26:2H-12, 26:2H-18.57
LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2025 **CHAPTER:** 70

NJSA: 26:2H-12, 26:2H-18.57 "Healthcare Finance Enhancement Act."

BILL NO: A5809 (Substituted for S4656 (1R))

SPONSOR(S) Murphy, Carol A. and others

DATE INTRODUCED: 6/26/2025

COMMITTEE: **ASSEMBLY:** Budget

SENATE: --

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 06/30/2025

SENATE: 06/30/2025

DATE OF APPROVAL: 6/30/2025

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (A5809 enacted)

ADVANCE LAW Yes

PAMPHLET LAW Yes

A5809

INTRODUCED BILL: (Includes sponsor(s) statement) Yes

REPRINT(S): No

TECHNICAL REVIEW OF BILL: No

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

(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: No

S4656 (1R)

INTRODUCED BILL: (Includes sponsor(s) statement) Yes

REPRINT(S): Yes SBA 6/26/25 1R

TECHNICAL REVIEW OF BILL: No

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes

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FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

LEGISLATOR STATEMENT: No

FOLLOWING WERE PRINTED:

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NEWSPAPER ARTICLES: No

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

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:

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

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 <u>thus</u> is new matter.

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.

[A**]** <u>Through State Fiscal Year 2025, a</u> 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.

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

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

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.

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

Effective July 1, 2018, the assessment shall apply to all general acute care hospitals, rehabilitation hospitals, **[**and**]** 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 <u>through Fiscal Year 2025</u>, 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.

<u>(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</u>

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.

(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).

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

3. This act shall take effect immediately.

STATEMENT

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.

"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.

(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)

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:

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.

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 <u>thus</u> is new matter.

(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.

[A**]** 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.

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

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

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.

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

Effective July 1, 2018, the assessment shall apply to all general acute care hospitals, rehabilitation hospitals, **[**and**]** 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 <u>through Fiscal Year 2025</u>, 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.

<u>(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.</u>

<u>(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</u>

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.

(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).

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

3. This act shall take effect immediately.

STATEMENT

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.

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.

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:

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

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 <u>thus</u> is new matter.

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.

【A】 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.

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

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

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.

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

Effective July 1, 2018, the assessment shall apply to all general acute care hospitals, rehabilitation hospitals, **[**and**]** 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 <u>through Fiscal Year 2025</u>, 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, 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.

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

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

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

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

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

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

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

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

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.

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:

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

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:
[1]Senate SBA committee amendments adopted June 26, 2025.

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.

【A】 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.

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

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

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

[Of the**]** <u>The</u> revenues raised by the hospital per adjusted admission charge **[**, $5 per adjusted admission**]** shall be used by the department to carry out its duties pursuant to P.L.1992, c.160 (C.26:2H-18.51 et al.) and **[**$5 per adjusted admission shall be used by the department**]** for administrative costs related to health planning.

Effective July 1, 2018, the assessment shall apply to all general acute care hospitals, rehabilitation hospitals, **[**and**]** long term acute care hospitals<u>, and non-public psychiatric hospitals</u>. 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 <u>through Fiscal Year 2025</u>, 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 [1]from its operating room services[1] , 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. [1]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.[1]

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

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

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

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

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

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

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

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

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	Year 1	Years 2 and 3
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.

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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

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