

P.L. 2025, CHAPTER 336, *approved January 20, 2026*
Senate Committee Substitute for
Senate, No. 5015

1 **AN ACT** concerning assessments on ambulatory care facilities and
2 amending and supplementing P.L.1992, c.160.

3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*

6
7 1. Section 7 of P.L.1992, c.160 (C.26:2H-18.57) is amended to
8 read as follows:

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

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

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

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

32 Funds from the Safety Net Graduate Medical Education pool
33 shall be available to eligible hospitals that meet the following
34 eligibility criteria: An eligible hospital has a Relative Medicaid
35 Percentage (RMP) that is in the top third of all acute care hospitals
36 that have a residency program. The RMP is a ratio calculated using
37 the 2016 Audited C.160 SHARE Cost Reports. The numerator of

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

Matter underlined thus is new matter.

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

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

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

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

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

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

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

1 per FTE for each hospital used to calculate the overall median cost
2 per FTE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

47 (5) Beginning in Fiscal Year 2026 and for each fiscal year
48 thereafter, the uniform gross receipts assessment shall be applied at

1 the rate of 2.5 percent to each facility subject to the assessment. A
2 facility shall pay its annual assessment to the department in four
3 payments in accordance with a timetable prescribed by the
4 commissioner.

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

16 (7) Effective the first day of the third quarter of Fiscal Year
17 2026, and subject to any necessary federal approvals applied for by
18 the Commissioner of Human Services pursuant to section 2 of
19 P.L. c. (pending before the Legislature as this bill), no facility
20 shall pay an assessment greater than \$2,000,000 annually under the
21 assessment enacted and imposed pursuant to paragraph (5) of this
22 subsection as amended by P.L.2025, c.70, effective June 30, 2025.

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

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

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

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

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

1 may impose for operating an ambulatory care facility without a
2 license.

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

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

11 (cf: P.L.2025, c.70, s.2)

12

13 2. (New section) If a federal Medicaid plan amendment is
14 required to effectuate the assessment on ambulatory care facilities
15 in the manner provided in paragraph (7) of subsection b. of section
16 7 of P.L.1992, c.160 (C.26:2H-18.57) or if a waiver is required
17 pursuant to 42 C.F.R. s.433.68, the Commissioner of Human
18 Services shall apply to the federal Centers for Medicare and
19 Medicaid Services for a State plan amendment or a waiver, as
20 applicable, and shall receive approval prior to implementing the
21 assessment on ambulatory care facilities.

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23 3. Section 2 of this act shall take effect immediately, and the
24 amendments made to section 7 of P.L.1992, c.160 (C.26:2H-18.57)
25 by section 1 of this act shall take effect upon the receipt of federal
26 approval of any Medicaid State plan amendments or waivers
27 necessary to effectuate such amendments and shall be retroactive to
28 the first day of the third quarter of Fiscal Year 2026.

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33 Makes changes to how uniform gross receipts assessment are
34 charged to ambulatory care facilities.