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**REPORTS:**

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No

P.L. 2004, CHAPTER 54, *approved June 29, 2004*  
Assembly, No. 3127

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

3

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

6

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

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

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

17 b. Effective July 1, 2004, the department shall assess each licensed  
18 ambulatory care facility that is licensed to provide one or more of the  
19 following ambulatory care services: ambulatory surgery, computerized  
20 axial tomography, comprehensive outpatient rehabilitation,  
21 extracorporeal shock wave lithotripsy, magnetic resonance imaging,  
22 megavoltage radiation oncology, positron emission tomography,  
23 orthotripsy and sleep disorder services. The Commissioner of Health  
24 and Senior Services may, by regulation, add additional categories of  
25 ambulatory care services that shall be subject to the assessment if such  
26 services are added to the list of services provided in N.J.A.C.8:43A-  
27 2.2(b) after the effective date of P.L. , c. (pending before the  
28 Legislature as this bill).

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

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

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

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

40 The commissioner shall provide notice no later than August 15,  
41 2004 to all facilities that are subject to the assessment that the first

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

Matter underlined **thus** is new matter.

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

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

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

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

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

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

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

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

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

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

11       e. The revenues raised by the ambulatory care facility assessment  
12 pursuant to this section shall be deposited in the Health Care Subsidy  
13 Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-  
14 18.58).

15 (cf: P.L.1995, c.133, s.3)

16  
17       2. Section 12 of P.L.1992, c.160 (C.26:2H-18.62) is amended to  
18 read as follows:

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

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

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

38       c. Notwithstanding any law to the contrary, each general hospital  
39 [whose revenue cap was established by the Hospital Rate Setting  
40 Commission in 1993 pursuant to P.L.1992, c.160 (C.26:2H-18.51 et  
41 al.)] and each specialty heart hospital shall pay .53% of its total  
42 operating revenue to the department for deposit in the Health Care  
43 Subsidy Fund, except that the amount to be paid by a hospital in a  
44 given year shall be prorated by the department so as not to exceed the  
45 \$40 million limit set forth in this subsection. The hospital shall make  
46 monthly payments to the department beginning July 1, 1993, except

1 that the total amount paid into the Health Care Subsidy Fund plus  
2 interest shall not exceed \$40 million per year. The commissioner shall  
3 determine the manner in which the payments shall be made.

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

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

11 (cf: P.L.1998, c.43, s.15)

12

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

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

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

36 b. "Health care service" means the preadmission, outpatient,  
37 inpatient and postdischarge care provided in or by a health care  
38 facility, and such other items or services as are necessary for such  
39 care, which are provided by or under the supervision of a physician for  
40 the purpose of health maintenance organizations, diagnosis or  
41 treatment of human disease, pain, injury, disability, deformity or  
42 physical condition, including, but not limited to, nursing service, home  
43 care nursing and other paramedical service, ambulance service, service  
44 provided by an intern, resident in training or physician whose  
45 compensation is provided through agreement with a health care  
46 facility, laboratory service, medical social service, drugs, biologicals,

1 supplies, appliances, equipment, bed and board, but excluding services  
2 provided by a physician in his private practice, except as provided in  
3 [section] sections 7 and 12 of P.L.1971, c.136 [(C.26:2H-7)]  
4 (C.26:2H-7 and 26:2H-12), or by practitioners of healing solely by  
5 prayer, and services provided by first aid, rescue and ambulance  
6 squads as defined in the "New Jersey Highway Safety Act of 1971,"  
7 P.L.1971, c.351 (C.27:5F-1 et seq.).

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

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

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

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

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

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

23 i. "Department" means the State Department of Health and Senior  
24 Services.

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

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

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

40 m. "Provider of health care" means an individual (1) who is a direct  
41 provider of health care service in that the individual's primary activity  
42 is the provision of health care services to individuals or the  
43 administration of health care facilities in which such care is provided  
44 and, when required by State law, the individual has received  
45 professional training in the provision of such services or in such  
46 administration and is licensed or certified for such provision or

1 administration; or (2) who is an indirect provider of health care in that  
2 the individual (a) holds a fiduciary position with, or has a fiduciary  
3 interest in, any entity described in subparagraph b(ii) or subparagraph  
4 b(iv); provided, however, that a member of the governing body of a  
5 county or any elected official shall not be deemed to be a provider of  
6 health care unless he is a member of the board of trustees of a health  
7 care facility or a member of a board, committee or body with authority  
8 similar to that of a board of trustees, or unless he participates in the  
9 direct administration of a health care facility; or (b) received, either  
10 directly or through his spouse, more than one-tenth of his gross annual  
11 income for any one or more of the following:

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

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

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

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

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

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

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

30 (cf: P.L.1998, c.43, s.2)

31

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

34 12. a. No health care service or health care facility shall be  
35 operated unless it shall: (1) possess a valid license issued pursuant to  
36 this act, which license shall specify the kind or kinds of health care  
37 services the facility is authorized to provide; (2) establish and maintain  
38 a uniform system of cost accounting approved by the commissioner;  
39 (3) establish and maintain a uniform system of reports and audits  
40 meeting the requirements of the commissioner; (4) prepare and review  
41 annually a long range plan for the provision of health care services;  
42 and (5) establish and maintain a centralized, coordinated system of  
43 discharge planning which assures every patient a planned program of  
44 continuing care and which meets the requirements of the commissioner  
45 which requirements shall, where feasible, equal or exceed those  
46 standards and regulations established by the federal government for all



1 federally-funded health care facilities but shall not require any person  
2 who is not in receipt of State or federal assistance to be discharged  
3 against his will.

4 b. (1) Application for a license for a health care service or health  
5 care facility shall be made upon forms prescribed by the department.  
6 The department shall charge a single, nonrefundable fee for the filing  
7 of an application for and issuance of a license and a single,  
8 nonrefundable fee for any renewal thereof, and a single, nonrefundable  
9 fee for a biennial inspection of the facility, as it shall from time to time  
10 fix in rules or regulations; provided, however, that no such licensing  
11 fee shall exceed \$10,000 in the case of a hospital and \$4,000 in the  
12 case of any other health care facility for all services provided by the  
13 hospital or other health care facility, and no such inspection fee shall  
14 exceed \$5,000 in the case of a hospital and \$2,000 in the case of any  
15 other health care facility for all services provided by the hospital or  
16 other health care facility. No inspection fee shall be charged for  
17 inspections other than biennial inspections. The application shall  
18 contain the name of the health care facility, the kind or kinds of health  
19 care service to be provided, the location and physical description of  
20 the institution, and such other information as the department may  
21 require. (2) A license shall be issued by the department upon its  
22 findings that the premises, equipment, personnel, including principals  
23 and management, finances, rules and bylaws, and standards of health  
24 care service are fit and adequate and there is reasonable assurance the  
25 health care facility will be operated in the manner required by this act  
26 and rules and regulations thereunder.

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

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

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

44 f. Notwithstanding the provisions of any other law to the contrary,  
45 an entity that provides magnetic resonance imaging or computerized  
46 axial tomography services shall be required to obtain a license from the

1 department to operate those services prior to commencement of  
2 services, except that a physician who is operating such services on the  
3 effective date of P.L. , c. (pending before the Legislature as this bill)  
4 shall have one year from the effective date of P.L. , c. (pending  
5 before the Legislature as this bill) to obtain the license.  
6 (cf: P.L.1998, c.43, s.12)

7

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

9

10

11

## STATEMENT

12

13 This bill imposes an assessment on certain licensed ambulatory care  
14 facilities, based on the facility's gross receipts, beginning July 1, 2004.  
15 The revenues raised by the assessment will be deposited in the Health  
16 Care Subsidy Fund.

17 The assessment would apply to facilities that are licensed to provide  
18 one or more of the following ambulatory care services: ambulatory  
19 surgery, computerized axial tomography, comprehensive outpatient  
20 rehabilitation, extracorporeal shock wave lithotripsy, magnetic  
21 resonance imaging, megavoltage radiation oncology, positron emission  
22 tomography, orthotripsy and sleep disorder services.

23 The assessment would not apply to an ambulatory care facility with  
24 annual gross receipts less than \$300,000, or to an ambulatory care  
25 facility that is licensed to a hospital in this State as on off-site  
26 ambulatory care service facility.

27 The bill provides as follows:

28 -- In Fiscal Year (FY) 2005, an ambulatory care facility with at  
29 least \$300,000 in gross receipts shall pay an assessment equal to 3.5%  
30 of its gross receipts or \$200,000, whichever amount is less. The  
31 assessment shall be payable to the department in four installments,  
32 with payments due October 1, 2004, January 1, 2005, March 15, 2005  
33 and June 15, 2005. The Commissioner of Health and Senior Services  
34 is directed to provide notice no later than August 15, 2004 to all  
35 facilities that are subject to the assessment that proof of gross receipts  
36 for the facility's tax year ending in calendar year 2003 must be  
37 provided by the facility to the commissioner no later than September  
38 15, 2004. If a facility fails to provide proof of gross receipts by that  
39 date, the facility shall be assessed the maximum rate of \$200,000 for  
40 FY 2005.

41 -- For FY 2006, the commissioner shall use the calendar year 2004  
42 data on patient visits, charges and gross revenues, submitted by the  
43 facility as required in the bill, to calculate a uniform gross receipts  
44 assessment rate to be applied to each facility that is subject to the  
45 assessment with gross receipts over \$300,000. The FY 2006 rate shall  
46 be calculated so as to raise the same amount in the aggregate as was

1 assessed in FY 2005, but no facility will pay more than \$200,000. A  
2 facility shall pay its assessment in four payments to the department, as  
3 specified by the commissioner.

4 -- Beginning in FY 2007 and each year thereafter, the uniform gross  
5 receipts assessment rate calculated for FY 2006 shall be applied to  
6 each facility subject to the assessment with gross receipts over  
7 \$300,000, but no facility will pay more than \$200,000. A facility shall  
8 pay its assessment in four payments to the department, as specified by  
9 the commissioner.

10 -- Each facility that is subject to the assessment will be required to  
11 submit an annual report including, at a minimum, data on volume of  
12 patient visits, charges and gross revenues, by payer type, for patient  
13 services, beginning with calendar year 2004 data. A facility that fails  
14 to provide the required information shall be liable to a civil penalty not  
15 to exceed \$500 for each day in which the facility is not in compliance.

16 -- The department may audit selected annual reports in order to  
17 determine their accuracy, and if, upon audit, it is determined that an  
18 ambulatory care facility's annual report to the department understated  
19 the facility's gross receipts, the facility's assessment, for any fiscal year,  
20 that was based on the defective report shall be retroactively increased  
21 to the appropriate amount, and the facility shall be liable for a penalty  
22 in the amount of the difference between the original and corrected  
23 assessment.

24 -- A facility that is operating one or more of the ambulatory care  
25 services listed in the bill without a license from the department, on or  
26 after July 1, 2004, shall be liable for double the amount of the  
27 assessment, in addition to such other penalties as the department may  
28 assess for operating an ambulatory care facility without a license.

29 This bill also amends N.J.S.A.26:2H-18.62 to clarify that the .53%  
30 assessment applies to general hospitals and specialty heart hospitals,  
31 and that total operating revenue shall include revenue from any  
32 ambulatory care facility that is licensed to a general hospital as an off-  
33 site ambulatory care service facility.

34 Finally, the bill amends N.J.S.A.26:2H-2 and 26:2H-12 to clarify  
35 that an entity that provides magnetic resonance imaging or  
36 computerized axial tomography services shall be required to obtain a  
37 license from the department to operate those services prior to  
38 commencement of services. The bill also provides that a physician who  
39 is operating such services on the effective date of the bill shall have  
40 one year from the effective date to obtain the license.

41

42

43

44 Establishes annual assessment on gross receipts of certain licensed  
45 ambulatory care facilities and requires licensure of certain health care  
46 services.

# ASSEMBLY, No. 3127

## STATE OF NEW JERSEY 211th LEGISLATURE

INTRODUCED JUNE 21, 2004

**Sponsored by:**

**Assemblyman PATRICK DIEGNAN, JR.**

**District 18 (Middlesex)**

**Co-Sponsored by:**

**Senator Bryant**

**SYNOPSIS**

Establishes annual assessment on gross receipts of certain licensed ambulatory care facilities and requires licensure of certain health care services.

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 6/25/2004)**

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

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4 **BE IT ENACTED** by the Senate and General Assembly of the State  
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8 read as follows:

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12 Of the revenues raised by the [assessment] hospital per adjusted  
13 admission charge, \$5.00 per adjusted admission shall be used by the  
14 department to carry out its duties pursuant to P.L.1992, c.160  
15 (C.26:2H-18.51 et al.) and \$5.00 per adjusted admission shall be used  
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18 ambulatory care facility that is licensed to provide one or more of the  
19 following ambulatory care services: ambulatory surgery, computerized  
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24 and Senior Services may, by regulation, add additional categories of  
25 ambulatory care services that shall be subject to the assessment if such  
26 services are added to the list of services provided in N.J.A.C.8:43A-  
27 2.2(b) after the effective date of P.L. , c. (pending before the  
28 Legislature as this bill).

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

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

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

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

40 The commissioner shall provide notice no later than August 15,  
41 2004 to all facilities that are subject to the assessment that the first  
42 payment of the assessment is due October 1, 2004 and that proof of  
43 gross receipts for the facility's tax year ending in calendar year 2003

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

Matter underlined thus is new matter.

1 shall be provided by the facility to the commissioner no later than  
2 September 15, 2004. If a facility fails to provide proof of gross  
3 receipts by September 15, 2004, the facility shall be assessed the  
4 maximum rate of \$200,000 for Fiscal Year 2005.

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22 recent annual report to the department, except that no facility shall pay  
23 an assessment greater than \$200,000. A facility shall pay its annual  
24 assessment to the department in four payments in accordance with a  
25 timetable prescribed by the commissioner.

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

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

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

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

45 (3) A facility that is operating one or more of the ambulatory care  
46 services listed in subsection b. of this section without a license from

1 the department, on or after July 1, 2004, shall be liable for double the  
2 amount of the assessment provided for in subsection b. of this section,  
3 in addition to such other penalties as the department may impose for  
4 operating an ambulatory care facility without a license.

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

9 e. The revenues raised by the ambulatory care facility assessment  
10 pursuant to this section shall be deposited in the Health Care Subsidy  
11 Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-  
12 18.58).

13 (cf: P.L.1995, c.133, s.3)

14  
15 2. Section 12 of P.L.1992, c.160 (C.26:2H-18.62) is amended to  
16 read as follows:

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

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

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

36 c. Notwithstanding any law to the contrary, each general hospital  
37 [whose revenue cap was established by the Hospital Rate Setting  
38 Commission in 1993 pursuant to P.L.1992, c.160 (C.26:2H-18.51 et  
39 al.)] and each specialty heart hospital shall pay .53% of its total  
40 operating revenue to the department for deposit in the Health Care  
41 Subsidy Fund, except that the amount to be paid by a hospital in a  
42 given year shall be prorated by the department so as not to exceed the  
43 \$40 million limit set forth in this subsection. The hospital shall make  
44 monthly payments to the department beginning July 1, 1993, except  
45 that the total amount paid into the Health Care Subsidy Fund plus  
46 interest shall not exceed \$40 million per year. The commissioner shall

1 determine the manner in which the payments shall be made.

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

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

9 (cf: P.L.1998, c.43, s.15)

10

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

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

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

34 b. "Health care service" means the preadmission, outpatient,  
35 inpatient and postdischarge care provided in or by a health care  
36 facility, and such other items or services as are necessary for such  
37 care, which are provided by or under the supervision of a physician for  
38 the purpose of health maintenance organizations, diagnosis or  
39 treatment of human disease, pain, injury, disability, deformity or  
40 physical condition, including, but not limited to, nursing service, home  
41 care nursing and other paramedical service, ambulance service, service  
42 provided by an intern, resident in training or physician whose  
43 compensation is provided through agreement with a health care  
44 facility, laboratory service, medical social service, drugs, biologicals,  
45 supplies, appliances, equipment, bed and board, but excluding services  
46 provided by a physician in his private practice, except as provided in



1 [section] sections 7 and 12 of P.L.1971, c.136 [(C.26:2H-7)]  
2 (C.26:2H-7 and 26:2H-12), or by practitioners of healing solely by  
3 prayer, and services provided by first aid, rescue and ambulance  
4 squads as defined in the "New Jersey Highway Safety Act of 1971,"  
5 P.L.1971, c.351 (C.27:5F-1 et seq.).

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

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

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

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

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

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

21 i. "Department" means the State Department of Health and Senior  
22 Services.

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

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

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

38 m. "Provider of health care" means an individual (1) who is a direct  
39 provider of health care service in that the individual's primary activity  
40 is the provision of health care services to individuals or the  
41 administration of health care facilities in which such care is provided  
42 and, when required by State law, the individual has received  
43 professional training in the provision of such services or in such  
44 administration and is licensed or certified for such provision or  
45 administration; or (2) who is an indirect provider of health care in that  
46 the individual (a) holds a fiduciary position with, or has a fiduciary

1 interest in, any entity described in subparagraph b(ii) or subparagraph  
2 b(iv); provided, however, that a member of the governing body of a  
3 county or any elected official shall not be deemed to be a provider of  
4 health care unless he is a member of the board of trustees of a health  
5 care facility or a member of a board, committee or body with authority  
6 similar to that of a board of trustees, or unless he participates in the  
7 direct administration of a health care facility; or (b) received, either  
8 directly or through his spouse, more than one-tenth of his gross annual  
9 income for any one or more of the following:

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

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

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

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

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

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

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

28 (cf: P.L.1998, c.43, s.2)

29

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

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

1 against his will.

2 b. (1) Application for a license for a health care service or health  
3 care facility shall be made upon forms prescribed by the department.  
4 The department shall charge a single, nonrefundable fee for the filing  
5 of an application for and issuance of a license and a single,  
6 nonrefundable fee for any renewal thereof, and a single, nonrefundable  
7 fee for a biennial inspection of the facility, as it shall from time to time  
8 fix in rules or regulations; provided, however, that no such licensing  
9 fee shall exceed \$10,000 in the case of a hospital and \$4,000 in the  
10 case of any other health care facility for all services provided by the  
11 hospital or other health care facility, and no such inspection fee shall  
12 exceed \$5,000 in the case of a hospital and \$2,000 in the case of any  
13 other health care facility for all services provided by the hospital or  
14 other health care facility. No inspection fee shall be charged for  
15 inspections other than biennial inspections. The application shall  
16 contain the name of the health care facility, the kind or kinds of health  
17 care service to be provided, the location and physical description of  
18 the institution, and such other information as the department may  
19 require. (2) A license shall be issued by the department upon its  
20 findings that the premises, equipment, personnel, including principals  
21 and management, finances, rules and bylaws, and standards of health  
22 care service are fit and adequate and there is reasonable assurance the  
23 health care facility will be operated in the manner required by this act  
24 and rules and regulations thereunder.

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

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

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

42 f. Notwithstanding the provisions of any other law to the contrary,  
43 an entity that provides magnetic resonance imaging or computerized  
44 axial tomography services shall be required to obtain a license from the  
45 department to operate those services prior to commencement of  
46 services, except that a physician who is operating such services on the

1 effective date of P.L. , c. (pending before the Legislature as this bill)  
2 shall have one year from the effective date of P.L. , c. (pending  
3 before the Legislature as this bill) to obtain the license.  
4 (cf: P.L.1998, c.43, s.12)

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

7  
8  
9 STATEMENT

10  
11 This bill imposes an assessment on certain licensed ambulatory care  
12 facilities, based on the facility's gross receipts, beginning July 1, 2004.  
13 The revenues raised by the assessment will be deposited in the Health  
14 Care Subsidy Fund.

15 The assessment would apply to facilities that are licensed to provide  
16 one or more of the following ambulatory care services: ambulatory  
17 surgery, computerized axial tomography, comprehensive outpatient  
18 rehabilitation, extracorporeal shock wave lithotripsy, magnetic  
19 resonance imaging, megavoltage radiation oncology, positron emission  
20 tomography, orthotripsy and sleep disorder services.

21 The assessment would not apply to an ambulatory care facility with  
22 annual gross receipts less than \$300,000, or to an ambulatory care  
23 facility that is licensed to a hospital in this State as on off-site  
24 ambulatory care service facility.

25 The bill provides as follows:

26 -- In Fiscal Year (FY) 2005, an ambulatory care facility with at  
27 least \$300,000 in gross receipts shall pay an assessment equal to 3.5%  
28 of its gross receipts or \$200,000, whichever amount is less. The  
29 assessment shall be payable to the department in four installments,  
30 with payments due October 1, 2004, January 1, 2005, March 15, 2005  
31 and June 15, 2005. The Commissioner of Health and Senior Services  
32 is directed to provide notice no later than August 15, 2004 to all  
33 facilities that are subject to the assessment that proof of gross receipts  
34 for the facility's tax year ending in calendar year 2003 must be  
35 provided by the facility to the commissioner no later than September  
36 15, 2004. If a facility fails to provide proof of gross receipts by that  
37 date, the facility shall be assessed the maximum rate of \$200,000 for  
38 FY 2005.

39 -- For FY 2006, the commissioner shall use the calendar year 2004  
40 data on patient visits, charges and gross revenues, submitted by the  
41 facility as required in the bill, to calculate a uniform gross receipts  
42 assessment rate to be applied to each facility that is subject to the  
43 assessment with gross receipts over \$300,000. The FY 2006 rate shall  
44 be calculated so as to raise the same amount in the aggregate as was  
45 assessed in FY 2005, but no facility will pay more than \$200,000. A  
46 facility shall pay its assessment in four payments to the department, as

1 specified by the commissioner.

2 -- Beginning in FY 2007 and each year thereafter, the uniform gross  
3 receipts assessment rate calculated for FY 2006 shall be applied to  
4 each facility subject to the assessment with gross receipts over  
5 \$300,000, but no facility will pay more than \$200,000. A facility shall  
6 pay its assessment in four payments to the department, as specified by  
7 the commissioner.

8 -- Each facility that is subject to the assessment will be required to  
9 submit an annual report including, at a minimum, data on volume of  
10 patient visits, charges and gross revenues, by payer type, for patient  
11 services, beginning with calendar year 2004 data. A facility that fails  
12 to provide the required information shall be liable to a civil penalty not  
13 to exceed \$500 for each day in which the facility is not in compliance.

14 -- The department may audit selected annual reports in order to  
15 determine their accuracy, and if, upon audit, it is determined that an  
16 ambulatory care facility's annual report to the department understated  
17 the facility's gross receipts, the facility's assessment, for any fiscal year,  
18 that was based on the defective report shall be retroactively increased  
19 to the appropriate amount, and the facility shall be liable for a penalty  
20 in the amount of the difference between the original and corrected  
21 assessment.

22 -- A facility that is operating one or more of the ambulatory care  
23 services listed in the bill without a license from the department, on or  
24 after July 1, 2004, shall be liable for double the amount of the  
25 assessment, in addition to such other penalties as the department may  
26 assess for operating an ambulatory care facility without a license.

27 This bill also amends N.J.S.A.26:2H-18.62 to clarify that the .53%  
28 assessment applies to general hospitals and specialty heart hospitals,  
29 and that total operating revenue shall include revenue from any  
30 ambulatory care facility that is licensed to a general hospital as an off-  
31 site ambulatory care service facility.

32 Finally, the bill amends N.J.S.A.26:2H-2 and 26:2H-12 to clarify  
33 that an entity that provides magnetic resonance imaging or  
34 computerized axial tomography services shall be required to obtain a  
35 license from the department to operate those services prior to  
36 commencement of services. The bill also provides that a physician who  
37 is operating such services on the effective date of the bill shall have  
38 one year from the effective date to obtain the license.

# ASSEMBLY BUDGET COMMITTEE

## STATEMENT TO

### ASSEMBLY, No. 3127

# STATE OF NEW JERSEY

DATED: JUNE 22, 2004

The Assembly Budget Committee reports favorably Assembly Bill No. 3127.

Assembly Bill No. 3127 imposes an assessment on certain licensed ambulatory care facilities, based on the facility's gross receipts, beginning July 1, 2004. The revenues raised by the assessment will be deposited in the Health Care Subsidy Fund.

The assessment would apply to facilities that are 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 assessment would not apply to an ambulatory care facility with annual gross receipts less than \$300,000, or to an ambulatory care facility that is licensed to a hospital in this State as an off-site ambulatory care service facility.

The bill provides as follows:

-- In Fiscal Year (FY) 2005, an ambulatory care facility with at least \$300,000 in gross receipts shall pay an assessment equal to 3.5% of its gross receipts or \$200,000, whichever amount is less. The 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. The Commissioner of Health and Senior Services is directed to provide notice no later than August 15, 2004 to all facilities that are subject to the assessment that proof of gross receipts for the facility's tax year ending in calendar year 2003 must 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 that date, the facility shall be assessed the maximum rate of \$200,000 for FY 2005.

-- For FY 2006, the commissioner shall use the calendar year 2004 data on patient visits, charges and gross revenues, submitted by the facility as required in the bill, to calculate a uniform gross receipts assessment rate to be applied to each facility that is subject to the assessment with gross receipts over \$300,000. The FY 2006 rate shall be calculated so as to raise the same amount in the aggregate as was assessed in FY 2005, but no facility will pay more than \$200,000. A

facility shall pay its assessment in four payments to the department, as specified by the commissioner.

-- Beginning in FY 2007 and each year thereafter, the uniform gross receipts assessment rate calculated for FY 2006 shall be applied to each facility subject to the assessment with gross receipts over \$300,000, but no facility will pay more than \$200,000. A facility shall pay its assessment in four payments to the department, as specified by the commissioner.

-- Each facility that is subject to the assessment will be required to 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. A facility that fails to provide the required information shall be liable to a civil penalty not to exceed \$500 for each day in which the facility is not in compliance.

-- The department may audit selected annual reports in order to determine their accuracy, and if, upon audit, it is determined that an ambulatory care facility's annual report to the department understated the facility's gross receipts, the facility's assessment, for any 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.

-- A facility that is operating one or more of the ambulatory care services listed in the substitute without a license from the department, on or after July 1, 2004, shall be liable for double the amount of the assessment, in addition to such other penalties as the department may assess for operating an ambulatory care facility without a license.

This bill also amends N.J.S.A.26:2H-18.62 to clarify that the .53% assessment applies to general hospitals and specialty heart hospitals, and that total operating revenue shall include revenue from any ambulatory care facility that is licensed to a general hospital as an off-site ambulatory care service facility.

Finally, the bill amends N.J.S.A.26:2H-2 and 26:2H-12 to clarify that 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. The bill also provides that a physician who is operating such services on the effective date of the bill shall have one year from the effective date to obtain the license.

#### FISCAL IMPACT

The proposed FY2005 Budget recommends the enactment of an ambulatory medical facilities assessment, which is estimated to generate a total of \$31 million in new revenue in FY2005.

**SENATE, No. 1659**

**STATE OF NEW JERSEY**  
**211th LEGISLATURE**

INTRODUCED JUNE 7, 2004

**Sponsored by:**

**Senator WAYNE R. BRYANT**

**District 5 (Camden and Gloucester)**

**SYNOPSIS**

Establishes annual assessment on gross receipts of certain licensed ambulatory care facilities.

**CURRENT VERSION OF TEXT**

As introduced.



**(Sponsorship Updated As Of: 6/22/2004)**



S1659 BRYANT

2

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

3

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

6

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

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

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

17 b. Effective July 1, 2004, the department shall assess each licensed  
18 ambulatory care facility that is licensed to provide one or more of the  
19 following ambulatory care services: ambulatory surgery, computerized  
20 axial tomography, comprehensive outpatient rehabilitation,  
21 extracorporeal shock wave lithotripsy, magnetic resonance imaging,  
22 megavoltage radiation oncology, positron emission tomography,  
23 orthotripsy and sleep disorder services. The Commissioner of Health  
24 and Senior Services may, by regulation, add additional categories of  
25 ambulatory care services that shall be subject to the assessment if such  
26 services are added to the list of services provided in N.J.A.C.8:43A-  
27 2.2(b) after the effective date of this act.

28 The assessment established in this subsection shall not apply to an  
29 ambulatory care facility that is licensed to a general hospital as on off-  
30 site ambulatory facility and whose revenues are included in the  
31 hospital's total operating revenue as provided in section 12 of  
32 P.L.1992, c.160 (C.26:2H-18.62).

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

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

38 (b) a facility with at least \$300,000 but less than \$1 million in gross  
39 receipts shall pay an assessment of \$25,000;

40 (c) a facility with at least \$1 million but less than \$2 million in gross  
41 receipts shall pay an assessment of \$50,000;

42 (d) a facility with at least \$2 million but less than \$3 million in gross  
43 receipts shall pay an assessment of \$75,000;

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.

S1659 BRYANT

1 (e) a facility with at least \$3 million but less than \$4 million in gross  
2 receipts shall pay an assessment of \$100,000; and

3 (f) a facility with \$4 million or more in gross receipts shall pay an  
4 assessment of \$150,000.

5 The commissioner shall provide notice no later than September 1,  
6 2004 to all facilities that are subject to the assessment, that they are  
7 assessed \$150,000 for Fiscal Year 2005. The assessment for a facility  
8 with gross receipts less than \$4 million for the 2003 tax year shall be  
9 adjusted by the commissioner, in accordance with the applicable  
10 assessment as provided in this paragraph (1), upon submission to the  
11 commissioner by the facility of proofs of gross receipts that are  
12 acceptable to the commissioner.

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

16 (2) For Fiscal Year 2006, the commissioner shall use the calendar  
17 year 2004 data submitted in accordance with subsection c. of this  
18 section to calculate a uniform gross receipts assessment rate for each  
19 facility with gross receipts over \$300,000 that is subject to the  
20 assessment. The rate shall be calculated so as to raise the same amount  
21 in the aggregate as was assessed in Fiscal Year 2005, adjusted to  
22 account for reductions in assessments as provided for in paragraph (1)  
23 of this subsection. A facility shall pay its assessment to the  
24 department in four payments in accordance with a timetable prescribed  
25 by the commissioner.

26 (3) Beginning in Fiscal Year 2007 and for each fiscal year  
27 thereafter, the uniform gross receipts assessment rate calculated in  
28 accordance with paragraph (2) of this subsection shall be applied to  
29 each facility subject to the assessment with gross receipts over  
30 \$300,000, as those gross receipts are documented in the facility's most  
31 recent annual report to the department. A facility shall pay its annual  
32 assessment to the department in four payments in accordance with a  
33 timetable prescribed by the commissioner.

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

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

43 d. (1) If, upon audit as provided for in subsection c. of this section,  
44 it is determined that an ambulatory care facility understated its gross  
45 receipts in its annual report to the department, the facility's assessment  
46 for the fiscal year that was based on the defective report shall be

1 retroactively increased to the appropriate amount and the facility shall  
2 be liable for a penalty in the amount of the difference between the  
3 original and corrected assessment.

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

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

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

17 e. The revenues raised by the ambulatory care facility assessment  
18 pursuant to this section shall be deposited in the Health Care Subsidy  
19 Fund established pursuant to section 8 of P.L.1992, c.160 (C.26:2H-  
20 18.58).

21 (cf: P.L.1995, c.133, s.3)

22  
23 2. Section 12 of P.L.1992, c.160 (C.26:2H-18.62) is amended to  
24 read as follows:

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

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

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

44 c. Notwithstanding any law to the contrary, each general hospital  
45 [whose revenue cap was established by the Hospital Rate Setting  
46 Commission in 1993 pursuant to P.L.1992, c.160 (C.26:2H-18.51 et

1 al.)] and each specialty heart hospital shall pay .53% of its total  
2 operating revenue to the department for deposit in the Health Care  
3 Subsidy Fund, except that the amount to be paid by a hospital in a  
4 given year shall be prorated by the department so as not to exceed the  
5 \$40 million limit set forth in this subsection. The hospital shall make  
6 monthly payments to the department beginning July 1, 1993, except  
7 that the total amount paid into the Health Care Subsidy Fund plus  
8 interest shall not exceed \$40 million per year. The commissioner shall  
9 determine the manner in which the payments shall be made.

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

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

17 (cf: P.L.1998, c.43, s.15)

18  
19 3. This act shall take effect July 1, 2004.

#### 20 21 22 STATEMENT

23  
24 This bill amends N.J.S.A.26:2H-18.57 to establish an assessment  
25 on certain licensed ambulatory care facilities, based on the facility's  
26 gross receipts, beginning July 1, 2004. The revenues raised by the  
27 assessment will be deposited in the Health Care Subsidy Fund.

28 The assessment would apply to facilities that are licensed to provide  
29 one or more of the following ambulatory care services: ambulatory  
30 surgery, computerized axial tomography, comprehensive outpatient  
31 rehabilitation, extracorporeal shock wave lithotripsy, magnetic  
32 resonance imaging, megavoltage radiation oncology, positron emission  
33 tomography, orthotripsy and sleep disorder services.

34 The assessment would not apply to: an ambulatory care facility with  
35 annual gross receipts less than \$300,000; and an ambulatory care  
36 facility that is licensed to a general hospital as on off-site ambulatory  
37 facility whose revenues are included in the calculation of total  
38 operating revenue for the hospital for the purposes of N.J.S.A.26:2H-  
39 18.62 (the .53% assessment).

40 The bill provides as follows:

41 -- In Fiscal Year (FY) 2005, the assessment on these ambulatory  
42 care facilities would be as follows:

- 43 - a facility with at least \$300,000 but less than \$1 million in  
44 gross receipts shall pay an assessment of \$25,000;  
45 - a facility with at least \$1 million but less than \$2 million in  
46 gross receipts shall pay an assessment of \$50,000;

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6

- 1           - a facility with at least \$2 million but less than \$3 million in  
2           gross receipts shall pay an assessment of \$75,000;  
3           - a facility with at least \$3 million but less than \$4 million in  
4           gross receipts shall pay an assessment of \$100,000; and  
5           - a facility with \$4 million or more in gross receipts shall pay  
6           an assessment of \$150,000.

7           -- The Commissioner of Health and Senior Services shall provide  
8           notice no later than September 1, 2004 to all facilities that are subject  
9           to the assessment, that they are assessed \$150,000 for FY 2005. The  
10          assessment for a facility with gross receipts less than \$4 million for the  
11          2003 tax year will be adjusted accordingly by the commissioner upon  
12          submission to the commissioner of acceptable proofs of gross receipts.  
13          The FY 2005 assessment shall be payable to the department in four  
14          installments, with payments due October 1, 2004, January 1, 2005,  
15          March 15, 2005 and June 15, 2005.

16          -- For FY 2006, the commissioner shall use the calendar year 2004  
17          data on patient visits, charges and gross revenues, submitted by the  
18          facility as required in the bill, to calculate a uniform gross receipts  
19          assessment rate to be applied to each facility that is subject to the  
20          assessment with gross receipts over \$300,000. The FY 2006 rate shall  
21          be calculated so as to raise the same amount in the aggregate as was  
22          assessed in FY 2005. A facility shall pay its assessment in four  
23          payments to the department, as specified by the commissioner.

24          -- Beginning in FY 2007 and each year thereafter, the uniform gross  
25          receipts assessment rate calculated for FY2006 shall be applied to each  
26          facility subject to the assessment with gross receipts over \$300,000.  
27          A facility shall pay its assessment in four payments to the department,  
28          as specified by the commissioner.

29          -- Each facility that is subject to the assessment will be required to  
30          submit an annual report including, at a minimum, data on volume of  
31          patient visits, charges, and gross revenues, by payer type, for patient  
32          services, beginning with calendar year 2004 data. A facility that fails  
33          to provide the required information shall be liable to a civil penalty not  
34          to exceed \$500 for each day in which the facility is not in compliance.

35          -- The department may audit selected annual reports in order to  
36          determine their accuracy, and if, upon audit, it is determined that an  
37          ambulatory care facility's annual report to the department understated  
38          the facility's gross receipts, the facility's assessment, for any fiscal year,  
39          that was based on the defective report shall be retroactively increased  
40          to the appropriate amount, and the facility shall be liable for a penalty  
41          in the amount of the difference between the original and corrected  
42          assessment.

43          -- A facility that is operating one or more of the ambulatory care  
44          services listed in the bill without a license from the department, on or  
45          after July 1, 2004, shall be liable for double the amount of the  
46          assessment, in addition to such other penalties as the department may

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7

1 assess for operating an ambulatory care facility without a license.

2 This bill also amends N.J.S.A.26:2H-18.62 to clarify that the .53%  
3 assessment applies to general hospitals and specialty heart hospitals,  
4 and that total operating revenue shall include revenue from any  
5 ambulatory care facility that is licensed to a general hospital as an off-  
6 site ambulatory facility.

# SENATE BUDGET AND APPROPRIATIONS COMMITTEE

## STATEMENT TO

### SENATE COMMITTEE SUBSTITUTE FOR **SENATE, No. 1659**

# **STATE OF NEW JERSEY**

DATED: JUNE 18, 2004

The Senate Budget and Appropriations Committee reports favorably a Senate Committee Substitute for Senate Bill No. 1659.

This committee substitute imposes an assessment on certain licensed ambulatory care facilities, based on the facility's gross receipts, beginning July 1, 2004. The revenues raised by the assessment will be deposited in the Health Care Subsidy Fund.

The assessment would apply to facilities that are 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 assessment would not apply to an ambulatory care facility with annual gross receipts less than \$300,000, or to an ambulatory care facility that is licensed to a hospital in this State as an off-site ambulatory care service facility.

The substitute provides as follows:

-- In Fiscal Year (FY) 2005, an ambulatory care facility with at least \$300,000 in gross receipts shall pay an assessment equal to 3.5% of its gross receipts or \$200,000, whichever amount is less. The 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. The Commissioner of Health and Senior Services is directed to provide notice no later than August 15, 2004 to all facilities that are subject to the assessment that proof of gross receipts for the facility's tax year ending in calendar year 2003 must 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 that date, the facility shall be assessed the maximum rate of \$200,000 for FY 2005.

-- For FY 2006, the commissioner shall use the calendar year 2004 data on patient visits, charges and gross revenues, submitted by the facility as required in the substitute, to calculate a uniform gross receipts assessment rate to be applied to each facility that is subject to the assessment with gross receipts over \$300,000. The FY 2006 rate

shall be calculated so as to raise the same amount in the aggregate as was assessed in FY 2005, but no facility will pay more than \$200,000. A facility shall pay its assessment in four payments to the department, as specified by the commissioner.

-- Beginning in FY 2007 and each year thereafter, the uniform gross receipts assessment rate calculated for FY 2006 shall be applied to each facility subject to the assessment with gross receipts over \$300,000, but no facility will pay more than \$200,000. A facility shall pay its assessment in four payments to the department, as specified by the commissioner.

-- Each facility that is subject to the assessment will be required to 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. A facility that fails to provide the required information shall be liable to a civil penalty not to exceed \$500 for each day in which the facility is not in compliance.

-- The department may audit selected annual reports in order to determine their accuracy, and if, upon audit, it is determined that an ambulatory care facility's annual report to the department understated the facility's gross receipts, the facility's assessment, for any 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.

-- A facility that is operating one or more of the ambulatory care services listed in the substitute without a license from the department, on or after July 1, 2004, shall be liable for double the amount of the assessment, in addition to such other penalties as the department may assess for operating an ambulatory care facility without a license.

This substitute also amends N.J.S.A.26:2H-18.62 to clarify that the .53% assessment applies to general hospitals and specialty heart hospitals, and that total operating revenue shall include revenue from any ambulatory care facility that is licensed to a general hospital as an off-site ambulatory care service facility.

Finally, the substitute amends N.J.S.A.26:2H-2 and 26:2H-12 to clarify that 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. The substitute also provides that a physician who is operating such services on the effective date of the substitute shall have one year from the effective date to obtain the license.

#### FISCAL IMPACT

The proposed FY2005 Budget recommends the enactment of an ambulatory medical facilities assessment, which is estimated to generate a total of \$31 million in new revenue in FY2005.



**LEGISLATIVE FISCAL ESTIMATE**  
**SENATE, No. 1659**  
**STATE OF NEW JERSEY**  
**211th LEGISLATURE**

DATED: JUNE 29, 2004

**SUMMARY**

**Synopsis:** Establishes annual assessment on gross receipts of certain licensed ambulatory care facilities.

**Type of Impact:** The Governor's FY 2005 recommended budget anticipates that \$31 million would be generated by this assessment.

**Agencies Affected:** Department of Health and Senior Services (DHSS).

**Office of Legislative Services Estimate**

<b>Fiscal Impact</b>	
<b>State Revenue</b>	Unable to determine, though the Governor's FY 2005 recommended budget anticipates that \$31 million would be generated by this assessment.

**BILL DESCRIPTION**

Senate Bill No. 1659 of 2004 amends N.J.S.A.26:2H-18.57 to establish an assessment on certain licensed ambulatory care facilities, based on the facility's gross receipts, beginning July 1, 2004. The revenue raised by the assessment will be deposited in the Health Care Subsidy Fund.

The assessment would apply to facilities that are 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, megavolt age radiation oncology, positron emission tomography, orthotripsy and sleep disorder services.

The assessment would not apply to: an ambulatory care facility with annual gross receipts less than \$300,000; and an ambulatory care facility that is licensed to a general hospital as an off-site ambulatory facility whose revenues are included in the calculation of total operating revenue for the hospital for the purposes of N.J.S.A.26:2H-18.62 (the .53% hospital assessment).

The bill provides that in State FY 2005, the assessment on these ambulatory care facilities would be as follows:

C A facility with at least \$300,000 but less than \$1 million in gross receipts shall pay an assessment of \$25,000;

- C A facility with at least \$1 million but less than \$2 million in gross receipts shall pay an assessment of \$50,000;
- C A facility with at least \$2 million but less than \$3 million in gross receipts shall pay an assessment of \$75,000;
- C A facility with at least \$3 million but less than \$4 million in gross receipts shall pay an assessment of \$100,000; and
- C A facility with \$4 million or more in gross receipts shall pay an assessment of \$150,000.

For FY 2006, the commissioner shall use calendar year 2004 data on patient visits, charges and gross revenues, submitted by the facility as required in the bill, to calculate a uniform gross receipts assessment rate to be applied to each facility that is subject to the assessment. The FY 2006 rate shall be calculated so as to raise the same amount in the aggregate as was assessed in FY 2005.

Beginning in FY 2007 and each year thereafter, the uniform gross receipts assessment rate calculated for FY2006 shall be applied to each facility subject to the assessment.

## **FISCAL ANALYSIS**

### ***EXECUTIVE BRANCH***

None received, however, the Governor's FY 2005 recommended budget anticipates that an assessment of this type would generate \$31 million.

### ***OFFICE OF LEGISLATIVE SERVICES***

The Office of Legislative Services (OLS) notes that the Governor's FY 2005 recommended budget anticipates that this type of assessment on ambulatory care facilities would generate \$31 million, of which \$1 million would be used for administrative purposes related to the assessment.

The OLS cannot confirm or refute the estimate because it does not have information as to the number of ambulatory care facilities affected by the legislation or financial information as to the amount of gross receipts such facilities generate.

Section: *Human Services*

Analyst: *Jay Hershberg*  
*Principal Fiscal Analyst*

Approved: *David J. Rosen*  
*Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L.1980, c.67.