graduate
27 Medical Education, for the State's graduate medical education
28 subsidy.

29 Notwithstanding the provisions of any law or regulation to the
30 contrary, and except as otherwise provided and subject to such
31 modifications as may be required by the Centers for Medicare and
32 Medicaid Services in order to achieve any required federal approval
33 and full federal financial participation, \$24,285,714 is appropriated
34 from the General Fund for Safety Net Graduate Medical Education,
35 and conditioned upon the following:

36 Funds from the Safety Net Graduate Medical Education pool shall
37 be available to eligible hospitals that meet the following eligibility
38 criteria: An eligible hospital has a Relative Medicaid Percentage
39 (RMP) that is in the top third of all acute care hospitals that have a
40 residency program. The RMP is a ratio calculated using the 2016
41 Audited C.160 SHARE Cost Reports. The numerator of the RMP
42 equals a hospital's gross revenue from patient care for Medicaid and
43 Medicaid HMO as reported on Line 1, Col. D & Col. H of Forms E5
44 and E6. The denominator of the RMP equals a hospital's gross
45 revenue from patient care as reported on Line 1, Col. E of Form E4.
46 For instances where hospitals that have a single Medicare

1 identification number submit a separate cost report for each campus,
2 the values referenced above shall be consolidated.

3 Payments to eligible hospitals shall be made in the following
4 manner:

5 (1) the subsidy payment shall be split into a Direct Medical
6 Education (DME) allocation, which is calculated by multiplying the
7 total subsidy amount by the ratio of 2016 total median Medicaid
8 managed care DME costs to total 2016 median Medicaid managed
9 care GME costs; and an Indirect Medical Education (IME) allocation,
10 which is calculated by multiplying the total subsidy amount by the
11 ratio of 2016 total Medicaid managed care IME costs to total 2016
12 Medicaid managed care GME costs.

13 (2) Each hospital's percentage of total 2016 Medicaid managed
14 care DME costs shall be multiplied by the DME allocation to
15 calculate its DME payment. Each hospital's percentage of total 2016
16 Medicaid managed care IME costs shall be multiplied by the IME
17 allocation to calculate its IME payment.

18 (3) Source data used shall come from the Medicaid cost report for
19 calendar year (CY) 2016 submitted by each acute care hospital by
20 November 30, 2017 and Medicaid Managed Care encounter
21 payments for Medicaid and NJ FamilyCare clients as reported by
22 insurers to the State for the following reporting period: services dates
23 between January 1, 2016 and December 31, 2016; payment dates
24 between January 1, 2016 and December 31, 2017; and a run date of
25 not later than January 31, 2018.

26 (4) In the event that a hospital reported less than 12 months of
27 2016 Medicaid costs, the number of reported months of data
28 regarding days, costs, or payments shall be annualized. In the event
29 the hospital completed a merger, acquisition, or business
30 combination or a supplemental cost report for the calendar year 2016
31 submitted by the affected acute care hospital by November 30, 2017
32 shall be used. In the event that a hospital did not report its Medicaid
33 managed care days on the cost report utilized in this calculation, the
34 Department of Health (DOH) shall ascertain Medicaid managed care
35 encounter days for Medicaid and NJ FamilyCare clients as reported
36 by insurers to the State.

37 (5) Medicaid managed care DME cost is defined as the approved
38 intern and residency program costs using the 2016 Medicaid cost
39 report total residency costs, reported on Worksheet B Pt I Column 21
40 line 21 plus Worksheet B Pt I Column 22 Line 22 divided by 2016
41 resident full time equivalent employees (FTE), reported on
42 Worksheet S--3 Pt 1 Column 9 line 14 to develop an average cost per
43 FTE for each hospital used to calculate the overall median cost per
44 FTE.

45 (6) The median cost per FTE is multiplied by the 2016 resident
46 FTEs reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop
47 approved total residency program costs.

A5809 MURPHY

1 (7) The approved residency costs are multiplied by the quotient
2 of Medicaid managed care days, reported on Worksheet S--3 Column
3 7 line 2, divided by the quantity of total days, on Worksheet S--3
4 Column 8 line 14, less nursery days, on Worksheet S--3 Column 8
5 line 13.

6 (8) Medicaid managed care IME cost is defined as the Medicare
7 IME factor multiplied by Medicaid managed care encounter
8 payments for Medicaid and NJ FamilyCare clients as reported by
9 insurers to the State.

10 (9) The IME factor is calculated using the Medicare IME formula
11 as follows: $1.35 * [(1 + x)^{0.405} - 1]$, in which "x" is the quotient of
12 submitted IME resident full--time equivalencies reported on
13 Worksheet S--3 Pt 1 Column 9 line 14 divided by the quantity of total
14 available beds less nursery beds reported on Worksheet S--3 Column
15 2 line 14.

16 (10) In the event that a hospital believes that there are
17 mathematical errors in the calculations, or data not matching the
18 actual source documents used to calculate the subsidy as defined
19 above, hospitals shall be permitted to file calculation appeals within
20 15 working days of receipt of the subsidy allocation letter. If upon
21 review it is determined by the department that the error has occurred
22 and would constitute at least a five percent change in the hospital's
23 allocation amount, a revised industry--wide allocation shall be
24 issued.

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

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

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

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

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

47 The commissioner shall provide notice no later than August 15,
48 2004 to all facilities that are subject to the assessment that the first

A5809 MURPHY

10

1 payment of the assessment is due October 1, 2004 and that proof of
2 gross receipts for the facility's tax year ending in calendar year 2003
3 shall be provided by the facility to the commissioner no later than
4 September 15, 2004. If a facility fails to provide proof of gross
5 receipts by September 15, 2004, the facility shall be assessed the
6 maximum rate of \$200,000 for Fiscal Year 2005.

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

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

19 (3) Beginning in Fiscal Year 2007 and for each fiscal year
20 thereafter through Fiscal Year 2010, the uniform gross receipts
21 assessment rate calculated in accordance with paragraph (2) of this
22 subsection shall be applied to each facility subject to the assessment
23 with gross receipts over \$300,000, as those gross receipts are
24 documented in the facility's most recent annual report to the
25 department, except that no facility shall pay an assessment greater
26 than \$200,000. A facility shall pay its annual assessment to the
27 department in four payments in accordance with a timetable
28 prescribed by the commissioner.

29 (4) Beginning in Fiscal Year 2011 and for each fiscal year
30 thereafter through Fiscal Year 2025, the uniform gross receipts
31 assessment shall be applied at the rate of 2.95 percent to each facility
32 subject to the assessment with gross receipts over \$300,000, as those
33 gross receipts are documented in the facility's most recent annual
34 report submitted to the department pursuant to subsection c. of this
35 section, except that no facility shall pay an assessment greater than
36 \$350,000. A facility shall pay its annual assessment to the
37 department in four payments in accordance with a timetable
38 prescribed by the commissioner.

39 (5) Beginning in Fiscal Year 2026 and for each fiscal year
40 thereafter, the uniform gross receipts assessment shall be applied at
41 the rate of 2.5 percent to each facility subject to the assessment. A
42 facility shall pay its annual assessment to the department in four
43 payments in accordance with a timetable prescribed by the
44 commissioner.

45 (6) An ambulatory care facility that was exempt from the
46 assessment prior to Fiscal Year 2026 pursuant to section 12 of
47 P.L.1971, c.136 (C.26:2H-12) shall report in Fiscal Year 2026 the
48 facility's gross receipts from its operating room services, pursuant to

1 subsection c. of this section, and the department shall assess 2.5
2 percent of the facility's gross receipts beginning in Fiscal Year 2027.
3 As used in this subparagraph, "operating room services" shall mean
4 surgical or diagnostic procedures performed in a room specifically
5 equipped to perform surgery, and designed and constructed to
6 accommodate invasive diagnostic and surgical procedures.

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

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

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

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

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

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

37 e. The revenues raised by the ambulatory care facility
38 assessment pursuant to this section shall be deposited in the Health
39 Care Subsidy Fund established pursuant to section 8 of P.L.1992,
40 c.160 (C.26:2H-18.58).
41 (cf: P.L.2018, c.116, s.1)

42

43 3. This act shall take effect immediately.

44

45

46

STATEMENT

47

48 This bill establishes the "Healthcare Finance Enhancement Act."

A5809 MURPHY

12

1 Under current law, the Department of Health imposes an
2 assessment on the gross receipts of ambulatory care facilities with
3 gross receipts over \$300,000. This assessment is imposed at a rate
4 of 2.95 percent on each facility that is subject to the assessment. The
5 assessments on ambulatory care facilities collected under this law are
6 to be deposited in the Health Care Subsidy Fund established pursuant
7 to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

8 This bill amends current law to reduce this assessment rate from
9 2.95 percent to 2.5 percent in fiscal year 2026 and to extend the
10 assessment to all ambulatory care facilities beginning in fiscal year
11 2027. The bill also eliminates the exemption from the ambulatory
12 care facility assessment for surgical practices beginning in fiscal year
13 2026.

14 The bill increases the per adjusted admission charge imposed on
15 hospitals by the Department of Health from \$10 to \$12.50 beginning
16 on July 1, 2025, and extends the imposition of this charge to non-
17 public psychiatric hospitals.

ASSEMBLY BUDGET COMMITTEE

STATEMENT TO

ASSEMBLY, No. 5809

STATE OF NEW JERSEY

DATED: JUNE 26, 2025

The Assembly Budget Committee reports favorably Assembly Bill No. 5809.

As reported, this bill establishes the “Healthcare Finance Enhancement Act.”

Under current law, the Department of Health imposes an assessment on the gross receipts of ambulatory care facilities with gross receipts over \$300,000. This assessment is imposed at a rate of 2.95 percent on each facility that is subject to the assessment. The assessments on ambulatory care facilities collected under this law are to be deposited in the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

This bill amends current law to reduce this assessment rate from 2.95 percent to 2.5 percent in fiscal year 2026 and to extend the assessment to all ambulatory care facilities beginning in fiscal year 2027. The bill also eliminates the exemption from the ambulatory care facility assessment for surgical practices beginning in fiscal year 2026.

The bill increases the per adjusted admission charge imposed on hospitals by the Department of Health from \$10 to \$12.50 beginning on July 1, 2025, and extends the imposition of this charge to non-public psychiatric hospitals.

FISCAL IMPACT:

Fiscal information is not available at this time.

SENATE, No. 4656

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED JUNE 23, 2025

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

SYNOPSIS

“Healthcare Finance Enhancement Act.”

CURRENT VERSION OF TEXT

As introduced.



S4656 VITALE

2

1 AN ACT concerning ambulatory care facility assessments and
2 hospital admission charges, and amending P.L.1971, c.136 and
3 P.L.1992, c.160.

4

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

7

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

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

27 b. (1) Application for a license for a health care service or health
28 care facility shall be made upon forms prescribed by the
29 department. The department shall charge a single, nonrefundable
30 fee for the filing of an application for and issuance of a license and
31 a single, nonrefundable fee for any renewal thereof, and a single,
32 nonrefundable fee for a biennial inspection of the facility, as it shall
33 from time to time fix in rules or regulations; provided, however,
34 that no such licensing fee shall exceed \$10,000 in the case of a
35 hospital and \$4,000 in the case of any other health care facility for
36 all services provided by the hospital or other health care facility,
37 and no such inspection fee shall exceed \$5,000 in the case of a
38 hospital and \$2,000 in the case of any other health care facility for
39 all services provided by the hospital or other health care facility.
40 No inspection fee shall be charged for inspections other than
41 biennial inspections. Any surgical practice required to apply for
42 licensure by the department as an ambulatory care facility pursuant
43 to P.L.2017, c.283 shall be exempt from the initial and renewal
44 license fees required by this section. The application shall contain
45 the name of the health care facility, the kind or kinds of health care

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 service to be provided, the location and physical description of the
2 institution, and such other information as the department may
3 require.

4 (2) A license shall be issued by the department upon its findings
5 that the premises, equipment, personnel, including principals and
6 management, finances, rules and bylaws, and standards of health
7 care service are fit and adequate and there is reasonable assurance
8 the health care facility will be operated in the manner required by
9 this act and rules and regulations thereunder.

10 (3) The department shall post on its Internet website each
11 inspection report prepared following an inspection of a residential
12 health care facility, as defined in section 1 of P.L.1953, c.212
13 (C.30:11A-1) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
14 seq.), that is performed pursuant to this subsection, along with any
15 other inspection report prepared by or on behalf of the department
16 for such facility.

17 If an inspection reveals a serious health and safety violation at a
18 residential health care facility, the department shall post the
19 inspection report, including the name of the facility and the owner
20 of the facility, on its website no later than 72 hours following the
21 inspection. If a license of a residential health care facility is
22 suspended, the department shall post the suspension on its website
23 no later than 72 hours following the suspension. The department
24 shall update its website to reflect the correction of a serious health
25 and safety violation, and the lifting of a suspension.

26 The department shall notify, as soon as possible, the
27 Commissioner of Human Services, or the commissioner's designee,
28 and the director of the county board of social services or county
29 welfare agency, as appropriate, in the county in which a residential
30 health care facility is located, of a serious health and safety
31 violation at the facility and of any suspension of a license to operate
32 such facility.

33 If the inspection responsibilities under this subsection with
34 respect to such facility are transferred or otherwise assigned to
35 another department, that other department shall post on its Internet
36 website each inspection report prepared following an inspection of
37 such facility performed pursuant to this subsection, along with any
38 other inspection report prepared by or on behalf of that department
39 for such facility, and shall comply with the other requirements
40 specified in this subsection.

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

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

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

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

19 g. (1) (Deleted by amendment, P.L.2017, c.283)

20 (2) (Deleted by amendment, P.L.2017, c.283)

21 (3) (Deleted by amendment, P.L.2017, c.283)

22 (4) A surgical practice in operation on the date of enactment of
23 P.L.2017, c.283 shall be required to apply to the department for
24 licensure as an ambulatory care facility licensed to provide surgical
25 and related services within one year of the date of enactment of
26 P.L.2017, c.283.

27 A surgical practice that is certified by the Centers for Medicare
28 and Medicaid Services (CMS) shall not be required to meet the
29 physical plant and functional requirements specified in
30 N.J.A.C.8:43A-19.1 et seq. A surgical practice that is not Medicare
31 certified, either by CMS or by any deeming authority recognized by
32 CMS, but which has obtained accreditation from the American
33 Association of Ambulatory Surgery Facilities or any accrediting
34 body recognized by CMS and is in operation on the date of
35 enactment of P.L.2017, c.283, shall not be required to meet the
36 physical plant and functional requirements specified in
37 N.J.A.C.8:43A-19.1 et seq. A surgical practice not in operation on
38 the date of enactment of P.L.2017, c.283, if it is certified by CMS
39 as an ambulatory surgery center provider, shall also be exempt from
40 these requirements. A surgical practice required by this subsection
41 to meet the physical plant and functional requirements specified in
42 N.J.A.C.8:43A-19.1 et seq. may apply for a waiver of any such
43 requirement in accordance with N.J.A.C.8:43A-2.9. The
44 commissioner shall grant a waiver of those physical plant and
45 functional requirements, as the commissioner deems appropriate, if
46 the waiver does not endanger the life, safety, or health of patients or
47 the public.

1 **[A]** Through State Fiscal Year 2025, a surgical practice required
2 to be licensed pursuant to this subsection shall be exempt from the
3 ambulatory care facility assessment pursuant to section 7 of
4 P.L.1992, c.160 (C.26:2H-18.57); except that, if the entity expands
5 to include any additional room dedicated for use as an operating
6 room, the entity shall be subject to the assessment. Beginning in
7 State Fiscal Year 2026, a surgical practice required to be licensed
8 pursuant to this subsection shall no longer be exempt from the
9 ambulatory care facility assessment.

10 (5) As used in this subsection and subsection i. of this section,
11 "surgical practice" means a structure or suite of rooms that has the
12 following characteristics:

13 (a) has no more than one room dedicated for use as an operating
14 room which is specifically equipped to perform surgery, and is
15 designed and constructed to accommodate invasive diagnostic and
16 surgical procedures;

17 (b) has one or more post-anesthesia care units or a dedicated
18 recovery area where the patient may be closely monitored and
19 observed until discharged; and

20 (c) is established by a physician, physician professional
21 association surgical practice, or other professional practice form
22 specified by the State Board of Medical Examiners pursuant to
23 regulation solely for the physician's, association's, or other
24 professional entity's private medical practice.

25 (6) Nothing in this subsection shall be construed to limit the
26 State Board of Medical Examiners from establishing standards of
27 care with respect to the practice of medicine.

28 h. An ambulatory care facility licensed to provide surgical and
29 related services shall be required to obtain ambulatory care
30 accreditation from an accrediting body recognized by the Centers
31 for Medicare and Medicaid Services as a condition of licensure by
32 the department.

33 An ambulatory care facility that is licensed to provide surgical
34 and related services on the effective date of this section of
35 P.L.2009, c.24 shall have one year from the effective date of this
36 section of P.L.2009, c.24 to obtain ambulatory care accreditation.

37 i. Beginning on the effective date of this section of P.L.2009,
38 c.24, and as provided in P.L.2017, c.283, the department shall not
39 issue a new license to an ambulatory care facility to provide
40 surgical and related services unless:

41 (1) in the case of a licensed facility in which a transfer of
42 ownership of the facility is proposed, the commissioner reviews the
43 qualifications of the new owner or owners and approves the
44 transfer;

45 (2) (a) except as provided in subparagraph (b) of this paragraph,
46 in the case of a licensed facility for which a relocation of the
47 facility is proposed, the relocation is within 20 miles of the facility's
48 current location or the relocation is to a "Health Enterprise Zone"

1 designated pursuant to section 1 of P.L.2004, c.139 (C.54A:3-7),
2 there is no expansion in the number of operating rooms provided at
3 the new location from that of the current location, and the
4 commissioner reviews and approves the relocation prior to its
5 occurrence; or

6 (b) in the case of a licensed facility described in paragraph (5)
7 or (6) of this subsection for which a relocation of the facility is
8 proposed, the commissioner reviews and approves the relocation
9 prior to its occurrence;

10 (3) the entity is a surgical practice required to be licensed
11 pursuant to subsection g. of this section and meets the requirements
12 of that subsection;

13 (4) the entity has filed its plans, specifications, and required
14 documents with the Health Care Plan Review Unit of the
15 Department of Community Affairs or the municipality in which the
16 surgical practice or facility will be located, as applicable, on or
17 before the 180th day following the effective date of this section of
18 P.L.2009, c.24;

19 (5) the facility is owned jointly by a general hospital in this
20 State and one or more other parties;

21 (6) the facility is owned by a hospital or medical school in this
22 State, or the facility is owned by any hospital approved on or before
23 the effective date of P.L.2015, c.305 to provide ambulatory surgery
24 services in this State, or the facility is owned by a hospital which
25 applied on or before the effective date of P.L.2015, c.305 to provide
26 ambulatory surgery services in this State so long as the hospital is
27 later approved to provide ambulatory surgery services at the
28 facility, or the facility is owned by any hospital approved to provide
29 ambulatory surgery services at another facility in this State; or

30 (7) (a) the facility is a newly licensed ambulatory surgical
31 facility that was created by combining two or more registered
32 surgical practices, provided that the number of operating rooms at
33 the newly licensed facility is not greater than the total number of
34 operating rooms prior to the establishment of the newly licensed
35 facility;

36 (b) the facility is a licensed ambulatory surgical facility that has
37 expanded by combining with one or more registered surgical
38 practices, provided that the number of operating rooms at the newly
39 expanded facility is not greater than the total number of operating
40 rooms prior to the combination of the practices and facility; or

41 (c) the facility is a licensed ambulatory surgical facility that has
42 expanded through the combination of two or more licensed
43 ambulatory surgical facilities, provided that the number of
44 operating rooms at the newly expanded facility is not greater than
45 the total number of operating rooms prior to the combining of the
46 facilities.

47 Beginning on the effective date of P.L.2017, c.283, the
48 department shall not issue a new registration to a surgical practice.

1 Any surgical practice in operation on the effective date of P.L.2017,
2 c.283 that proposes to relocate on or after the effective date of
3 P.L.2017, c.283 shall be required to be licensed by the department
4 as an ambulatory care facility providing surgical and related
5 services pursuant to subsection g. of this section.

6 j. (Deleted by amendment, P.L.2017, c.283)

7 k. An ambulatory care facility licensed to provide surgical and
8 related services and a surgical practice shall:

9 (1) report to the department any change in ownership of the
10 facility within 30 days of the change in ownership; and

11 (2) annually report to the department the name of the facility's
12 medical director, physician director, and physician director of
13 anesthesia, as applicable, and the director of nursing services. The
14 facility shall notify the department if there is any change in a named
15 director within 30 days of the change of the director.

16 (cf: P.L.2017, c.283, s.1)

17

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

20 7. a. Effective January 1, 1994 through June 30, 2025, the
21 Department of Health shall assess each hospital a per adjusted
22 admission charge of \$10. Effective July 1, 2025, the Department of
23 Health shall assess each hospital a per adjusted admission charge of
24 \$12.50.

25 **【Of the】** The revenues raised by the hospital per adjusted
26 admission charge **【, \$5 per adjusted admission】** shall be used by the
27 department to carry out its duties pursuant to P.L.1992, c.160
28 (C.26:2H-18.51 et al.) and **【\$5 per adjusted admission shall be used**
29 **by the department】** for administrative costs related to health
30 planning.

31 Effective July 1, 2018, the assessment shall apply to all general
32 acute care hospitals, rehabilitation hospitals, **【and】** long term acute
33 care hospitals, and non-public psychiatric hospitals. Any General
34 Fund savings resulting from the assessment meeting the
35 permissibility standards set forth in 42 C.F.R. s.433.68 shall be used
36 to create a supplemental funding pool, known as Safety Net
37 Graduate Medical Education, for the State's graduate medical
38 education subsidy. Notwithstanding the provisions of any law or
39 regulation to the contrary, and except as otherwise provided and
40 subject to such modifications as may be required by the Centers for
41 Medicare and Medicaid Services in order to achieve any required
42 federal approval and full federal financial participation,
43 \$24,285,714 is appropriated from the General Fund for Safety Net
44 Graduate Medical Education, and conditioned upon the following:

45 Funds from the Safety Net Graduate Medical Education pool
46 shall be available to eligible hospitals that meet the following
47 eligibility criteria: An eligible hospital has a Relative Medicaid

S4656 VITALE

1 Percentage (RMP) that is in the top third of all acute care hospitals
2 that have a residency program. The RMP is a ratio calculated using
3 the 2016 Audited C.160 SHARE Cost Reports. The numerator of
4 the RMP equals a hospital's gross revenue from patient care for
5 Medicaid and Medicaid HMO as reported on Line 1, Col. D & Col.
6 H of Forms E5 and E6. The denominator of the RMP equals a
7 hospital's gross revenue from patient care as reported on Line 1,
8 Col. E of Form E4. For instances where hospitals that have a single
9 Medicare identification number submit a separate cost report for
10 each campus, the values referenced above shall be consolidated.

11 Payments to eligible hospitals shall be made in the following
12 manner:

13 (1) the subsidy payment shall be split into a Direct Medical
14 Education (DME) allocation, which is calculated by multiplying the
15 total subsidy amount by the ratio of 2016 total median Medicaid
16 managed care DME costs to total 2016 median Medicaid managed
17 care GME costs; and an Indirect Medical Education (IME)
18 allocation, which is calculated by multiplying the total subsidy
19 amount by the ratio of 2016 total Medicaid managed care IME costs
20 to total 2016 Medicaid managed care GME costs.

21 (2) Each hospital's percentage of total 2016 Medicaid managed
22 care DME costs shall be multiplied by the DME allocation to
23 calculate its DME payment. Each hospital's percentage of total 2016
24 Medicaid managed care IME costs shall be multiplied by the IME
25 allocation to calculate its IME payment.

26 (3) Source data used shall come from the Medicaid cost report
27 for calendar year (CY) 2016 submitted by each acute care hospital
28 by November 30, 2017 and Medicaid Managed Care encounter
29 payments for Medicaid and NJ FamilyCare clients as reported by
30 insurers to the State for the following reporting period: services
31 dates between January 1, 2016 and December 31, 2016; payment
32 dates between January 1, 2016 and December 31, 2017; and a run
33 date of not later than January 31, 2018.

34 (4) In the event that a hospital reported less than 12 months of
35 2016 Medicaid costs, the number of reported months of data
36 regarding days, costs, or payments shall be annualized. In the event
37 the hospital completed a merger, acquisition, or business
38 combination or a supplemental cost report for the calendar year
39 2016 submitted by the affected acute care hospital by November 30,
40 2017 shall be used. In the event that a hospital did not report its
41 Medicaid managed care days on the cost report utilized in this
42 calculation, the Department of Health (DOH) shall ascertain
43 Medicaid managed care encounter days for Medicaid and NJ
44 FamilyCare clients as reported by insurers to the State.

45 (5) Medicaid managed care DME cost is defined as the
46 approved intern and residency program costs using the 2016
47 Medicaid cost report total residency costs, reported on Worksheet B
48 Pt I Column 21 line 21 plus Worksheet B Pt I Column 22 Line 22

1 divided by 2016 resident full time equivalent employees (FTE),
2 reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop an
3 average cost per FTE for each hospital used to calculate the overall
4 median cost per FTE.

5 (6) The median cost per FTE is multiplied by the 2016 resident
6 FTEs reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop
7 approved total residency program costs.

8 (7) The approved residency costs are multiplied by the quotient
9 of Medicaid managed care days, reported on Worksheet S--3
10 Column 7 line 2, divided by the quantity of total days, on
11 Worksheet S--3 Column 8 line 14, less nursery days, on Worksheet
12 S--3 Column 8 line 13.

13 (8) Medicaid managed care IME cost is defined as the Medicare
14 IME factor multiplied by Medicaid managed care encounter
15 payments for Medicaid and NJ FamilyCare clients as reported by
16 insurers to the State.

17 (9) The IME factor is calculated using the Medicare IME
18 formula as follows: $1.35 * [(1 + x)^{0.405} - 1]$, in which "x" is the
19 quotient of submitted IME resident full--time equivalencies
20 reported on Worksheet S--3 Pt 1 Column 9 line 14 divided by the
21 quantity of total available beds less nursery beds reported on
22 Worksheet S--3 Column 2 line 14.

23 (10) In the event that a hospital believes that there are
24 mathematical errors in the calculations, or data not matching the
25 actual source documents used to calculate the subsidy as defined
26 above, hospitals shall be permitted to file calculation appeals within
27 15 working days of receipt of the subsidy allocation letter. If upon
28 review it is determined by the department that the error has
29 occurred and would constitute at least a five percent change in the
30 hospital's allocation amount, a revised industry--wide allocation
31 shall be issued.

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

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

46 (1) For Fiscal Year 2005, the assessment on an ambulatory care
47 facility providing one or more of the services listed in this

1 subsection shall be based on gross receipts for the 2003 tax year as
2 follows:

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

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

8 The commissioner shall provide notice no later than August 15,
9 2004 to all facilities that are subject to the assessment that the first
10 payment of the assessment is due October 1, 2004 and that proof of
11 gross receipts for the facility's tax year ending in calendar year 2003
12 shall be provided by the facility to the commissioner no later than
13 September 15, 2004. If a facility fails to provide proof of gross
14 receipts by September 15, 2004, the facility shall be assessed the
15 maximum rate of \$200,000 for Fiscal Year 2005.

16 The Fiscal Year 2005 assessment shall be payable to the
17 department in four installments, with payments due October 1,
18 2004, January 1, 2005, March 15, 2005, and June 15, 2005.

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

29 (3) Beginning in Fiscal Year 2007 and for each fiscal year
30 thereafter through Fiscal Year 2010, the uniform gross receipts
31 assessment rate calculated in accordance with paragraph (2) of this
32 subsection shall be applied to each facility subject to the assessment
33 with gross receipts over \$300,000, as those gross receipts are
34 documented in the facility's most recent annual report to the
35 department, except that no facility shall pay an assessment greater
36 than \$200,000. A facility shall pay its annual assessment to the
37 department in four payments in accordance with a timetable
38 prescribed by the commissioner.

39 (4) Beginning in Fiscal Year 2011 and for each fiscal year
40 thereafter through Fiscal Year 2025, the uniform gross receipts
41 assessment shall be applied at the rate of 2.95 percent to each
42 facility subject to the assessment with gross receipts over \$300,000,
43 as those gross receipts are documented in the facility's most recent
44 annual report submitted to the department pursuant to subsection c.
45 of this section, except that no facility shall pay an assessment
46 greater than \$350,000. A facility shall pay its annual assessment to
47 the department in four payments in accordance with a timetable
48 prescribed by the commissioner.

1 (5) Beginning in Fiscal Year 2026 and for each fiscal year
2 thereafter, the uniform gross receipts assessment shall be applied at
3 the rate of 2.5 percent to each facility subject to the assessment. A
4 facility shall pay its annual assessment to the department in four
5 payments in accordance with a timetable prescribed by the
6 commissioner.

7 (6) An ambulatory care facility that was exempt from the
8 assessment prior to Fiscal Year 2026 pursuant to section 12 of
9 P.L.1971, c.136 (C.26:2H-12) shall report in Fiscal Year 2026 the
10 facility's gross receipts, pursuant to subsection c. of this section,
11 and the department shall assess 2.5 percent of the facility's gross
12 receipts beginning in Fiscal Year 2027.

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

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

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

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

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

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

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

48 (cf: P.L.2018, c.116, s.1)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

3. This act shall take effect immediately.

STATEMENT

This bill reduces and expands the assessment imposed on ambulatory care facilities, and increases and expands the hospital admission charge.

Under current law, the Department of Health imposes an assessment on the gross receipts of ambulatory care facilities with gross receipts over \$300,000. This assessment is imposed at a rate of 2.95 percent on each facility that is subject to the assessment. The assessments on ambulatory care facilities collected under this law are to be deposited in the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

This bill amends current law to reduce this assessment rate from 2.95 percent to 2.5 percent in fiscal year 2026 and to extend the assessment to all ambulatory care facilities beginning in fiscal year 2027. The bill also eliminates the exemption from the ambulatory care facility assessment for surgical practices beginning in fiscal year 2026.

The bill increases the per adjusted admission charge imposed on hospitals by the Department of Health from \$10 to \$12.50 beginning on July 1, 2025, and extends the imposition of this charge to non-public psychiatric hospitals.

[First Reprint]

SENATE, No. 4656

STATE OF NEW JERSEY

221st LEGISLATURE

INTRODUCED JUNE 23, 2025

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

SYNOPSIS

“Healthcare Finance Enhancement Act.”

CURRENT VERSION OF TEXT

As reported by the Senate Budget and Appropriations Committee on June 26, 2025, with amendments.



1 AN ACT concerning ambulatory care facility assessments and
2 hospital admission charges, and amending P.L.1971, c.136 and
3 P.L.1992, c.160.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 1. Section 12 of P.L.1971, c.136 (C.26:2H-12) is amended to
9 read as follows:

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

27 b. (1) Application for a license for a health care service or
28 health care facility shall be made upon forms prescribed by the
29 department. The department shall charge a single, nonrefundable
30 fee for the filing of an application for and issuance of a license and
31 a single, nonrefundable fee for any renewal thereof, and a single,
32 nonrefundable fee for a biennial inspection of the facility, as it shall
33 from time to time fix in rules or regulations; provided, however,
34 that no such licensing fee shall exceed \$10,000 in the case of a
35 hospital and \$4,000 in the case of any other health care facility for
36 all services provided by the hospital or other health care facility,
37 and no such inspection fee shall exceed \$5,000 in the case of a
38 hospital and \$2,000 in the case of any other health care facility for
39 all services provided by the hospital or other health care facility.
40 No inspection fee shall be charged for inspections other than
41 biennial inspections. Any surgical practice required to apply for
42 licensure by the department as an ambulatory care facility pursuant
43 to P.L.2017, c.283 shall be exempt from the initial and renewal
44 license fees required by this section. The application shall contain
45 the name of the health care facility, the kind or kinds of health care

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Senate SBA committee amendments adopted June 26, 2025.

1 service to be provided, the location and physical description of the
2 institution, and such other information as the department may
3 require.

4 (2) A license shall be issued by the department upon its findings
5 that the premises, equipment, personnel, including principals and
6 management, finances, rules and bylaws, and standards of health
7 care service are fit and adequate and there is reasonable assurance
8 the health care facility will be operated in the manner required by
9 this act and rules and regulations thereunder.

10 (3) The department shall post on its Internet website each
11 inspection report prepared following an inspection of a residential
12 health care facility, as defined in section 1 of P.L.1953, c.212
13 (C.30:11A-1) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et
14 seq.), that is performed pursuant to this subsection, along with any
15 other inspection report prepared by or on behalf of the department
16 for such facility.

17 If an inspection reveals a serious health and safety violation at a
18 residential health care facility, the department shall post the
19 inspection report, including the name of the facility and the owner
20 of the facility, on its website no later than 72 hours following the
21 inspection. If a license of a residential health care facility is
22 suspended, the department shall post the suspension on its website
23 no later than 72 hours following the suspension. The department
24 shall update its website to reflect the correction of a serious health
25 and safety violation, and the lifting of a suspension.

26 The department shall notify, as soon as possible, the
27 Commissioner of Human Services, or the commissioner's designee,
28 and the director of the county board of social services or county
29 welfare agency, as appropriate, in the county in which a residential
30 health care facility is located, of a serious health and safety
31 violation at the facility and of any suspension of a license to operate
32 such facility.

33 If the inspection responsibilities under this subsection with
34 respect to such facility are transferred or otherwise assigned to
35 another department, that other department shall post on its Internet
36 website each inspection report prepared following an inspection of
37 such facility performed pursuant to this subsection, along with any
38 other inspection report prepared by or on behalf of that department
39 for such facility, and shall comply with the other requirements
40 specified in this subsection.

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

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

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

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

19 g. (1) (Deleted by amendment, P.L.2017, c.283)

20 (2) (Deleted by amendment, P.L.2017, c.283)

21 (3) (Deleted by amendment, P.L.2017, c.283)

22 (4) A surgical practice in operation on the date of enactment of
23 P.L.2017, c.283 shall be required to apply to the department for
24 licensure as an ambulatory care facility licensed to provide surgical
25 and related services within one year of the date of enactment of
26 P.L.2017, c.283.

27 A surgical practice that is certified by the Centers for Medicare
28 and Medicaid Services (CMS) shall not be required to meet the
29 physical plant and functional requirements specified in
30 N.J.A.C.8:43A-19.1 et seq. A surgical practice that is not Medicare
31 certified, either by CMS or by any deeming authority recognized by
32 CMS, but which has obtained accreditation from the American
33 Association of Ambulatory Surgery Facilities or any accrediting
34 body recognized by CMS and is in operation on the date of
35 enactment of P.L.2017, c.283, shall not be required to meet the
36 physical plant and functional requirements specified in
37 N.J.A.C.8:43A-19.1 et seq. A surgical practice not in operation on
38 the date of enactment of P.L.2017, c.283, if it is certified by CMS
39 as an ambulatory surgery center provider, shall also be exempt from
40 these requirements. A surgical practice required by this subsection
41 to meet the physical plant and functional requirements specified in
42 N.J.A.C.8:43A-19.1 et seq. may apply for a waiver of any such
43 requirement in accordance with N.J.A.C.8:43A-2.9. The
44 commissioner shall grant a waiver of those physical plant and
45 functional requirements, as the commissioner deems appropriate, if
46 the waiver does not endanger the life, safety, or health of patients or
47 the public.

1 **[A]** Through State Fiscal Year 2025, a surgical practice required
2 to be licensed pursuant to this subsection shall be exempt from the
3 ambulatory care facility assessment pursuant to section 7 of
4 P.L.1992, c.160 (C.26:2H-18.57); except that, if the entity expands
5 to include any additional room dedicated for use as an operating
6 room, the entity shall be subject to the assessment. Beginning in
7 State Fiscal Year 2026, a surgical practice required to be licensed
8 pursuant to this subsection shall no longer be exempt from the
9 ambulatory care facility assessment.

10 (5) As used in this subsection and subsection i. of this section,
11 "surgical practice" means a structure or suite of rooms that has the
12 following characteristics:

13 (a) has no more than one room dedicated for use as an operating
14 room which is specifically equipped to perform surgery, and is
15 designed and constructed to accommodate invasive diagnostic and
16 surgical procedures;

17 (b) has one or more post-anesthesia care units or a dedicated
18 recovery area where the patient may be closely monitored and
19 observed until discharged; and

20 (c) is established by a physician, physician professional
21 association surgical practice, or other professional practice form
22 specified by the State Board of Medical Examiners pursuant to
23 regulation solely for the physician's, association's, or other
24 professional entity's private medical practice.

25 (6) Nothing in this subsection shall be construed to limit the
26 State Board of Medical Examiners from establishing standards of
27 care with respect to the practice of medicine.

28 h. An ambulatory care facility licensed to provide surgical and
29 related services shall be required to obtain ambulatory care
30 accreditation from an accrediting body recognized by the Centers
31 for Medicare and Medicaid Services as a condition of licensure by
32 the department.

33 An ambulatory care facility that is licensed to provide surgical
34 and related services on the effective date of this section of
35 P.L.2009, c.24 shall have one year from the effective date of this
36 section of P.L.2009, c.24 to obtain ambulatory care accreditation.

37 i. Beginning on the effective date of this section of P.L.2009,
38 c.24, and as provided in P.L.2017, c.283, the department shall not
39 issue a new license to an ambulatory care facility to provide
40 surgical and related services unless:

41 (1) in the case of a licensed facility in which a transfer of
42 ownership of the facility is proposed, the commissioner reviews the
43 qualifications of the new owner or owners and approves the
44 transfer;

45 (2) (a) except as provided in subparagraph (b) of this paragraph,
46 in the case of a licensed facility for which a relocation of the
47 facility is proposed, the relocation is within 20 miles of the facility's
48 current location or the relocation is to a "Health Enterprise Zone"

1 designated pursuant to section 1 of P.L.2004, c.139 (C.54A:3-7),
2 there is no expansion in the number of operating rooms provided at
3 the new location from that of the current location, and the
4 commissioner reviews and approves the relocation prior to its
5 occurrence; or

6 (b) in the case of a licensed facility described in paragraph (5)
7 or (6) of this subsection for which a relocation of the facility is
8 proposed, the commissioner reviews and approves the relocation
9 prior to its occurrence;

10 (3) the entity is a surgical practice required to be licensed
11 pursuant to subsection g. of this section and meets the requirements
12 of that subsection;

13 (4) the entity has filed its plans, specifications, and required
14 documents with the Health Care Plan Review Unit of the
15 Department of Community Affairs or the municipality in which the
16 surgical practice or facility will be located, as applicable, on or
17 before the 180th day following the effective date of this section of
18 P.L.2009, c.24;

19 (5) the facility is owned jointly by a general hospital in this
20 State and one or more other parties;

21 (6) the facility is owned by a hospital or medical school in this
22 State, or the facility is owned by any hospital approved on or before
23 the effective date of P.L.2015, c.305 to provide ambulatory surgery
24 services in this State, or the facility is owned by a hospital which
25 applied on or before the effective date of P.L.2015, c.305 to provide
26 ambulatory surgery services in this State so long as the hospital is
27 later approved to provide ambulatory surgery services at the
28 facility, or the facility is owned by any hospital approved to provide
29 ambulatory surgery services at another facility in this State; or

30 (7) (a) the facility is a newly licensed ambulatory surgical
31 facility that was created by combining two or more registered
32 surgical practices, provided that the number of operating rooms at
33 the newly licensed facility is not greater than the total number of
34 operating rooms prior to the establishment of the newly licensed
35 facility;

36 (b) the facility is a licensed ambulatory surgical facility that has
37 expanded by combining with one or more registered surgical
38 practices, provided that the number of operating rooms at the newly
39 expanded facility is not greater than the total number of operating
40 rooms prior to the combination of the practices and facility; or

41 (c) the facility is a licensed ambulatory surgical facility that has
42 expanded through the combination of two or more licensed
43 ambulatory surgical facilities, provided that the number of
44 operating rooms at the newly expanded facility is not greater than
45 the total number of operating rooms prior to the combining of the
46 facilities.

47 Beginning on the effective date of P.L.2017, c.283, the
48 department shall not issue a new registration to a surgical practice.

1 Any surgical practice in operation on the effective date of P.L.2017,
2 c.283 that proposes to relocate on or after the effective date of
3 P.L.2017, c.283 shall be required to be licensed by the department
4 as an ambulatory care facility providing surgical and related
5 services pursuant to subsection g. of this section.

6 j. (Deleted by amendment, P.L.2017, c.283)

7 k. An ambulatory care facility licensed to provide surgical and
8 related services and a surgical practice shall:

9 (1) report to the department any change in ownership of the
10 facility within 30 days of the change in ownership; and

11 (2) annually report to the department the name of the facility's
12 medical director, physician director, and physician director of
13 anesthesia, as applicable, and the director of nursing services. The
14 facility shall notify the department if there is any change in a named
15 director within 30 days of the change of the director.

16 (cf: P.L.2017, c.283, s.1)

17

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

20 7. a. Effective January 1, 1994 through June 30, 2025, the
21 Department of Health shall assess each hospital a per adjusted
22 admission charge of \$10. Effective July 1, 2025, the Department of
23 Health shall assess each hospital a per adjusted admission charge of
24 \$12.50.

25 **【Of the】** The revenues raised by the hospital per adjusted
26 admission charge **【, \$5 per adjusted admission】** shall be used by the
27 department to carry out its duties pursuant to P.L.1992, c.160
28 (C.26:2H-18.51 et al.) and **【\$5 per adjusted admission shall be used**
29 **by the department】** for administrative costs related to health
30 planning.

31 Effective July 1, 2018, the assessment shall apply to all general
32 acute care hospitals, rehabilitation hospitals, **【and】** long term acute
33 care hospitals, and non-public psychiatric hospitals. Any General
34 Fund savings resulting from the assessment meeting the
35 permissibility standards set forth in 42 C.F.R. s.433.68 shall be used
36 to create a supplemental funding pool, known as Safety Net
37 Graduate Medical Education, for the State's graduate medical
38 education subsidy. Notwithstanding the provisions of any law or
39 regulation to the contrary, and except as otherwise provided and
40 subject to such modifications as may be required by the Centers for
41 Medicare and Medicaid Services in order to achieve any required
42 federal approval and full federal financial participation,
43 \$24,285,714 is appropriated from the General Fund for Safety Net
44 Graduate Medical Education, and conditioned upon the following:

45 Funds from the Safety Net Graduate Medical Education pool
46 shall be available to eligible hospitals that meet the following
47 eligibility criteria: An eligible hospital has a Relative Medicaid

1 Percentage (RMP) that is in the top third of all acute care hospitals
2 that have a residency program. The RMP is a ratio calculated using
3 the 2016 Audited C.160 SHARE Cost Reports. The numerator of
4 the RMP equals a hospital's gross revenue from patient care for
5 Medicaid and Medicaid HMO as reported on Line 1, Col. D & Col.
6 H of Forms E5 and E6. The denominator of the RMP equals a
7 hospital's gross revenue from patient care as reported on Line 1,
8 Col. E of Form E4. For instances where hospitals that have a single
9 Medicare identification number submit a separate cost report for
10 each campus, the values referenced above shall be consolidated.

11 Payments to eligible hospitals shall be made in the following
12 manner:

13 (1) the subsidy payment shall be split into a Direct Medical
14 Education (DME) allocation, which is calculated by multiplying the
15 total subsidy amount by the ratio of 2016 total median Medicaid
16 managed care DME costs to total 2016 median Medicaid managed
17 care GME costs; and an Indirect Medical Education (IME)
18 allocation, which is calculated by multiplying the total subsidy
19 amount by the ratio of 2016 total Medicaid managed care IME costs
20 to total 2016 Medicaid managed care GME costs.

21 (2) Each hospital's percentage of total 2016 Medicaid managed
22 care DME costs shall be multiplied by the DME allocation to
23 calculate its DME payment. Each hospital's percentage of total 2016
24 Medicaid managed care IME costs shall be multiplied by the IME
25 allocation to calculate its IME payment.

26 (3) Source data used shall come from the Medicaid cost report
27 for calendar year (CY) 2016 submitted by each acute care hospital
28 by November 30, 2017 and Medicaid Managed Care encounter
29 payments for Medicaid and NJ FamilyCare clients as reported by
30 insurers to the State for the following reporting period: services
31 dates between January 1, 2016 and December 31, 2016; payment
32 dates between January 1, 2016 and December 31, 2017; and a run
33 date of not later than January 31, 2018.

34 (4) In the event that a hospital reported less than 12 months of
35 2016 Medicaid costs, the number of reported months of data
36 regarding days, costs, or payments shall be annualized. In the event
37 the hospital completed a merger, acquisition, or business
38 combination or a supplemental cost report for the calendar year
39 2016 submitted by the affected acute care hospital by November 30,
40 2017 shall be used. In the event that a hospital did not report its
41 Medicaid managed care days on the cost report utilized in this
42 calculation, the Department of Health (DOH) shall ascertain
43 Medicaid managed care encounter days for Medicaid and NJ
44 FamilyCare clients as reported by insurers to the State.

45 (5) Medicaid managed care DME cost is defined as the
46 approved intern and residency program costs using the 2016
47 Medicaid cost report total residency costs, reported on Worksheet B
48 Pt I Column 21 line 21 plus Worksheet B Pt I Column 22 Line 22

1 divided by 2016 resident full time equivalent employees (FTE),
2 reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop an
3 average cost per FTE for each hospital used to calculate the overall
4 median cost per FTE.

5 (6) The median cost per FTE is multiplied by the 2016 resident
6 FTEs reported on Worksheet S--3 Pt 1 Column 9 line 14 to develop
7 approved total residency program costs.

8 (7) The approved residency costs are multiplied by the quotient
9 of Medicaid managed care days, reported on Worksheet S--3
10 Column 7 line 2, divided by the quantity of total days, on
11 Worksheet S--3 Column 8 line 14, less nursery days, on Worksheet
12 S--3 Column 8 line 13.

13 (8) Medicaid managed care IME cost is defined as the Medicare
14 IME factor multiplied by Medicaid managed care encounter
15 payments for Medicaid and NJ FamilyCare clients as reported by
16 insurers to the State.

17 (9) The IME factor is calculated using the Medicare IME
18 formula as follows: $1.35 * [(1 + x)^{0.405} - 1]$, in which "x" is the
19 quotient of submitted IME resident full--time equivalencies
20 reported on Worksheet S--3 Pt 1 Column 9 line 14 divided by the
21 quantity of total available beds less nursery beds reported on
22 Worksheet S--3 Column 2 line 14.

23 (10) In the event that a hospital believes that there are
24 mathematical errors in the calculations, or data not matching the
25 actual source documents used to calculate the subsidy as defined
26 above, hospitals shall be permitted to file calculation appeals within
27 15 working days of receipt of the subsidy allocation letter. If upon
28 review it is determined by the department that the error has
29 occurred and would constitute at least a five percent change in the
30 hospital's allocation amount, a revised industry--wide allocation
31 shall be issued.

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

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

46 (1) For Fiscal Year 2005, the assessment on an ambulatory care
47 facility providing one or more of the services listed in this

1 subsection shall be based on gross receipts for the 2003 tax year as
2 follows:

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

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

8 The commissioner shall provide notice no later than August 15,
9 2004 to all facilities that are subject to the assessment that the first
10 payment of the assessment is due October 1, 2004 and that proof of
11 gross receipts for the facility's tax year ending in calendar year 2003
12 shall be provided by the facility to the commissioner no later than
13 September 15, 2004. If a facility fails to provide proof of gross
14 receipts by September 15, 2004, the facility shall be assessed the
15 maximum rate of \$200,000 for Fiscal Year 2005.

16 The Fiscal Year 2005 assessment shall be payable to the
17 department in four installments, with payments due October 1,
18 2004, January 1, 2005, March 15, 2005, and June 15, 2005.

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

29 (3) Beginning in Fiscal Year 2007 and for each fiscal year
30 thereafter through Fiscal Year 2010, the uniform gross receipts
31 assessment rate calculated in accordance with paragraph (2) of this
32 subsection shall be applied to each facility subject to the assessment
33 with gross receipts over \$300,000, as those gross receipts are
34 documented in the facility's most recent annual report to the
35 department, except that no facility shall pay an assessment greater
36 than \$200,000. A facility shall pay its annual assessment to the
37 department in four payments in accordance with a timetable
38 prescribed by the commissioner.

39 (4) Beginning in Fiscal Year 2011 and for each fiscal year
40 thereafter through Fiscal Year 2025, the uniform gross receipts
41 assessment shall be applied at the rate of 2.95 percent to each
42 facility subject to the assessment with gross receipts over \$300,000,
43 as those gross receipts are documented in the facility's most recent
44 annual report submitted to the department pursuant to subsection c.
45 of this section, except that no facility shall pay an assessment
46 greater than \$350,000. A facility shall pay its annual assessment to
47 the department in four payments in accordance with a timetable
48 prescribed by the commissioner.

1 (5) Beginning in Fiscal Year 2026 and for each fiscal year
2 thereafter, the uniform gross receipts assessment shall be applied at
3 the rate of 2.5 percent to each facility subject to the assessment. A
4 facility shall pay its annual assessment to the department in four
5 payments in accordance with a timetable prescribed by the
6 commissioner.

7 (6) An ambulatory care facility that was exempt from the
8 assessment prior to Fiscal Year 2026 pursuant to section 12 of
9 P.L.1971, c.136 (C.26:2H-12) shall report in Fiscal Year 2026 the
10 facility's gross receipts ¹from its operating room services¹ ,
11 pursuant to subsection c. of this section, and the department shall
12 assess 2.5 percent of the facility's gross receipts beginning in Fiscal
13 Year 2027. ¹As used in this subparagraph, "operating room
14 services" shall mean surgical or diagnostic procedures performed in
15 a room specifically equipped to perform surgery, and designed and
16 constructed to accommodate invasive diagnostic and surgical
17 procedures.¹

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

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

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

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

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

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

S4656 [1R] VITALE

12

1 e. The revenues raised by the ambulatory care facility
2 assessment pursuant to this section shall be deposited in the Health
3 Care Subsidy Fund established pursuant to section 8 of P.L.1992,
4 c.160 (C.26:2H-18.58).
5 (cf: P.L.2018, c.116, s.1)

6

7 3. This act shall take effect immediately.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE, No. 4656

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 26, 2025

The Senate Budget and Appropriations Committee reports favorably and with committee amendments Senate Bill No. 4656.

As amended and reported, this bill establishes the “Healthcare Finance Enhancement Act.”

Under current law, the Department of Health imposes an assessment on the gross receipts of ambulatory care facilities with gross receipts over \$300,000. This assessment is imposed at a rate of 2.95 percent on each facility that is subject to the assessment. The assessments on ambulatory care facilities collected under this law are to be deposited in the Health Care Subsidy Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-18.58).

This bill amends current law to reduce this assessment rate from 2.95 percent to 2.5 percent in fiscal year 2026 and to extend the assessment to all ambulatory care facilities beginning in fiscal year 2027. The bill also eliminates the exemption from the ambulatory care facility assessment for surgical practices beginning in fiscal year 2026.

The bill increases the per adjusted admission charge imposed on hospitals by the Department of Health from \$10 to \$12.50 beginning on July 1, 2025, and extends the imposition of this charge to non-public psychiatric hospitals.

COMMITTEE AMENDMENTS:

The committee amendments:

(1) provide that an ambulatory care facility that was exempt from the assessment prior to Fiscal Year 2026 is to report in Fiscal Year 2026 the facility’s gross receipts from its operating room services; and

(2) define “operating room services.”

FISCAL IMPACT:

Fiscal information for this bill is currently unavailable.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

SENATE, No. 4656 STATE OF NEW JERSEY 221st LEGISLATURE

DATED: JULY 3, 2025

SUMMARY

Synopsis: "Healthcare Finance Enhancement Act."
Type of Impact: Annual increase in State expenditures and revenues.
Agencies Affected: Department of Health.

Office of Legislative Services Estimate

Fiscal Impact	<u>Year 1</u>	<u>Years 2 and 3</u>
State Expenditure Increase	Indeterminate	Indeterminate
State Revenue Increase	Minimum of \$63.7 million	Minimum of \$63.8 million

- The Office of Legislative Services (OLS) determines that Department of Health costs will increase by an indeterminate amount for the department to hire additional staff to administer the changes to the ambulatory care facility assessment and the hospital admission charge under the bill, and to provide oversight of the facilities newly subject to these Medicaid provider taxes.
- The OLS concludes that the expansion of the ambulatory care facility assessment to currently-exempt facilities and the increase and expansion of the hospital admission charge will increase State revenues by \$63.7 million in Year 1, and by \$63.8 million in each of Year 2 and Year 3. Of this amount, approximately \$42.7 million per year will be attributable to federal Medicaid matching funds.
- The Executive anticipates \$73.0 million in additional revenues from the changes to the assessment on ambulatory care facilities and the expansion of the hospital admission charge. The OLS is unable to verify the Executive's higher revenue estimate without access to certain data upon which this revenue estimate is based.

BILL DESCRIPTION

The bill reduces and expands the assessment imposed on ambulatory care facilities, and increases and expands the hospital admission charge.

Under current law, the Department of Health imposes a 2.95 percent assessment on the gross receipts of ambulatory care facilities with gross annual receipts over \$300,000, with the total annual assessment capped at \$350,000 per facility. Ambulatory care facilities reporting gross annual receipts below \$300,000 and surgical practices, however, are exempt from the assessment. The assessments on ambulatory care facilities collected under this law are deposited in the Health Care Subsidy Fund.

This bill reduces the assessed rate on ambulatory care facilities from 2.95 percent to 2.5 percent and removes the statutory \$350,000 cap on the assessment in FY 2026. The bill also newly extends the assessment to ambulatory care facilities reporting gross annual receipts below \$300,000, beginning in FY 2027. The bill additionally eliminates the exemption from the ambulatory care facility assessment for surgical practices beginning in FY 2026.

The bill increases the per adjusted admission charge imposed on hospitals by the Department of Health from \$10 to \$12.50 beginning on July 1, 2025, and extends the imposition of this charge to include non-public psychiatric hospitals.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received. However, communications from the Office of Revenue and Economic Analysis in the Department of the Treasury anticipated that the changes to the ambulatory care facility assessment in the FY 2026 Governor's Budget, when combined with regular trend changes, would increase Health Care Subsidy Fund revenues from the assessment by approximately \$31.0 million in FY 2026. However, the FY 2026 Governor's Budget anticipates \$60.0 million in combined State and federal revenues from the recommended changes to the ambulatory care facility assessment, and shows a \$34.6 million increase in revenues from the assessment accruing to the Health Care Subsidy Fund in FY 2026.

Although the department's estimate assumes the reduction in the ambulatory care facility assessment rate from 2.95 percent to 2.5 percent, the removal of the \$350,000 assessment cap, and the application of the assessment to ambulatory care facilities with gross annual receipts below \$300,000, it does not appear to incorporate the application of the assessment to surgical practices beginning in FY 2026 or the delay in the application of the assessment to ambulatory care facilities with gross annual receipts below \$300,000 until FY 2027, as provided under the bill.

The Department of Health, in response to FY 2026 OLS Discussion Point questions, anticipated that the recommended \$2.50 increase in the hospital admission charge in FY 2026, when combined with the application of this charge to non-public psychiatric hospitals, would increase revenues by \$13.0 million annually, with \$8.0 million of this total from federal Medicaid revenues. So, combined with the \$60.0 million in combined State and federal revenues from the changes to the ambulatory facility assessment, the Executive anticipates a total of \$73.0 million in additional revenues from the proposed changes.

OFFICE OF LEGISLATIVE SERVICES

Based upon data provided by the Department of Health in response to a question posed during the April 3, 2025 Senate Budget Committee hearing, the OLS determines that the bill's provisions

will increase State revenues by a minimum of \$63.7 million in Year 1. Of this amount, \$21.0 million will reflect increased revenues collected under the ambulatory care facility assessment and the hospital admission charge. As the revenues generated under these fees are used to support Medicaid providers, federal Medicaid matching funds will comprise the remaining amount, or \$42.7 million. In Years 2 and 3, the OLS concludes that the bill's provisions will increase total revenues by a minimum of \$63.8 million, of which \$21.1 reflects increased fee revenues and \$42.7 million is attributable to federal Medicaid matching funds.

The provisions affecting the ambulatory care facility assessment will constitute the majority of the revenue increase under the bill, or a minimum of \$50.7 million in FY 2026 and a minimum of \$50.8 million in both FY 2027 and FY 2028. The revenue increases under the bill will further increase by an indeterminate amount, depending upon the number of, and gross receipts reported by, surgical practices that will be newly subject to the assessment in FY 2026. Given that the number of the surgical practices that will be subject to the assessment and the gross annual receipts of these practices are not publicly available, the OLS lacks the informational basis to estimate the additional revenues attributable to this requirement.

The bill's provisions increasing the hospital admission charge will increase revenues by \$13.0 million annually, of which \$8.7 million is attributable to federal Medicaid matching funds. Given that the number of admissions to private psychiatric hospitals, which will be newly subject to the charge under the bill, is not readily accessible, the additional revenues attributable to this provision are indeterminate. For context, a New Jersey Hospital Association fact sheet from March 2025 states that 17 psychiatric hospitals are currently operating in the State; however, the fact sheet does not indicate whether or not this figure includes the four State psychiatric hospitals and the four county-operated psychiatric hospitals.

The OLS additionally determines that Department of Health costs will increase by an indeterminate amount for the department to hire additional staff to administer the changes to the ambulatory care facility assessment and the hospital admission charge, and to provide oversight of the facilities newly subject to the requirements under the bill.

Section: Human Services

*Analyst: Anne Cappabianca
Senior Fiscal Analyst*

*Approved: Thomas Koenig
Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

Bills Gov Acted On

Posted on - 06/30/2025

The Governor has acted on the following bills:

BILL SIGNINGS:

S-4620/A-5879 (McKnight, Mukherji/McCann Stamato) - Amends Fiscal Year 2025 annual appropriations act to assign distribution of Old Courthouse asbestos remediation funding from Hudson County to Jersey City

S-2788wGR/A-4569 (Cruz-Perez, Turner/Freiman, Katz, Simmons) - Appropriates \$128.241 million from constitutionally dedicated CBT revenues to State Agriculture Development Committee for farmland preservation purposes

A-5100/S-3991 (Rodriguez/Stack) - Re-appropriates unexpended balance of FY 2024 appropriation for Town of West New York to support recreation center; appropriates \$3 million for Town of West New York – Recreation Center to restore lapsed FY 2024 funding

A-5807/S-4655 (Pintor Marin/Sarlo) - Makes FY2025 supplemental appropriations of \$142,615,000; adds various language provisions to FY2025 Appropriations Act

A-5803/SCS for S-3064 (Bagolie/McKeon, Turner) - Modifies tax on certain forms of online gaming and wagering

ACS for A-4455/SCS for S-4503 (Freiman, Schaer, Karabinchak /Sarlo, Mukherji) - Allows exemption from New Jersey gross income of certain capital gains from sale or exchange of qualified small business stock

A-5805/SCS for S-4659 and 4661 (Venezia/Sarlo, Vitale) - Modifies tax rate on certain nicotine products

A-5804/S-4666 (Reynolds-Jackson/Wimberly) - Modifies payer of additional fees and taxes imposed on certain real property transfers; modifies fees and taxes imposed on property transfers valued over \$2 million

A-5809/S-4656 (Murphy/Vitale) - "Healthcare Finance Enhancement Act"

S-3189/A-2365 (Zwicker, Sarlo/Tully, Murphy, DePhillips) - Makes various changes to “New Jersey Angel Investor Tax Credit Act” and Technology Business Tax Certificate Transfer Program; repeals “New Jersey Ignite Act”

S-4654/A-5878 (Scutari, A.M. Bucco/Schnall, Inganamort) - Provides for publication of required legal notices on government Internet websites and through certain online news publications

A-5801/S-4692 (Freiman/Sarlo) - Appropriates \$247,128,000 from “New Jersey Debt Defeasance and Prevention Fund”; establishes process for authorizing future appropriations for debt defeasance and capital projects

(BUDGET BILL – w/Rev Cert. LIV, Summary)

BILL VETOED:

[S-2026/A-5800](#) (Sarlo/Pintor Marin, Park) – w/LINE ITEM Appropriates \$58,782,119,000 in State funds and \$31,007,261,743 in federal funds for the State budget for fiscal year 2026

BILL SIGNINGS:

A-5810/S-4660 (Pintor Marin, Dolon, Bagolie/McKeon, McKnight) - Promotes equity in health insurance appeal process

S-4632/A-5812 (Scutari, Ruiz/Schaer) - Establishes grant program in DOE for public schools to purchase and install point-of-use filtered bottle-filling stations and filtered faucets

S-3618/A-4926 (Smith, Greenstein/Calabrese, Tully, Haider) - Directs DEP and DOT to establish “Wildlife Corridor Action Plan”

S-3933/A-5075 (Ruiz, McKnight/Swain, Morales, Bagolie) - Establishes School Supervisor Mentorship Pilot Program; appropriates \$500,000

A-5077/S-4375 (Morales, Bagolie, Carter/Ruiz, Zwicker) - Extends statutory pause on collection of student growth objective data

A-5795/S-4619 (Pintor Marin, Freiman, Drulis/Zwicker) - Modifies certain provisions of "New Jersey Innovation Evergreen Act"

S-4618/A-5827 (Mukherji, Gopal/Pintor Marin, Peterpaul, Donlon) - Modifies certain requirements and award availability under film and digital media content production tax credit program

S-4122/A-5257 (Burzichelli/Stanley, Egan) - Revises apportionment of State lottery contributions

Governor Murphy Signs Fiscal Year 2026 Budget into Law

Posted on - 06/30/2025

Budget Builds on Governor Murphy's Historic Record of Fiscal Responsibility – With a \$6.7 Billion Surplus to Help Weather Future Financial Challenges Compared to Just \$409 Million Surplus Inherited in 2018

Budget Provides An All-Time High Level of Property Tax Relief, the Highest Level of School Funding in History, and a Fifth Consecutive Full Pension Payment

Budget Makes Historic Investments in Women's Health Care and Provides Funding to Fully Modernize NJ TRANSIT's Fleet

TRENTON – Governor Phil Murphy today signed into law the Fiscal Year 2026 Appropriations Act, marking a culmination of the Murphy Administration's longstanding commitment to fiscal responsibility, affordability, and opportunity. Over nine budgets spanning nearly eight years in office, Governor Murphy has presided over sustained economic growth while making long overdue investments in addressing the needs of working New Jerseyans, from property tax relief, to school funding, to restoring funding for the State's pension systems.

The \$58.78 billion Fiscal Year 2026 (FY2026) budget, which was passed by the Legislature earlier today, redirects over 75 percent of the total budget back into our communities in the form of grants-in-aid for property tax relief, social services, higher education, as well as State aid to schools, municipalities, and counties. The budget includes an all-time high level of direct property tax relief for homeowners and renters, yields the highest level of school funding in history, and delivers a fifth consecutive full pension payment. It also prioritizes quality health services for women and families, and it invests in beginning to fully modernize NJ TRANSIT's fleet.

Upon taking office, Governor Murphy inherited a \$409 million surplus from his predecessor. Eight years later, the Governor will leave his successor with a surplus 16 times greater than that amount—\$6.7 billion.

"This budget exemplifies our dedication to fiscal responsibility, affordability, and opportunity for all New Jerseyans," **said Governor Murphy**. "Over nearly eight years in office, we have maintained a steadfast commitment to building a stronger and fairer New Jersey and righting our fiscal ship. I'm proud that this budget caps off an eight-year journey to turn our state around and delivers greater economic security and opportunity to every family. With the help of our legislative partners, we are moving New Jersey toward a brighter future for every child, student, worker, parent, and senior citizen who calls our great state home."

"The budget upholds our administration's promise to make sure that New Jersey remains the best state in the nation to live, work, raise a family, and retire," **said Lieutenant Governor Tahesha Way**. "Over the past seven and a half years, we have made historic strides in making our state more affordable for hardworking residents and families through expanded tax relief and major investments in affordable housing, social services, and

education. This state budget is a direct result of the strong collaboration between Governor Murphy, Treasurer Muoio, and legislative leadership.”

“This budget is the culmination of a nearly eight-year effort to improve conditions for all New Jerseyans, building a fiscally stronger state that is more affordable for all,” **said State Treasurer Elizabeth Maher Muoio.** “As always, this budget could not have been completed without the hard work of my staff at the Department of the Treasury and particularly the folks at the Office of Management and Budget and the Office of Revenue and Economic Analysis. I want to thank all of them for their tireless work, dedication, and exemplary professionalism over the past seven and a half years.”

“This is a fiscally responsible budget that puts New Jersey families first. At a time when working people are being left behind by misguided decisions in Washington, we’re making smart, strategic investments that deliver meaningful support, especially through historic property tax reductions, strong funding for public education, higher education, healthcare, transit, and a full pension payment,” **said Senate President Nick Scutari, Senate Majority Leader M. Teresa Ruiz and Senator Paul Sarlo, Chair of the Senate Budget Committee.** “We’re grateful to Governor Murphy and our colleagues in the Legislature for coming together to enact a disciplined, forward-looking budget that safeguards essential services, expands opportunity, and reinforces New Jersey’s long-term fiscal strength.”

Fiscal Responsibility

The budget once again provides a full payment to the pension systems. This year’s \$7.2 billion payment marks the fifth year in a row Governor Murphy has fully funded the systems. Total pension contributions by the Murphy Administration are on track to exceed \$47 billion – nearly four times the \$12.2 billion in total contributions of the previous six governors combined.

With an eye toward ensuring New Jersey remains prepared for the future, this budget provides a surplus of \$6.7 billion, more than ten times larger than the average surplus under the previous administration.

Additionally, the budget includes \$788 million in funding from the Corporate Transit Fee dedicated to support NJ TRANSIT and builds upon \$1.358 billion in interest saved by taxpayers over the last four years by paying down debt and minimizing new debt taken on.

The budget also includes several tax policy changes, including increases for the highest tier of realty transfer fees, sports betting, and cigarettes and vaping, as well as a new exemption for small business investment and reforms to the Angel Investor Tax Credit.

These changes, along with the cuts in appropriations, help ensure that revenues are more closely in line with expenditures.

Affordability and Economic Security

Continuing efforts to make New Jersey affordable for all, this budget includes nearly \$4.3 billion in direct property tax relief for New Jersey homeowners and renters, including \$2.4 billion for the continuation of the popular ANCHOR program, which last year delivered more than \$2.2 billion in property tax relief to nearly two million residents. The budget also continues the Senior Freeze program, with a \$239 million allocation to benefit more than 235,000 taxpayers.

The budget also includes additional funding for the landmark Stay NJ program, allocating \$600 million in

resources to significantly reduce property taxes for more than 432,000 senior homeowners. Stay NJ is expected to launch for the 2025 tax season and will reimburse eligible seniors for up to 50 percent of their property tax bills.

Continuing the focus on making the state more affordable for working and middle-class families, the budget maintains recent expansions of the Earned Income Tax Credit, the Child and Dependent Care Tax Credit, and the Child Tax Credit.

The tax relief included in this budget brings the total relief provided by the Murphy Administration and our partners in the Legislature to more than double any prior administration.

Continuing efforts to provide quality health services for all, a top priority of this administration, the budget includes \$165 million for the continuation of Cover All Kids; \$55.4 million for the Pharmaceutical Assistance to the Aged and Disabled (PAAD) and Senior Gold programs, helping more than 149,000 seniors and residents with disabilities; \$52 million for family planning services and reproductive health programs; and \$35.8 million for Family Connects NJ, which has provided nearly 2,500 free in-home nurse visits to families with newborns and is now available in 11 counties; and \$52 million for family planning services and reproductive health programs.

The proposal also includes \$10 million for a new initiative to provide State employees with full pay while they take family leave to care for a newborn, adopted, or fostered child.

Supporting the Next Generation of New Jerseyans

Last year, Governor Murphy became the first Governor to fully fund the K-12 school funding formula. This budget builds on that commitment, providing record-high school funding in FY2026. The budget includes a record \$12.1 billion for K-12 schools, a nearly \$4 billion increase since FY2018. This budget also addresses feedback from school districts by capping losses in major school aid categories and reducing input volatility, ensuring no district sees a steep reduction in aid from one year to the next. A district's K-12 State aid will not decrease by an amount greater than 3% of the prior year's State aid in the four primary categories: equalization, special education, security, and transportation.

The budget also proposes \$7.5 million in new grant funding to support districts in providing high-impact tutoring to students in need of extra academic support, as well as \$3 million in incentive grants for schools that want to go entirely phone-free, giving students the best opportunity to learn without distraction.

Continuing the push for universal pre-school throughout New Jersey, the FY2026 budget proposes \$1.27 billion for Preschool Education Aid. Since 2018, the Murphy Administration has expanded pre-K to 229 school districts and created nearly 20,000 new seats.

Building New Jersey's Future

In an effort to fortify our transportation infrastructure, this budget includes \$1.23 billion for critical investments in State and local highway and bridge projects, and another \$767 million for NJ TRANSIT to begin to fully modernize its fleet.

To ensure stability and future success for New Jersey's institutions of higher education, this budget provides \$755.2 million in institutional support for State colleges and universities, as well as \$169.1 million for county colleges and \$8.6 million for independent institutions of higher education in New Jersey. This totals \$932.9 million, a nearly 50% increase over the \$629.6 million in funding provided in FY2018.

The budget agreement also provides for \$250 million in bonding for capital grants to higher education institutions. This builds on the \$400 million in capital grants announced in 2023.

The budget also sets aside \$222 million from the Debt Defeasance and Prevention Fund for a critical investment in the construction of a new correctional facility to replace the Edna Mahan Correctional Facility for Women.

An additional one-page policy summary on the central commitments of the FY2026 budget can be found online [here](#).

Governor Murphy signed the Appropriations Act into law today:

S-2026/A-5800 (Sarlo/Pintor Marin, Park) – w/LINE ITEM Appropriates \$58,782,119,000 in State funds and \$31,007,261,743 in federal funds for the State budget for fiscal year 2026

[Line Item Veto Message](#)

[Line Item Veto Summary](#)

[Revenue Certification](#)

In addition to the Appropriations Act, Governor Murphy also signed the following bills into law today:

S-4620/A-5879 (McKnight, Mukherji/McCann Stamato) - Amends Fiscal Year 2025 annual appropriations act to assign distribution of Old Courthouse asbestos remediation funding from Hudson County to Jersey City

S-2788wGR/A-4569 (Cruz-Perez, Turner/Freiman, Katz, Simmons) - Appropriates \$128.241 million from constitutionally dedicated CBT revenues to State Agriculture Development Committee for farmland preservation purposes

A-5100/S-3991 (Rodriguez/Stack) - Re-appropriates unexpended balance of FY 2024 appropriation for Town of West New York to support recreation center; appropriates \$3 million for Town of West New York – Recreation Center to restore lapsed FY 2024 funding

A-5807/S-4655 (Pintor Marin/Sarlo) - Makes FY2025 supplemental appropriations of \$142,615,000; adds various language provisions to FY2025 Appropriations Act

A-5803/SCS for S-3064 (Bagolie/McKeon, Turner) - Modifies tax on certain forms of online gaming and wagering

ACS for A-4455/SCS for S-4503 (Freiman, Schaer, Karabinchak /Sarlo, Mukherji) - Allows exemption from New Jersey gross income of certain capital gains from sale or exchange of qualified small business stock

A-5805/SCS for S-4659 and 4661 (Venezia/Sarlo, Vitale) - Modifies tax rate on certain nicotine products

A-5804/S-4666 (Reynolds-Jackson/Wimberly) - Modifies payer of additional fees and taxes imposed on certain real property transfers; modifies fees and taxes imposed on property transfers valued over \$2 million

A-5809/S-4656 (Murphy/Vitale) - "Healthcare Finance Enhancement Act

S-3189/A-2365 (Zwicker, Sarlo/Tully, Murphy, DePhillips) - Makes various changes to "New Jersey Angel Investor Tax Credit Act" and Technology Business Tax Certificate Transfer Program; repeals "New Jersey Ignite Act"

S-4654/A-5878 (Scutari, A.M. Bucco/Schnall, Inganamort) - Provides for publication of required legal notices on government Internet websites and through certain online news publications

A-5801/S-4692 (Freiman/Sarlo) - Appropriates \$247,128,000 from "New Jersey Debt Defeasance and Prevention Fund"; establishes process for authorizing future appropriations for debt defeasance and capital projects

A-5810/S-4660 (Pintor Marin, Dolon, Bagolie/McKeon, McKnight) - Promotes equity in health insurance appeal process

S-4632/A-5812 (Scutari, Ruiz/Schaer) - Establishes grant program in DOE for public schools to purchase and install point-of-use filtered bottle-filling stations and filtered faucets

S-3618/A-4926 (Smith, Greenstein/Calabrese, Tully, Haider) - Directs DEP and DOT to establish "Wildlife Corridor Action Plan"

S-3933/A-5075 (Ruiz, McKnight/Swain, Morales, Bagolie) - Establishes School Supervisor Mentorship Pilot Program; appropriates \$500,000

A-5077/S-4375 (Morales, Bagolie, Carter/Ruiz, Zwicker) - Extends statutory pause on collection of student growth objective data

A-5795/S-4619 (Pintor Marin, Freiman, Drulis/Zwicker) - Modifies certain provisions of "New Jersey Innovation Evergreen Act"

S-4618/A-5827 (Mukherji, Gopal/Pintor Marin, Peterpaul, Donlon) - Modifies certain requirements and award availability under film and digital media content production tax credit program

S-4122/A-5257 (Burzichelli/Stanley, Egan) - Revises apportionment of State lottery contributions