SUBCHAPTER 11. CHARITY CARE

SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

SUBCHAPTER 11. CHARITY CARE

10:52-11.1 Charity care audit functions

(a) The Department of Health and Senior Services shall conduct an audit of disproportionate share hospitals' charity care reported as written-off each calendar year. The Department of Health and Senior Services shall audit charity care at least once, but no more than six times each calendar year.

(b) The Department of Health and Senior Services shall report to the Division of Medical Assistance and Health Services on charity care. This report shall include any adjustments made pursuant to N.J.A.C. 10:52-11.15 or 13.4 or approvals made pursuant to N.J.A.C. 10:52-11.8(c) and (d).

10:52-11.2 Sampling methodology

(a) The Department of Health and Senior Services shall audit charity care claims based on a sample which will be developed from the charity claims submitted for pricing as described in N.J.A.C. 10:52-12.2.

(b) The Department of Health and Senior Services shall require hospitals to make a small number of additional charity care accounts available upon audit.

10:52-11.3 Charity care write-off amount

(a) The Department of Health and Senior Services shall value charity care claims at the Medicaid rate. The Medicaid rate, for purposes of valuing a given charity care claim, shall be based on the New Jersey Medicaid program's pricing and program policies pursuant to N.J.A.C. 10:52-12.1 and 12.2. For write-off and billing purposes, the hospital shall use the following procedures:

1. Charity Care Write Off Amount equals Charity Care Eligibility Percentage, as determined by N.J.A.C. 10:52-11.8(b) and (c) multiplied by the Medicaid payment rate.
2. In the event that there is a partial payment from a third party, the charity care write-off amount is determined as follows: Charity Care Write Off Amount equals Medicaid payment rate minus third party payment multiplied by Charity Care Eligibility Percentage. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to all Federal disproportionate share rules, including the Omnibus Budget Reconciliation Act of 1993, Section 13621.
3. If the third party payment is greater than the Medicaid payment rate, the charity care write-off amount shall be listed as zero.

(b) Applicants eligible for charity care at 100 percent shall not be billed. Any difference between hospital charges and the Medicaid rate shall be recorded as a contractual allowance.

(c) Applicants eligible for charity care at less than 100 percent shall be billed as follows:

1. Applicant Responsibility equals 100 percent minus Charity Care Eligibility Percentage multiplied by Hospital Charges minus any third party payment.

2. Contractual allowance equals Hospital Charges minus any third party payment minus Charity Care Write Off plus Applicant Responsibility.

(d) The Department of Health and Senior Services will calculate the cost of charity care services at the rate that would have been paid by the New Jersey Medicaid program.

10:52-11.4 Differing documentation requirements if patient admitted through emergency room

N.J.A.C. 10:52-11.5 through 11.10 govern documentation requirements for all charity care applications except those for patients admitted through the hospital's emergency room. Documentation requirements for applications of patients admitted through the emergency room are governed by N.J.A.C. 10:52-11.16.

10:52-11.5 Charity care screening and documentation requirements

(a) The hospital shall provide all patients with an individual written notice of the availability of charity care and Medicaid or NJ FamilyCare, in a form provided by the Department of Health and Senior Services, at the time of service, but no later than the issuance of the first billing statement to the patient.

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this subchapter. The applicant's financial file for audit shall contain the completed charity care application in a format approved by the Department of Health and Senior Services, as well as the supporting documentation which led to the determination of eligibility. For purposes of the audit, the hospital shall include in or with the file all other information necessary to demonstrate compliance with any of the audit steps.

(c) The hospital shall ask the applicant if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers compensation policy. If the applicant claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified, or the reason why the coverage could not be verified. Verification of insurance shall include the hospital contacting the identified third party insurer. Beginning July 1, 1995, charity care

availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(d) If the applicant is uninsured, or the applicant's health insurance is unlikely to pay the bill in full (based on hospital staff's previous experience with the insurer), and the applicant has not paid at the time of service any amounts likely to be remaining, the hospital shall make an initial determination for eligibility for any medical assistance programs available. The hospital shall refer the applicant to the appropriate medical assistance program and shall advise the medical assistance office of the applicant's possible eligibility. The applicant's financial file for audit shall indicate either that the applicant declined to be screened for medical assistance; that the applicant was screened but was determined ineligible; or that the applicant was screened and referred to the medical assistance program for possible eligibility. If the hospital does not screen the applicant for medical assistance, the record shall indicate the reason(s) why the applicant was not screened and the efforts the hospital made to obtain the screening. If an applicant affirmatively declines to be screened or is referred to a medical assistance program and does not return with an appropriate determination, the hospital will use the following procedures:

1. If the applicant affirmatively declines to be screened, or does not complete the medical assistance application process within three months after the date of service, or files an application after the application deadline, but is otherwise documented as eligible for charity care, the hospital:

i. May bill the applicant, consistent with the manner applied to other patients;

ii. Shall report the Medicaid value amount as charity care; and

iii. Shall report any amounts collected from the applicant or any third party as a charity care recovery.

2. If the hospital has not received a response to the medical assistance application from the county board of social services or other medical assistance office within seven months of receipt of a complete application, the hospital shall approve the applicant's charity care application if the applicant meets all other charity care criteria. Should medical assistance be approved following the hospital's charity care approval, the hospital shall report the amounts collected from the medical assistance program as a charity care recovery and issue a redetermination that states that because the applicant is eligible for medical assistance, he or she is no longer eligible for charity care.

3. If the hospital does not inform the applicant of medical assistance by the individual written notice required in (a) above or does not refer an applicant who could reasonably be considered eligible for a medical assistance program within three months of the date of service, the hospital shall record the applicant's bill as a courtesy adjustment and shall not bill or otherwise attempt to collect from the applicant or the Charity Care Program.

(e) Hospitals shall make arrangements for reimbursement for services from private sources, and Federal, state and local government third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing the services to charity care except in the situations described in (h) and (i) below. The hospital shall, as part of this

obligation, pursue reimbursement for the uncollected copayments and deductibles of indigent participants in Title XVIII of the Social Security Act (Medicare). Hospitals shall report any amounts collected from any third party as a charity care recovery. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(f) An applicant who is responsible for complying with his or her insurer's pre-certification requirements (the specific steps with which the insured must comply in order to have the services reimbursed) shall not be determined to be eligible for charity care, if the bill was unpaid because he or she failed to comply with these requirements. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(g) An applicant who is determined to be eligible for, and is accepted into, the HealthStart Program shall not be deemed eligible for charity care for services which are covered under this program. Beginning July 1, 1995, charity care availability shall be subject to Federal disproportionate share rules.

(h) Applicants who are eligible for reimbursement under the Violent Crimes Compensation Program shall be screened for eligibility for charity care before referral to the Violent Crimes Compensation Program (see N.J.A.C. 13:75). If the applicant is not eligible for 100 percent coverage under charity care, the charges which are not eligible for coverage under charity care shall be referred to the Violent Crimes Compensation Program. The hospital shall request the applicant to submit a copy of his or her charity care determination form to the Violent Crimes Compensation Board.

(i) Applicants who are eligible for reimbursement under the Catastrophic Illness in Children Relief Fund shall be screened for eligibility for charity care before referral to this Fund. If the applicant is not eligible for 100 percent coverage under charity care, the applicant shall be referred to the Catastrophic Illness in Children Relief Fund (see N.J.A.C. 10:155) for the uncovered portion of the claims.

(j) Hospitals with a Federal Hill-Burton obligation at the time of the application may include applicants written-off to the Hill-Burton Program as eligible for charity care if the applicant meets all of the eligibility standards and documentation requirements set forth in this section through N.J.A.C. 10:52-11.10.

(k) The Charity Care Program shall be the payer of last resort, except for the payers identified in (h) and (i) above.

(l) A charity care applicant shall be eligible for charity care for services rendered per N.J.A.C. 8:31B-4.38 on or after January 1, 1995 if he or she meets the criteria in this subchapter.

10:52-11.6 Identification

(a) Applicants for charity care shall provide the hospital with the following proper identification: paragraph (a)3 below represents an alternative measure for documenting identification as described in N.J.A.C. 10:52-11.11.

1. The applicant shall provide the hospital with one of the following identification documents: driver's license, social security card, alien registry card, birth certificate, baptismal certificate, paycheck stub, passport, visa, death certificate, employee identification, or attestation that the person is homeless and does not possess any of the above mentioned identification documents. If the documents listed above are not available to the applicant, the hospital staff shall document why the applicant was unable to comply, and shall ask for one of the identification documents listed in (a)2 below. If the applicant is unable to comply for medical reasons, such as, if the applicant is deceased, or noncommunicative until discharge for medical reasons, and a person to identify the patient cannot be found, the requirement for identification shall be waived.

2. The applicant shall provide the hospital with one of the following documents containing his or her name and address: a driver's license, a voter registration card, a union membership card, an insurance or welfare plan identification card, a student identification card, a utility bill, a Federal income tax form, a state income tax form, or an unemployment benefits statement. If the documents listed above are not available to the applicant, the hospital staff shall document why the applicant was unable to comply and shall ask for proof of identification as described in (a)3 below.

3. The applicant shall provide proof of identification in one of the following ways: a piece of mail addressed and delivered to the applicant; a signed attestation (which includes the party's name, address and telephone number) from a third party attesting to the applicant's identity; or a signed statement attesting to his or her own identity.

(b) The hospital shall obtain a photocopy of the applicant's identification or attestation and shall produce the copy on audit.

(c) The hospital shall attempt to collect the following information regarding the applicant and, if applicable, the responsible party: name; mailing address; residence telephone number; date of birth; social security number; place and type of employment; and employment address and telephone number, as applicable.

10:52-11.7 New Jersey residency

(a) Applicants for charity care shall provide the hospital with proof of New Jersey residency. An applicant shall provide proof that he or she has been residing in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. Paragraph (a)3 below represents an alternative measure for documenting proof of residency.

1. The applicant shall provide the hospital with any of the identification documents listed in N.J.A.C. 10:52-11.6(a)2 that contains the applicant's current residence address and a date from which the hospital can reasonably infer that the applicant has resided in

New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State. The hospital may accept an attestation from the applicant that he or she is homeless. If the applicant is unable to provide one of the documents listed at N.J.A.C. 10:52-11.6(a)2, the hospital staff shall document why the applicant was unable to comply, and shall ask for proof of residency as described in (a)2 below.

2. If the applicant cannot provide any of the documentation listed in N.J.A.C. 10:52-11.6(a)2, the applicant shall supply a copy of any undated identification listed in N.J.A.C. 10:52-11.6(a)1 and this paragraph, or any mail received showing the applicant's name and current residence address. If the applicant is unable to provide these documents, the hospital staff shall document why the applicant was unable to comply and ask for proof of residency as described in (a)3 below.

3. The applicant shall provide a signed attestation stating that he or she has been residing in New Jersey since the time of service, has no residency in any other state or country, and has the intent to remain in the State.

(b) Non-New Jersey residents requiring immediate medical attention for an emergency medical condition may apply for charity care. Emergency medical condition shall be restrictively defined as a serious medical situation requiring immediate treatment, in which delay would cause serious risk to life or health. Services available to non-New Jersey residents shall include only those not reasonably available at an alternative non-New Jersey site at the time services are requested.

10:52-11.8 Income eligibility criteria and documentation

(a) The hospital shall determine the applicant's family size in accordance with this section. Family size for an adult applicant includes the applicant, spouse, any minor children whom he or she supports, and adults for whom the applicant is legally responsible. The family size for a minor applicant includes both parents, the spouse of a parent, minor siblings and any adults in the family for whom the applicant's parent(s) are legally responsible. If an applicant documents that he or she has been abandoned by a spouse or parent, that spouse or parent shall not be included as a family member. A pregnant female counts as two family members.

(b) The provisions of 42 U.S.C. 9902(2), the poverty guidelines revised annually by the United States Department of Health and Human Services (HHS), are hereby incorporated by reference. (For further information on the poverty guidelines, contact the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C. 20201, Telephone (202) 690-6141.) A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

1. A person whose individual or, if applicable, family income, as determined by (e) below, is less than or equal to 200 percent of the HHS Poverty Guidelines shall be eligible for charity care for necessary health services without cost.

2. A person whose individual or, if applicable, family, income as determined by (e) below, is greater than 200 percent of the HHS Poverty Guidelines but not more than 300 percent of these guidelines is eligible for charity care at a reduced rate as described in (c) below.

(c) A person who is eligible for reduced charge health services shall be charged a percentage of the normal charge for health services as described in the table below. The reduced percentage can be applied to the total bill or, until July 1, 1995, to any remainder after third party payment. Beginning July 1, 1995, charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

Income as a percentage of HHS Poverty Guidelines	Percentage of Charges Paid by Applicant
>200 to 225	20
>225 to 250	40
>250 to 275	60
>275 to 300	80

(d) If qualified medical expenses, as defined for the purposes of Federal income tax deductibility, for applicants eligible for reduced charge charity care exceeds 30 percent of the applicant's or family's, if applicable, annual gross income as calculated by (e) below, such excess will be eligible for 100 percent coverage under charity care. The 30 percent threshold must be met once per family in a 12 month period.

(e) An applicant's income, for the purpose of determining eligibility for charity care or reduced charge charity care, shall be determined as follows:

1. The applicant may provide proof of the actual gross income for the 12 months immediately preceding the services;

2. The applicant may provide proof of actual gross income for the three months immediately preceding services. The hospital shall multiply this amount by four to determine the gross annual income; or

3. The applicant may provide proof of actual gross income for the month immediately preceding service. The hospital shall multiply this amount by 12 to determine the gross annual income.

4. If the applicant provides documentation for more than one salary period specified in paragraphs (e)1 through 3 above, the hospital shall use the period of time during which the salary was the lowest.

5. If the applicant is a welfare recipient and has not documented income as described in (e)1 through 3 above, the hospital shall document income status by obtaining a photocopy of the applicant's welfare identification, and document that the staff of the hospital obtained verification in writing or by phone of the applicant's current benefit amount from the appropriate local welfare office.

6. An applicant shall supply a signed attestation showing his or her unreported income in order for that income to be considered in the eligibility determination, as described in (b) above.

10:52-11.9 Proof of income

(a) Applicants for charity care shall provide the hospital with proof of income as listed below. Paragraph (a)3 below shall be considered alternative documentation, as described in N.J.A.C. 10:52-11.11.

1. An applicant shall provide the hospital with proof of income, which includes the following items: Federal or State income tax return; pay check stubs; W-2 forms; a letter from an employer on company letterhead stating the applicant's income; or a statement of the gross benefit amount from any governmental agency providing benefit to the applicant. If an applicant has been employed for at least one month, he or she may document his or her income by providing one paycheck stub immediately prior to the date of service if the paycheck stub indicates a year-to-date income, and if the applicant documents the length of time he or she has been employed by the employer.

i. If an applicant is a recipient of Social Security benefits, he or she may document this income by either providing the annual benefits statement from the Social Security Administration, or copies of bank statements from three months prior which indicate direct deposit of the social security check, or a copy of one social security check.

ii. An applicant with no income or benefits of any type may present the hospital with a signed attestation to this effect. If the applicant is homeless, the hospital may accept a signed attestation which states that the applicant is homeless and receives no support, income or benefits.

iii. If the applicant is unable to provide one of the documents listed above, the hospital staff shall document reasons for the applicant's inability to comply and request the documentation listed in (a)2 below.

2. An applicant may document his or her income by providing one paycheck stub immediately prior to the date of service. If the applicant is unable to provide this documentation, the hospital staff must document reasons for the applicant's inability to comply and request the documentation listed in (a)3 below.

3. An applicant may document his or her income by providing an attestation which states the income received in one of the time periods described in N.J.A.C. 10:52-11.8(e)1 through 3.

(b) Family income that must be considered for the eligibility determination includes the income of all members for whom the applicant is legally responsible including, but not limited to, a spouse and any minor children for an adult. For a minor applicant, the income of the family, as determined by N.J.A.C. 10:52-11.8(a), will be considered. In situations where a minor applicant's parents are divorced, and the custodial parent(s) are remarried, the non-parental spouse's income shall be considered. In situations where both divorced parents have responsibility for the minor applicant's medical care, each parent shall complete a charity care application. For a minor applicant, the income of the family shall be considered, except for earned income of the minor child and siblings. In cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available by the following steps in (c) below.

(c) If a minor applicant's parents are divorced, and one of the parents is uncooperative, as defined in (c)1 through 3 below, with the application process, the requirement for that parent's income may be waived by the hospital, after the case is reviewed by the Department of Health and Senior Services based on the following:

1. A parent or spouse may be deemed uncooperative if the applicant documents at least one unsuccessful attempt to obtain the necessary information from the parent or spouse; and

2. The parent or spouse does not respond to a letter from the hospital indicating the possibility of collection or legal action if he or she does not provide the necessary information for the application; and

3. The parent or spouse does not respond to the hospital in-house collection process.

(d) If an applicant is separated, but not legally divorced, from his or her spouse, the applicant may document that he or she has no financial ties with the estranged spouse in accordance with (d)1 through 4 below, and the hospital may waive the requirement for the estranged spouse's income, after the case is reviewed by the Department of Health and Senior Services, if documentation has been provided in accordance with the following:

1. A separated spouse may be deemed to have no financial ties to the applicant if the applicant provides proof to the hospital that he or she is not living with the estranged spouse, and does not own any property or share a lease to a rental property with the estranged spouse; and

2. The applicant provides a copy of his or her most recent tax return indicating that the applicant filed taxes separately. If estrangement occurred after filing jointly, the hospital may hold the application until the applicant files the next tax return separately. If an applicant does not file tax returns, he or she must sign an attestation to this effect explaining his or her reasons; and

3. The applicant provides copies of all his or her financial accounts showing the applicant with sole ownership of his or her assets; and

4. The applicant provides an affidavit stating that he or she is separated from and has no financial ties to the estranged spouse.

(e) The hospital may request that the applicant document his or her living expenses.

(f) A minor applicant who documents that both parents have abandoned him or her shall provide documentation of the income and assets of his or her guardian(s).

(g) The hospital may accept a charity care determination from another New Jersey hospital as proof of income, provided that the effective date of the charity care determination is not more than one year earlier than the date of service at the second hospital and that the second hospital verifies the determination with the hospital that issued the determination. The determination by the second hospital is valid for one year from the effective date of the first hospital's determination.

10:52-11.10 Assets eligibility criteria

(a) An applicant shall provide proof that:

1. His or her individual assets as of the date of service do not exceed $ 7,500; and
2. His or her family's assets, if applicable, do not exceed $ 15,000 as of the date of service.

(b) Family members whose assets must be considered are all legally responsible individuals as defined in N.J.A.C. 10:52-11.8(a).

(c) Assets, as used in this section, are items which are, or which can be readily converted into, cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, Individual Retirement Accounts (IRAs), trust funds, and equity in real estate other than the applicant's or family's, if applicable, primary residence. A primary residence, for purposes of charity care, is defined as a structure within which the applicant currently lives. If an applicant jointly owns assets with another person(s), for whom the applicant is not legally responsible, the value of these assets shall be prorated equally among all the owners.

(d) The applicant shall document the value of all applicable assets as described in (d)1 through 3 below. Paragraph (d)3 below represents alternative documentation as described in N.J.A.C. 10:52-11.8.

1. The applicant shall present the hospital with a statement from a bank or other applicable financial institution showing the value of the asset(s) as of the date of service. If an applicant has no assets, he or she may sign an attestation to that effect, and this fulfills the requirement for proof of assets. If the applicant is unable to obtain such documentation, the hospital staff shall document, in writing, the reason why the proof could not be provided, and request proof of assets as described in (d)2 below.
2. The applicant shall provide the hospital with a statement from the bank or other applicable financial institution showing the average daily balance of the asset(s) within one month of the date of service. If the applicant is unable to obtain such documentation, the hospital staff shall document, in writing, the reason why the proof could not be provided, and request proof of assets as described in (d)3 below.
3. The applicant shall present the hospital with a signed statement attesting to the type and value of the assets.

(e) The assets of an applicant for charity care shall be counted only after the applicant has had an opportunity to apply any amount of assets in excess of the limits in (a) above toward qualified medical expenses. Qualified medical expenses are those amounts deductible for the purpose of calculation of Federal income tax liability.

10:52-11.11 Limit on accounts with alternative documentation

The total of all sample dollars in which identification, New Jersey residency, income, and assets documented by the alternative procedures described in N.J.A.C. 10:52-11.6(a)3, 11.7(a)3, 11.9(a)3, or 11.10(d) 3 shall be limited to no more than 10 percent of the total dollars sampled on audit. Sample dollars that exceed 10 percent on the expanded sample shall be adjusted in accordance with N.J.A.C. 10:52-11.15(b).

10:52-11.12 Additional information to be supplied to facility by applicant

(a) A hospital shall, as a condition of finding any applicant eligible for charity care or reduced charge charity care, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and assets and that is within the applicant's ability to supply.

(b) An applicant who willfully presents false information will be liable for all hospital charges and subject to civil penalties pursuant to N.J.S.A. 26:2H-18.63.

10:52-11.13 Application and determination

(a) Consistent with the requirements of N.J.A.C. 10:52-11.6, 11.7, 11.8, 11.9, 11.10, 11.11 and 11.12, the Department of Health and Senior Services shall specify the elements to be included in charity care application and eligibility determination forms used by all disproportionate share hospitals for the Charity Care Program; hospitals shall not omit or add to these elements. The application form shall advise patients of the penalties for providing false information on a charity care application. The list of required elements may be obtained from the Department of Health and Senior Services, Division of Health Services Oversight, Hospital Financial Reporting and Support.

(b) An applicant or responsible party may submit a completed application for a hospital to make a determination for charity care or reduced charge charity care at any time up to one year from the date of outpatient service or inpatient discharge. The hospital shall make the charity care determination and notify the applicant in writing, as soon as possible, but no later than 10 working days from the day the applicant submits a completed initial application. If the application does not include sufficient documentation to make the determination, the hospital shall notify the applicant, in writing, as soon as possible, but no later than 10 working days from the day the applicant submits an incomplete application. The applicant shall be permitted to supply additional documentation at any time up to one year after the date of discharge (inpatient) or service (outpatient). At the hospital's discretion, the hospital may accept a completed application within two years of the date of service (outpatient) or date of discharge (inpatient).

(c) A determination that an applicant is eligible shall indicate:

1. The date on which the eligibility determination was made;
2. The date on which hospital services were requested;
3. The date on which the services were or will be provided to the applicant;
4. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;
5. The applicant's family size, income and eligibility computation;
6. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old; and
7. The name and telephone number of a person a hospital can contact to verify eligibility.

(d) The hospital shall provide each applicant who requests charity care and is denied it, in whole or part, with a written and dated statement of the reasons for the denial, including information required in (c) above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. Where a denial is based on a presumption that the applicant is eligible for, but not enrolled in Medicaid or NJ FamilyCare, the information upon which the denial is based must be documented.

10:52-11.14 Collection procedures and prohibited action

Persons determined to be eligible for charity care shall not receive a bill for services or be subject to collection procedures. Persons determined to be eligible for reduced charge charity care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge charity care.

10:52-11.15 Adjustment methodology

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

"Alternative documentation adjustment" means an adjustment to a hospital's charity care write-off amount as a result of the periodic audits of a sample of claims submitted during a calendar year. This audit determines whether the total value of sampled claims that are documented by the alternative procedures described in N.J.A.C. 10:52-11.6(a)3, 11.7(a)3, 11.9(a)3 or 11.10(d)3, exceeds permitted limits.

"Charity care write-off amount" means the rendered charity care services, priced at the rate used by the Medicaid program before adjustment, if any, for direct graduate medical education and indirect medical education factors.

"Compliance adjustment" means an adjustment to a hospital's charity care write-off amount as a result of the periodic audits of a sample of claims submitted during a calendar year. This audit determines whether there is appropriate documentation

showing that all charity care eligibility requirements at N.J.A.C. 10:52-11.5 through 11.11 and 11.16 have been met.

"Listing adjustment" means an adjustment to a hospital's charity care write-off amount as a result of the audit of a sample of these claims submitted during a calendar year. The purpose of this audit is to ensure that the claims contain only those charges that are eligible for reimbursement.

(b) The charity care write-off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid program. To the extent that a hospital's total charity care write-off amount is overstated, the amount will be reduced by the amount of the overstatement.

(c) In addition to adjustments required to ensure that the charity care write-off amount is equal to the Medicaid reimbursement rates, the write-off amount may also be revised on the basis of listing, alternative documentation and/or compliance adjustments, in that order.

(d) Examples of listing adjustments include changes made if:

1. Medicare or other third-party payer payments were not reflected in the claim;
2. Ineligible expenses, such as standard convenience or personal comfort items as listed in Uniform Billing requirements, are included; or
3. The percentage of the claim to be written off to charity care, based on the hospital's determination of the applicant's eligibility, was erroneous.

(e) In accordance with the provisions of N.J.A.C. 10:52-11.11, use of alternative documentation in any one of the steps to determine an applicant's eligibility for charity care shall cause that applicant's file to be designated as an alternative documentation file. A ratio shall be developed using sample dollars with alternative documentation as a percentage of total sample dollars. If this ratio is less than or equal to .10, there shall be no adjustment. If this ratio is greater than .10, the ratio shall be reduced by .10 and then multiplied by the hospital's charity care write-off amount at the Medicaid rate for the calendar year being audited. This amount shall be subtracted from the hospital's charity care write-off amount for the calendar year being audited at the Medicaid rate after listing adjustment.

(f) In accordance with the provisions of N.J.A.C. 10:52-11.5 through 11.11, noncompliance with any one of the steps to determine an applicant's eligibility for charity care shall cause that applicant's file to be designated as a failed compliance file. A ratio shall be developed using sample dollars from failed compliance files as a percentage of total sample dollars. If this ratio is less than .10, there shall be no adjustment. If this ratio is equal to or greater than .10, the ratio shall be multiplied by the hospital's charity care write-off amount for the calendar year being audited at the Medicaid rate. This amount shall be subtracted from the hospital's charity care write-off amount at the Medicaid rate after alternative documentation adjustment.

(g) The hospital's charity care write-off amount total adjusted for (d), (e) and (f) above will constitute the hospital's audited charity care write-off amount for claims submitted during the calendar year being audited, except for further adjustments that may occur in accordance with N.J.A.C. 10:52-13.4.

(h) The Department of Health and Senior Services' auditor will provide the hospital with a copy of its audit findings and recommended adjustments. Eligible hospitals shall sign the auditor's audit findings, indicating their agreement or disagreement with the audited charity care write-off amount. If the hospital disagrees with the audit findings, the hospital shall submit a request for a departmental review within 15 days of receiving the auditor's report and shall, within the request, detail the reasons for disagreement with the auditor's findings. The Department will review the auditor's findings, as well as the hospital's objections, and will advise the hospital within 30 days of receipt of the request for review of the total dollar value of the hospital's charity care write-off for the period audited, priced at the Medicaid rate.

(i) A hospital which disagrees with the audit findings may request an administrative hearing, which shall be conducted in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

10:52-11.16 Charity care applications of patients admitted through emergency room

(a) If a charity care applicant is admitted through the hospital's emergency room, the requirements set forth in this section shall apply.

1. The hospital shall notify the patient, orally and by providing a copy of the individual written notice referenced in N.J.A.C. 10:52-11.5(a), of the availability of charity care. This notice shall be given prior to the patient's discharge from the hospital.

(b) The hospital shall correctly assess and document the applicant's eligibility for charity care, based upon the criteria set forth in this section. The applicant's financial file for audit purposes shall contain the supporting documentation described in this section.

(c) If the applicant's medical condition permits, the hospital shall ask the applicant, prior to discharge, if he or she has any third party health insurance, including, but not limited to, coverage through a parent or spouse or coverage for the services under an automobile insurance or workers' compensation policy. If the applicant claims to have insurance, the hospital shall document the name of the insurer and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified, or the reason why the coverage could not be verified. Verification of insurance shall include the hospital contacting the identified third party insurer. Charity care availability for persons with health insurance shall be subject to Federal disproportionate share rules.

(d) If the applicant's medical condition permits, the hospital shall also, prior to the applicant's discharge, request the following information, which shall be recorded by the hospital on a form approved by the Department of Health and Senior Services:

1. The applicant's name;

2. The address of the applicant's residence;

3. Whether the applicant intends to remain a resident of New Jersey (assuming current residence in New Jersey);

4. The applicant's home telephone number, if any;

5. Whether the applicant is employed and, if so, the employer's name and address;

6. Applicant's best estimate of annual income, including sources of income and income from each source; and

7. Whether the applicant has an account with a bank and, if so, the name and location of the bank.

(e) If the hospital is able to obtain the information listed in (d) above, the hospital shall, prior to the applicant's discharge, ask the applicant to read the form on which the information has been recorded, and verify the information's accuracy by signing the form. The form shall also include a statement authorizing the hospital to contact any person or entity listed on the form in order to obtain and/or verify information relating to the charity care application.

(f) The hospital shall verify that the applicant is not enrolled in a medical assistance program.

(g) If the applicant is determined to be uninsured and not enrolled in a medical assistance program, and the hospital has been able to obtain the information and applicant's signature described in (d) and (e) above, then the hospital shall process the charity care application based on the information obtained. (If the information and applicant's signature described in (d) and (e) above cannot be obtained by the hospital, in whole or in part, then the provisions of (h) below shall apply.) The applicant's charity care eligibility shall be determined based on the following requirements:

1. The applicant's self-identification shall be acceptable to establish identity;

2. The applicant shall be a resident of New Jersey at the time of service, and shall have the intent to remain in the State as demonstrated by the applicant's statement of intent. The hospital shall verify, by telephone or visit, that the applicant can be contacted at the address provided; if the address is in the State, this shall establish New Jersey residency for this purpose. The method of verification shall be documented in the financial file for audit purposes;

3. There shall be an assumption that the applicant's family size, for purposes of the charity care application, is one, consisting of the applicant. The charity care income eligibility guidelines set forth at N.J.A.C. 10:52-11.8(b) and (c) shall be applied to determine eligibility. If the applicant identified an employer, the hospital shall contact that employer to determine the applicant's income. The hospital shall record that information, if provided, and include it in the financial file for audit purposes. If the employer declines to provide that information, that fact shall likewise be documented. The hospital shall annualize any income amount provided by the employer, if

necessary, to assess the applicant's eligibility. If the applicant did not identify an employer, or the employer declines to provide income information regarding the applicant, then the applicant's best estimate of annual income (see (d) above) shall be used to determine the applicant's annual income for this purpose; and

4. There shall be an assumption for the purposes of this section that bank account deposits constitute the only assets relevant to the application. If the applicant identified a bank at which he or she holds deposits, then the hospital shall contact the bank to verify the amount held. If the bank provides the requested information, then the amount shall be documented in the financial file for audit purposes. If the bank declines to provide the information, that fact shall likewise be documented. If no bank was identified by the applicant, or the bank declines to provide information regarding the account, there shall be an assumption that the applicant has no assets. Eligibility shall be assessed under the asset limitation set forth at N.J.A.C. 10:52-11.11(a)1.

(h) If the applicant is determined to be uninsured and not enrolled in a medical assistance program, and if the hospital was unable to obtain the information and applicant signature described in (d) and (e) above, then the hospital shall make the following efforts to determine whether the applicant is eligible for charity care. The hospital shall:

1. Make at least two attempts to contact the patient by phone, if a phone number is available, to try to schedule an in-person interview to obtain information relevant to the application. If such an interview can be arranged, the hospital shall obtain the relevant information and process the application based on that information. If such an interview cannot be arranged, this shall be documented in the financial file for audit purposes;

2. Visit the address given by the applicant, or otherwise obtained, and attempt to verify that the applicant lives there. If the applicant is homeless and has not provided the address of a shelter or other temporary residence, this requirement shall not apply. This shall be achieved by direct contact with the applicant, if possible, or by asking persons at the address, neighbors, or by observing the surroundings (for example, name on mailbox). The results of this attempt shall be documented in the financial file for audit purposes. If the hospital is able to achieve direct contact with the applicant, the hospital shall try to conduct or schedule an in-person interview to obtain information relevant to the application. If such an interview can be arranged, the hospital shall obtain the relevant information and process the application based on that information. If such an interview cannot be arranged, this shall be documented in the financial file for audit purposes; and

3. Attempt to determine the applicant's income and assets, that shall include observing the nature of the applicant's housing, to determine that there are no indications that the applicant would not likely be eligible for charity care, and obtaining information from persons at the applicant's address or from neighbors regarding the applicant's employment or other means of support. The results of these attempts shall be documented in the financial file for audit purposes.

(i) If the applicant is determined to be eligible for charity care under (g) above or, in the alternative, if the hospital has completed and documented the efforts set forth in (h) above, then the hospital may write off to charity care the claim(s) arising from the

admission. Notwithstanding any other provision of this subchapter, if an applicant is determined to be eligible for charity care under (g) above, or in the alternative, if the hospital has completed and documented the efforts set forth in (h) above, and the patient is subsequently transferred to, and admitted at, another hospital, then the hospital admitting the transferred patient may rely upon the charity care determination of the transferring hospital, and write off to charity care the claim(s) arising from the transfer admission. See N.J.A.C. 10:52-11.3 regarding the charity care write off amount. The applicant shall not be deemed to be eligible for charity care for future services based on this determination but would, instead, be required to meet the requirements set forth at N.J.A.C. 10:52-11.5 through 11.10 and 11.12 at the time that future services were rendered unless the applicant was admitted through the emergency room in the future, in which case this section would apply.

(j) Claims that are written off to charity care under (i) above shall not be included when determining the "alternative documentation" adjustment. See N.J.A.C. 10:52-11.11 and 11.15.

10:52-11.17 (Reserved)

SUBCHAPTER 12. CHARITY CARE COMPONENT OF THE DISPROPORTIONATE SHARE HOSPITAL SUBSIDIES

10:52-12.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Adjudication" means the processing of all submitted claims accepted by the Fiscal Agent during a monthly adjudication cycle, with the outcome being the claim is priced, denied, or processed as a void or adjustment of a previous claim. Voids and adjustments are also either priced or denied.

1. Claims included in files that are rejected during preprocessing are not adjudicated because the claims never enter the system for pricing.

2. Adjudicated claims are reported monthly to the hospital or the hospital's designated agent on the Remittance Advice.

"Adjudication cycle date" is the date on which claims are accepted for pricing by the Fiscal Agent and are adjudicated.

"Clean charity care claim" means a charity care claim that is received by the Fiscal Agent and accepted by the Fiscal Agent in accordance with electronic media procedures and is adjudicated and priced no later than two years after the date of patient discharge (inpatient) or date of service (outpatient). Claims that are denied are not clean claims. A clean charity care claim includes:

1. The name and provider number assigned by the Department of Health and Senior Services to each licensed hospital;

2. The name and, if available, Social Security number of the charity care eligible recipient of the services;

3. The diagnosis(es);

4. The date of service for outpatient services or dates of admission and discharge for inpatient services;

5. The services rendered and the charge for the service; and

6. The data required by the Fiscal Agent in accordance with the Fiscal Agent Billing Supplement, provided that the requirement is not in conflict with the provisions of the New Jersey Administrative Code.

"Pricing cycle" means the Fiscal Agent's charity care claims submission schedule, as described in N.J.A.C. 10:52-12.2(c).

"Remittance Advice (RA)" means the hospital's account statement of activity for the most recent monthly adjudication cycle which reflects the status of all charity care claims, tracked according to a unique Internal Control Number (ICN), adjudicated by the Fiscal Agent during that cycle.

"Submission cut-off date" means the date by which claims shall be received by the Fiscal Agent to assure processing for and possible adjudication in the pricing cycle.

10:52-12.2 Claims for the charity care component of the disproportionate share subsidies of the Health Care Subsidy Fund

(a) This subchapter sets forth the requirements of the New Jersey State Department of Health and Senior Services that the provider shall adhere to when submitting a charity care claim.

(b) A charity care claim shall be submitted in accordance with the electronic media claims (EMC) manual, which is part of the Fiscal Agent Billing Supplement (see (d) below), by an approved method of electronic automated data exchange. In order for a charity care claim to be priced, it must be a clean charity care claim.

(c) The State of New Jersey uses a Fiscal Agent for the pricing of charity care claims.

1. The Department of Health and Senior Services will advise hospitals in December of each year of the Fiscal Agent's pricing cycle and submission cut-off dates for the following calendar year. Charity care claims shall be adjudicated monthly by the Fiscal Agent.

2. Hospitals shall submit claims at least monthly to the Fiscal Agent. Claims submitted after the submission cut-off date shall not be guaranteed to be processed for the upcoming monthly cycle. Hospitals shall be solely responsible for meeting submission cut-off deadlines.

3. Hospitals shall be solely responsible for submission of clean charity care claims in an electronic format that can be processed by the Fiscal Agent.

4. Hospitals shall be solely responsible for verifying receipt and acceptance or rejection by the Fiscal Agent of all submitted claims files.

5. The Fiscal Agent shall reject partially or in its entirety an electronic claims file containing any technical defect(s) that prevent electronic processing. The Fiscal Agent shall advise the hospital or its designated agent in writing, within 10 days of the attempted processing, that the file could not be processed. The notice shall document the reason(s) for the failure to process the electronic claims file. If the hospital designates an agent to submit its charity care claims to the Fiscal Agent, all notices from the Fiscal Agent to the hospital's designated agent shall constitute notice to the hospital.

6. The Fiscal Agent shall deny for pricing all claims that do not meet the criteria for clean charity care claims.

7. The Fiscal Agent shall provide the hospital a charity care claim remittance advice once a month, unless the hospital has failed to submit any claims capable of adjudication during the adjudication cycle. The charity care claim remittance advice shall constitute the hospital's account statement for all charity care claims adjudicated by the Fiscal Agent during the most recent adjudication cycle. The charity care claim remittance advice shall identify codes for claims on the remittance advice, both priced and unpriced. If the hospital designates an agent to submit its charity care claims to the Fiscal Agent, all notices from the Fiscal Agent to the hospital's designated agent shall constitute notice to the hospital.

8. A unique internal control number (ICN) is assigned to each charity care claim that is adjudicated by the fiscal agent. The ICN is reflected on the remittance advice. The ICN can be used to track the status of a claim.

9. All charity care claims adjudicated by the Fiscal Agent are classified as either priced or denied claims. Void and adjustment claims may also be either priced or denied.

i. Priced claims shall be processed in accordance with this subchapter. A charity care claim that is a clean charity care claim for a covered service provided to an eligible charity care recipient by an approved hospital will be priced. The status of the claim shall appear on the claim status page, or pages, of the remittance advice, along with the status of all other claims which are being priced in that cycle.

ii. Denied claims shall be processed in accordance with this subchapter. Reasons for denial of a charity care claim shall be provided on the remittance advice in the form of a code. The hospital shall have the opportunity to resubmit a denied charity care claim in a subsequent cycle, within two years of the date of service (outpatient) or date of discharge (inpatient).

iii. Void and adjustment claims will be processed and adjudicated in accordance with this subchapter. Void and negative adjustment (reduction in payment) claims may be submitted at any time. Adjustments resulting in an increased payment amount shall be submitted within two years of date of service (outpatient) or date of discharge (inpatient).

(d) In addition to information in this section about submitting claims for pricing of outpatient and inpatient charity care claims, a Fiscal Agent Billing Supplement (FAB) and an Electronic Claims Manual are included as Appendices A and B to this chapter, incorporated herein by reference. The FAB includes information regarding the following:

1. The proper completion and submission of claim forms;
2. The procedure to follow when claims are denied and returned to the provider by the Fiscal Agent during the adjudication process;
3. Third party liability verification;
4. EMC submission;
5. Remittance Advice statements for pricing of claims and adjustments of Medicare;
6. The procedure to follow when a claim is priced in error (void);
7. The procedure for inquiries about claims;
8. The procedure for ordering forms;
9. Provider services; and
10. Item by item instructions for completing the claim form and other forms.

(e) The Fiscal Agent Billing Supplement is not published in the New Jersey Administrative Code but is referenced as an Appendix to this chapter and is not a legal description of the charity care program rules. Should there be any conflict between the Fiscal Agent Billing Supplement and the applicable laws or rules governing the charity care program, the charity care rules contained in this chapter and in N.J.A.C. 10:49 shall take precedence.

10:52-12.3 Basis of pricing for charity care claims

(a) All hospital outpatient and inpatient charity care claims shall be priced based on the New Jersey Medicaid program's pricing and program policies for hospital outpatient and inpatient hospital services. (See this chapter, and, specifically, N.J.A.C. 10:52-1.6, Covered services (inpatient and outpatient services) and N.J.A.C. 10:52-4, Basis of Payment.)

1. Exception: Although the New Jersey Medicaid program reimburses dental services on a fee-for-service schedule for outpatient hospital charity care claims, dental services shall be priced based on hospital outpatient cost to charge ratio as described in N.J.A.C. 10:52-4.3. All other hospital outpatient services for charity care shall also be priced according to the Medicaid hospital outpatient methodology. (See N.J.A.C. 10:52-4.3.)

(b) All hospital outpatient and inpatient charity care claims pricing results shall be considered final and not subject to cost settlements or adjustments resulting from subsequent rate appeal changes when evaluating total charity care amounts.

SUBCHAPTER 13. ELIGIBILITY FOR AND BASIS OF PAYMENT FOR DISPROPORTIONATE SHARE HOSPITALS

10:52-13.1 Disproportionate share adjustment--general eligibility

(a) A disproportionate share hospital (DSH) shall be a hospital designated as such by the Commissioner of the Department of Human Services. At a minimum, each hospital with a Medicaid inpatient hospital utilization rate that is one standard deviation above the mean Medicaid utilization rate for hospitals receiving Medicaid payments in the State, and every hospital with a low-income utilization rate above 25 percent will be treated as a disproportionate share hospital.

(b) The Commissioner of the Department of Human Services may designate additional hospitals as disproportionate share hospitals if it is determined they serve a large number of low-income mentally ill or developmentally disabled clients.

(c) The Commissioner of the Department of Human Services may make additional disproportionate share payments to facilities operating under N.J.S.A. 18A:64G-1 et. seq. providing a high level of charity and uncompensated care to low-income persons and persons with special needs.

(d) The Commissioner of the Department of Human Services may also designate a hospital as eligible for additional disproportionate share payments if it is determined that the hospital provides a high percentage of care (as defined in N.J.A.C. 10:52-13.5) in proportion to total operating revenue to patients with HIV, mental illness, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse. In addition, to be designated as eligible for this additional disproportionate share payment, the facility shall have a high Charity Care plus Medicaid utilization rate (as defined in N.J.A.C. 10:52-13.5).

10:52-13.2 Disproportionate share hospital (DSH) payment--general

The disproportionate share adjustment shall include an adjustment amount annually determined, as to N.J.A.C. 10:52-13.4, by the Commissioner, Department of Health and Senior Services in consultation with the Commissioner, Department of Human Services and, as to N.J.A.C. 10:52-13.3, 13.5, 13.6 and 13.7 by the Commissioner, Department of Human Services based upon a determination regarding payments for charity care. The annual DSH payments shall be calculated and distributed in accordance with all applicable Federal laws and regulations.

10:52-13.3 Eligibility and disproportionate share hospital payments for hospitals operating under N.J.S.A. 18A:64G-1

For facilities operating under N.J.S.A. 18A:64G-1 et seq., the disproportionate share allocation may be increased by an amount recommended by the Office of Management and Budget which will consider the total operating cost of the facility less any third party payments, including all other Medicaid payments, as well as payments from non-State sources for services provided by the hospital during the hospital's fiscal year.

10:52-13.4. Eligibility for disproportionate share hospital payments from the Charity Care Component of the Health Care Subsidy Fund

(a) The recommendation from the Department of Health and Senior Services (DHSS) shall be calculated in the following manner pursuant to N.J.S.A 26:2H-18.

1. The determination of the value of the Charity Care Component of the Health Care Subsidy Fund shall be calculated in the following manner:

i. The Department of Health and Senior Services shall use the results of the charity care audit conducted as its definition of charity care incurred by all hospitals.

ii. The New Jersey Department of Health and Senior Services shall report the results of its audit of New Jersey acute care hospital's charity care that was conducted in accordance with N.J.A.C. 10:52-11 to the Division of Medical Assistance and Health Services.

(1) For purposes of determining annual charity care costs, the criteria in N.J.A.C. 10:52-11 shall not apply to a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction pursuant to N.J.S.A. 30:4-1 et seq. A patient so found shall qualify for 100 percent charity care coverage. Hospitals with patients who qualify under this provision shall include the appropriate documentation from the court in the patient's file for audit.

(b) All charity care accounts shall be valued in accordance with the Medicaid methodology as follows:

1. For inpatient accounts, the New Jersey Department of Health and Senior Services and the New Jersey Department of Human Services shall value each account at the rate Medicaid would have reimbursed hospitals for the services(s).

2. For outpatient accounts, outpatient charity care accounts submitted during the calendar year will be valued as follows: annual outpatient charity care charges multiplied by the ratio of the annual outpatient Medicaid interim payments to the annual outpatient Medicaid charges associated with paid claims. This Medicaid outpatient payment-to-charge ratio excludes billings for HealthStart and dental services.

3. Disproportionate share adjustments and final rate settlements for the service period shall not be taken into account for the recognition of charity care costs.

(c) For eligible hospitals, charity care subsidy amounts are determined as follows:

1. Eligible hospitals annual charity care subsidy amount is equal to charity care costs as determined by the audit and valued at Medicaid rates.

2. In no instances shall payments made during a calendar year exceed the preceding years audited and Medicaid rate valued amounts inflated by TEFRA rates used in the hospital rate setting system.

3. Any overpayments which result from interim payments exceeding the audited payment levels shall be recovered by offsetting all Medicaid payments.

(d) For periods in which the data source excludes Direct Graduate Medical Education (GME) and Indirect Medical Education (IME) in the Medicaid rate, the Medicaid rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified, for periods through State Fiscal Year 1999, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. Effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-ons shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. These GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid rate adjustments. For the purpose of pricing charity care claims under this section, unless otherwise indicated, the Medicaid rate shall be defined as the Medicaid rate in effect on the date of discharge. The add-ons shall be calculated as follows:

1. The GME add-on shall be calculated as follows:

i. For charity care payments made for January 1998 through June 1998, the charity care GME add-on shall be calculated based on charity care's share of the teaching hospital's aggregate approved GME amount from Worksheet E-3 Part IV as reported on the 1996 submitted Medicare cost report. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, after desk audit. The resulting charity care GME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996, and shall be based on the percentage of charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

ii. For charity care payments made in State Fiscal Year 1999, the charity care GME add-on shall be calculated based on the charity care's share of the teaching hospital's aggregate approved GME amount from Worksheet E-3 Part IV as reported on the most recent submitted Medicare cost report as of October 1 preceding the distribution year. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, after desk audit.

iii. For charity care payments made after State Fiscal Year 1999, the charity care GME add-on shall be calculated based on the charity care share of the teaching hospital's aggregate approved GME amount from Worksheet E-3 Part IV as reported on the most recent submitted Medicare cost report as of February 1 of each year

preceding the distribution year. The hospital-specific charity care share shall be calculated using the sum of the hospital's total charity care gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, divided by the sum of the hospital's gross charges from the New Jersey Hospital Cost Report as reported on Forms E-5 and E-6, after desk audit.

2. The IME add-on shall be calculated as follows:

i. For charity care payments made for January 1998 through June 1998, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the 1996 Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the 1996 Medicare submitted cost report. This charity care IME add-on shall be adjusted to exclude those inpatient charity care claims priced at the Medicaid rates prior to October 1, 1996. (Charity care claims are priced at the Medicaid rate in effect when the services are rendered.) This adjustment shall be based on the percentage of inpatient charges written off as charity care between October 1, 1995 and September 30, 1996 with dates of service prior to October 1, 1995.

ii. For charity care payments made in State Fiscal Year 1999, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report as of October 1 preceding the distribution year. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

iii. For charity care payments made after State Fiscal Year 1999, the IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the hospital-specific charity care inpatient claims priced at the Medicaid rate to arrive at the charity care IME add-on. The components of the IME formula, IME intern and resident FTEs and maintained beds shall be taken from the most recent available Medicare submitted cost report as of February 1 of each year preceding the distribution year. The IME formula used shall be the Medicare formula approved for the most recent available Medicare submitted cost report used for the calculation.

(e) As provided in N.J.S.A. 26:2H-18.59e, the charity care subsidy shall be determined according to the following methodology:

1. The hospital-specific "documented charity care" shall be calculated from the dollar amount of charity care provided by the hospital that is submitted to the charity care fiscal intermediary and valued at the same rate paid to that hospital by the Medicaid program. A sample of the claims submitted by the hospital to the fiscal intermediary shall be subject to an audit conducted pursuant to charity care eligibility criteria. For each fiscal year, documented charity care claims shall be equal to the Medicaid-priced amounts of charity care claims submitted to the fiscal intermediary for the most recent calendar year, adjusted as necessary to reflect the audit results, as well as GME/IME, in accordance with (d) above.

2. The hospital-specific "operating margin" shall be calculated using data from the three most current years' New Jersey Hospital Cost Reports (see N.J.A.C. 8:31B-3.16) and shall be equal to income from operations minus charity care subsidies divided by total operating revenue minus charity care subsidies. After calculating each hospital's operating margin, the Department shall determine the Statewide median operating margin.

3. The hospital-specific "profitability factor" shall be determined annually as follows. Those hospitals that are equal to or below the Statewide median operating margin shall be assigned a profitability factor of "1." For those hospitals that are above the Statewide median operating margin, the profitability factor shall be equal to:

$$1 - \frac{.75 \text{ X (hospital specific operating margin – Statewide median operating margin)}}{\text{Highest hospital specific operating margin – Statewide median operating margin}}$$

4. The hospital-specific "adjusted charity care" shall be equal to a hospital's documented charity care times its profitability factor.

5. The hospital-specific "revenue from private payers" shall be equal to the sum of the gross revenues reported to the Department in the hospital's most recently available New Jersey Hospital Cost Report (see N.J.A.C. 8:31B-3.16) for all non-governmental, or private third party payers, including, but not limited to, Blue Cross and Blue Shield plans, commercial insurers and the non-governmental, or private accounts of health maintenance organizations. Gross revenue derived from governmental accounts of health maintenance organizations from the Medicare, Medicaid and NJ FamilyCare (including NJ KidCare) programs, will not be included in the category of "revenue from private payers."

6. The hospital-specific "payer mix factor" shall be equal to a hospital's adjusted charity care divided by its revenue from private payers.

7. The "Statewide target payer mix factor" shall be equal to the lowest payer mix factor to which all hospitals receiving charity care subsidies can be reduced by spending all available charity care subsidy funding for that year.

8. The hospital-specific "income from operations" shall be defined by the Department of Health and Senior Services (Department) in accordance with financial reporting requirements established pursuant to N.J.A.C. 8:31B-3.3.

9. The hospital-specific "total operating revenue" shall be defined by the Department in accordance with financial reporting requirements established pursuant to N.J.A.C. 8:31B-3.3.

10. Charity care subsidy payments shall be based upon hospital-specific documented charity care.

11. If the Statewide total of adjusted charity care is less than available charity care funding, a hospital's charity care subsidy shall equal its adjusted charity care.

12. If the Statewide total of adjusted charity care is greater than available charity care funding, then the hospital-specific charity care subsidy shall be determined by allocating available charity care funds so as to equalize hospital-specific payer mix factors to the Statewide target payer mix factor. Those hospitals with a payer mix factor greater than the Statewide target payer mix factor shall be eligible to receive a subsidy sufficient to reduce their factor to that Statewide level. Those hospitals with a payer mix factor that is equal to or less than the Statewide target payer mix factor shall not be eligible to receive a subsidy.

(f) The charity care subsidy payment schedule for the fiscal year shall be implemented the first month after the Department distributes the schedule to all disproportionate share hospitals. The charity care subsidy payment schedule constitutes advice to the hospitals of the allocation of charity care subsidies available for that fiscal year. Hospitals shall receive the charity care subsidy payments in 12 monthly installments.

1. A hospital which suspects that the charity care subsidy payment schedule reflects a calculation error shall notify the Commissioner of DHSS in writing of the suspected calculation error within 15 days of issuance of the schedule. Failure by the charity care subsidy payment schedule to reflect specific charity care claims or hospital cost report data, including corrections, shall not constitute a calculation error. If, upon review, the Commissioner determines that a calculation error did occur, a revised charity care subsidy payment schedule shall be issued.

2. A notice by a hospital of an intent to appeal the amount of its charity care subsidy indicated on the charity care subsidy payment schedule, for reasons other than a calculation error, shall be submitted in writing to the Commissioner within 15 calendar days of issuance of the charity care subsidy payment schedule. Within 30 calendar days of issuance of the charity care subsidy payment schedule, the hospital shall submit to the Commissioner two copies of its appeal, describing in detail the basis of its appeal of the charity care subsidy payment schedule. Appeals shall not include new submissions pertaining to claims and/or cost report data that was not previously submitted in accordance with the time frames and procedures specified in N.J.A.C. 10:52-11 and 12 and N.J.A.C. 8:31B. The appeal document shall list all factual and legal issues, including citation to the applicable provisions of the charity care rules, and shall include written documentation supporting each appeal issue. If the hospital fails to submit the required documentation within the prescribed time frame, such hospital shall have forfeited its right of appeal and the charity care subsidy payment schedule shall be deemed to have been accepted by the hospital.

3. The Commissioner of the Department of Health and Senior Services shall schedule a detailed review to be conducted by the Department with the hospital not more than 45 calendar days following receipt of the appeal document. If the hospital fails to appear on the established date, it shall have forfeited its right of appeal and the charity care subsidy payment schedule shall be deemed to have been accepted by the hospital.

4. At the detailed review with the hospital, the Department representative shall indicate whether the appeal is supported by sufficient documentation to permit a resolution, and the hospital shall be permitted 10 calendar days after the date of the review in which to submit the additional documentation which the Department indicates is needed for resolution. Following receipt of this documentation, the Department shall neither request nor require further documentation. The Commissioner shall give consideration only to documentation submitted pursuant to the deadlines set forth in this section in deciding upon any of the hospital's appeal issues.

5. Within 30 calendar days of the review with the hospital, the Commissioner will render detailed findings on the factual and legal issues concerning whether an adjustment to the Charity Care Subsidy Payment Schedule is warranted. The Commissioner's decision shall constitute the final agency adjudication.

10:52-13.5 Eligibility for and payment of Hospital Relief Subsidy Fund DSH

(a) Hospitals eligible for additional disproportionate share payments may receive an additional payment determined by the Commissioner of the Department of Human Services from the Hospital Relief Subsidy Fund. This additional payment shall be based upon the facility's percentage of clients with HIV, mental health, tuberculosis, substance abuse and addiction, complex neonates, HIV as a secondary diagnosis, and mothers with substance abuse.

1. Payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the most recent calendar year hospital data available as of October 1 of each year for periods through State Fiscal Year 1999. Effective for periods after State Fiscal Year 1999, payments from the Hospital Relief Subsidy Fund shall be calculated and distributed to eligible disproportionate share hospitals, if funds are available, using the most recent calendar year hospital data available as of February 1 of each State fiscal year preceding the distribution year. For the purpose of pricing the problem billed cases listed at (a)1ii(1) below for periods prior to July 6, 1998, the Medicaid rate shall be defined as the rate in effect as of October 1 of each year preceding the distribution year. For the purpose of pricing the problem billed cases listed at (a)1ii(1) below effective on or after July 6, 1998, the Medicaid rate shall be defined as the rate in effect as of February 1 of each State fiscal year preceding the distribution year. Effective for payments on or after July 6, 1998, this payment shall no longer be distributed over a Calendar Year. Instead, it shall be distributed over the State Fiscal Year, July through June.

i. For purposes of determining which hospitals are eligible for payment from the HRSF, a hospital shall satisfy both of the two following independent criteria:

(1) The hospital's cases for the seven categories listed at (a)1ii(1) below, priced at the Medicaid rate, divided by the hospital's Total Operating Revenue, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey Hospitals receiving Medicaid payments. For periods in which the data source excludes GME and IME in the rate, the Medicaid rate shall be adjusted by a hospital-specific GME and IME add-ons. The hospital-

specific GME and IME add-ons shall be calculated as defined in (a)1iv below; and

(2) The hospital's charity care days plus the hospital's Medicaid and NJ FamilyCare-Plan A days, divided by the hospital's total days, expressed as a percentage, shall be equal to or greater than the median percentage for New Jersey hospitals receiving Medicaid and NJ FamilyCare-Plan A payments. For payments distributed in State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid and NJ FamilyCare-Plan A managed care days if the data is available by May 31, 1998. For payments distributed in State Fiscal Years after State Fiscal Year 1999, the hospital's Medicaid days shall include Medicaid and NJ FamilyCare-Plan A managed care days if the data is available by February 1 prior to the State fiscal year of distribution.

ii. The subsidy shall be an amount allocated by the Commissioner during the fiscal year for this purpose and shall be distributed in the following manner:

(1) The payments for admissions for the following categories are taken from the same calendar year hospital data as defined in (a)4i above maintained by the New Jersey Department of Health and Senior Services (DHSS):

HIV (MDC 24);

Mental Health (MDC 19);

Substance Abuse (MDC 20);

Complex Neonates (DRG 600 through 618, 622, 623, 626, or 627);

Tuberculosis as a major or minor diagnosis (ICD-9 CM; 010.0 through 018.9);

Mothers with substance abuse (MDC 14 with the following codes: ICD-9 CM; 6483, 6555, 304, and 305); and

HIV as a secondary diagnosis (excluding MDC 24; including ICD-9 CM; 0420 through 0422, 0429 through 0433, 0439, 0440, and 0449).

iii. The funding for the subsidy shall be distributed among eligible facilities based upon the hospital's percentage of payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)1iv below, for patient with the categories in (a)1ii(1) above as a percentage of all payments, priced at the Medicaid rate, including the relevant GME and IME add-ons as defined in (a)1iv below, for patients in these categories in eligible hospitals.

iv. For periods in which the data source excludes GME and IME costs in the Medicaid and NJ FamilyCare-Plan A fee-for-service rate, the rate shall be adjusted by hospital-specific GME and IME add-ons. Unless otherwise specified in this section, for periods through State Fiscal Year 1999, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of October 1 of each year preceding the distribution year. Unless otherwise specified in this section, effective for periods after State Fiscal Year 1999, the hospital-specific GME and IME add-on shall be calculated using the most recent hospital data as of February 1 of each State fiscal year preceding the distribution year. GME and IME add-ons shall not be revised as a result of any subsequent settlement and/or retrospective Medicaid or NJ FamilyCare-Plan A rate. The add-ons shall be calculated as follows:

(1) A hospital-specific GME add-on shall be calculated based on the hospital-specific GME per discharge multiplied by the number of cases of the categories defined in (a)1ii(1) above. The hospital-specific GME per discharge shall be calculated on the inpatient share of the aggregate approved GME amount from Worksheet E-3 Part IV of the Medicare submitted cost report divided by the hospital-specific total hospital discharges from Worksheet S-3 Part I of the Medicare submitted cost report.

(2) The hospital-specific IME add-on shall be calculated based on Medicare's IME formula, at 42 C.F.R. 412.105, incorporated herein by reference, as amended and supplemented. The teaching hospital's IME factor, as calculated by the Medicare IME calculation, shall be multiplied by the number of cases of the categories defined in (a)1ii(1) above, priced at the current available Medicaid inpatient rates. The components of the IME formula, IME intern and resident FTEs, and maintained beds shall be taken from the Medicare submitted cost report. The IME formula used shall be the Medicare formula approved for the Medicare submitted cost report used in the calculation.

10:52-13.6 Eligibility and payment for DSH funding from the Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients

(a) Disproportionate Share Hospitals which service a large number of low-income mentally ill or developmentally disabled clients may also be eligible to receive increased disproportionate share payments. The amount of payment to be made to facilities which serve a large number of mentally ill low-income clients will be based upon recommendation by the Division of Mental Health Services (DMHS) within the Department of Human Services to the Commissioner of the Department of Human Services. This recommendation will identify hospitals essential to preserve the fragile network of mental health providers in the State. The Division of Developmental Disabilities may also recommend an additional payment to facilities that serve a large number of developmentally disabled clients. These additional payments will assure that these low-income and special needs clients continue to have access to critical care.

1. The Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients shall be an amount allocated by the Commissioner during the fiscal year for this purpose. It shall be distributed in the following manner:

i. Hospitals who receive funding from the Hospital Relief Subsidy Fund shall only be eligible for a payment from this fund if recognized by the Division of Mental Health Services as a Short Term Care Facility (STCF) or a Child Community Inpatient Serviced STCF and CCIS shall be based upon its distribution of beds for these services times a projection of the cost of providing the service in a state facility. Any hospital adding these beds will be eligible for payments from this fund. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year but may be redistributed on a quarterly basis as new beds are added or removed from service, at the discretion of DMHS.

ii. Hospitals who are not a STCF or CCIS, but which are under contract with the Division of Mental Health Services shall receive an allocation of funds based upon the percentage of services provided by the hospital as a percentage of all services provided by all hospitals. The initial redistribution of the funds among eligible hospitals will be carried out in August, 1994. In subsequent years, the redistribution will be carried out in January of each year but may be redistributed on a quarterly basis as new beds are added or removed from service, at the discretion of DMHS.

10:52-13.7 Calculation and distribution of disproportionate share hospital (DSH) payments as a result of a hospital closure; purpose and procedure

(a) The purpose of this rule is to provide a procedure to redistribute disproportionate share hospital (DSH) payments to provide for the patients who would have been served by a closed general hospital, had the hospital remained open. Hospital closure is defined as cessation of operations as a general hospital facility. When a hospital closes, DSH payments to the closed hospital will immediately cease. The DSH payments that would have gone to that hospital, had that hospital not closed, shall be reallocated and distributed to eligible hospitals, in accordance with Federal and State laws, rules and regulations. The eligible hospitals that are serving or are expected to serve the patients who would have gone to the closed hospital will receive the closed hospital's remaining allocation for the State fiscal year in which the hospital closed. This rule shall be applied to specify the eligible hospitals and the calculation and distribution of the closed hospital's DSH payments. Subsections (b), (c) and (d) below address the charity care subsidy allocated pursuant to N.J.S.A. 26:2H-18.59(e), and any supplemental charity care subsidy allocated pursuant to any appropriations act that may provide for supplemental charity care subsidies; subsection (e) below addresses the Hospital Relief Subsidy Fund.

(b) To be eligible for a portion of the closed hospital's charity care allocation and/or supplemental charity care allocation, a hospital shall satisfy all three of the following criteria:

1. The hospital shall have received a charity care subsidy allocation, under the methodology set forth in N.J.S.A. 26:2H-18.59e, and/or a supplemental charity care subsidy allocation, under the methodology set forth in any appropriations act that may provide for supplemental charity care subsidies, during the State Fiscal Year in which the closed hospital ceased operations as a general hospital;

2. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined, based on the most recent available complete calendar year UB data maintained by the Department of Health and Senior Services (DHSS), as follows:

i. Rank zip codes from highest to lowest, based on the percentage of total admissions drawn from each zip code by the closed hospital; and

ii. Include the ranked zip codes in the closed hospital's market area (beginning with the highest-ranked zip code) until the percentage of admissions, when added together, constitutes 75 percent of the closed hospital's total admissions; and

3. The hospital shall demonstrate that it has a market share of 25 percent or more of admissions from the market area that the closed hospital served, as defined in (b)2 above. This determination shall likewise be made based on the most recent available complete calendar year UB data maintained by DHSS, but the closed hospital's UB data will not be included in making this determination.

(c) The available charity care and/or supplemental charity care funds to be reallocated, with respect to the State fiscal year in which the hospital closed, shall be distributed among eligible hospitals based upon each eligible hospital's market share of admissions as a percentage of the market share of admissions of all eligible hospitals, as determined from the results of the calculations in (b)3 above.

(d) In each year after the hospital closed in which the source hospital data precedes the year of closure and includes at least six months of hospital charity care claims data, a charity care and/or supplemental charity care allocation that would have gone to the closed hospital shall be initially calculated. Then the reallocation of the closed hospital's calculated charity care and/or supplemental charity care allocation shall be calculated and distributed to eligible hospitals, using the methodology set forth in (b) above to identify eligible hospitals. The available charity care and/or supplemental charity care funds to be reallocated under this subsection shall be distributed among eligible hospitals based upon each eligible hospital's market share of admissions as a percentage of the market share of admissions of all eligible hospitals, as determined from the results of the calculations pursuant to (b) above.

(e) In each year after the hospital closed in which the source hospital data precedes the year of closure and includes at least six months of hospital data, a Hospital Relief Subsidy Fund (HRSF) allocation that would have gone to the closed hospital shall be initially calculated. Then the reallocation of the closed hospital's calculated HRSF allocation shall be calculated and distributed to eligible DSHs using the same data as was used for the original allocation, with the exception of market share admission data, which shall be taken from the most recent available UB data in the following manner:

1. To be eligible to receive a portion of the closed hospital's HRSF allocation a hospital shall satisfy all three of the following independent criteria:

i. The hospital shall have received a HRSF allocation, under the methodology set forth in N.J.A.C. 10:52-13.5, during the State fiscal year in which the closed hospital ceased operations as a general hospital;

ii. The hospital shall draw its patients from the same market area, identified by United States Postal Service zip codes, which the closed hospital served. The market area served by the closed hospital shall be determined as defined in (b)2 above; and

iii. The hospital shall have a market share of 25 percent or more of problem-billed admissions. The market share problem-billed admissions shall be based on the number of admissions from the same market area, identified by zip code that the

closed hospital served as defined in (e)1ii above, for the problem-billed categories specified in N.J.A.C. 10:52-13.5(a)1i(2) and (a)1ii(1).

2. The available HRSF payments to be reallocated shall be distributed among eligible hospitals based upon each eligible hospital's market share of problem-billed admissions as a percentage of the market share of problem-billed admissions of all eligible hospitals, as determined from the results of the calculations in (e)1iii above. The reallocated funds shall be distributed on a monthly basis.

(f) Notwithstanding any other provision of this rule, if the Commissioner of Health and Senior Services and the Commissioner of Human Services agree that, in the case of closure of a hospital eligible to receive DSH funds, maintaining beneficiary access to health care services requires an alternative distribution of a closed hospital's DSH funds, they will do so in accordance with this subsection. Factors the Commissioners will consider in determining whether an alternative distribution will be made shall include, but shall not be limited to, the following:

1. Maintenance of continued timely access to hospital-based services for persons eligible to participate in the New Jersey Hospital Care Payment Assistance Program and/or persons receiving services in the Hospital Relief Subsidy Fund categories; or

2. Continued operation in the same or adjoining municipality as the closed hospital of an acute care hospital, eligible to receive Disproportionate Share payments, belonging to the same system as the closed hospital and serving substantially the same eligible population.