STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Instate Acute Care Inpatient Hospital Services
Disproportionate Share Hospital

3. Health Care Subsidy Fund - Charity Care Subsidy

a) The charity care subsidy shall be determined according to the following methodology:

i) 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." If the statewide total of adjusted charity care is more than available charity care funding, the subsidy formula scripted below in this SPA shall define the allocation process.

ii) Charity care subsidy payments shall be based on actual documented charity care.

b) As used in the distribution of the charity care subsidy:

The hospital's revenue from private payers shall be equal to the sum of the gross revenues, as reported on the Department of Health and Senior Services' (DHSS) most recent available New Jersey Hospital Cost Reports for all non-governmental third party payers including, but not limited to, Blue Cross and Blue Shield plans, commercial insurers and health maintenance organizations. However, gross revenue from HMOs that result from contracts with the Medicare and/or Medicaid/FamilyCare programs are not included in the category of "revenue from private payers".

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c) Beginning July 1, 2010 and each year thereafter:

1. Documented charity care shall be equal to the Medicaid-priced amounts of charity care claims submitted to the Department of Health and Senior Services for the most recent calendar year, adjusted, as necessary, to reflect the annual audit results. These amounts shall be augmented to reflect payments to hospitals by the Medicaid program for Graduate Medical Education and Indirect Medical Education based on the most recent Graduate Medical Education and Indirect Medical Education formulas utilized by the Federal Medicare program.

2. Hospital-specific documented charity care shall be equal to the Medicaid-priced dollar amount of charity care provided by a hospital as submitted to the Department of Health and Senior Services for the most recent calendar year, and include payments for GME and IME. A sample of the claims submitted by the hospital to the department shall be subject to an annual audit conducted pursuant to applicable charity care eligibility criteria.

TN: 10-06-MA (NJ) **Approval Date:** JUL 11 2012

Supersedes: 04-08-MA (NJ) **Effective Date: July 1, 2010**

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3. The charity care subsidy shall be determined according to the following methodology:

i) Each hospital shall be ranked in order of its hospital-specific, relative charity care percentage, or RCCP, by dividing the amount of hospital-specific gross revenue for charity care patients by the hospital's total gross revenue for all patients.

a. source data used shall be from calendar year 2009 for documented charity care claims data and hospital-specific gross revenue for charity care patients, and shall include all adjustments and void claims related to calendar year 2009 and any prior year submitted claim, as submitted by each acute care hospital or determined by the Department of Health and Senior Services;

b. source data used for each hospital's total gross revenue for all patients shall be from the Acute Care Hospital Cost Report (as defined by Form E4, Line 1, Column E data) and shall be according to the DHSS advance submission request dated February 11, 2010, as submitted by each acute care hospital by March 11, 2010, and source data used for Medicare Cost Report data shall be from calendar year 2008;

c. for an eligible hospital that failed to submit its total gross revenue for all patients from the Acute Care Hospital Cost Report (as defined by Form E4, Line 1, Column E data) according to the DHSS advance submission request dated February 11, 2010, source data from calendar year 2008 shall be used for hospital--specific gross revenue for charity care patients and for hospital total gross revenue for all patients (as defined by Form E4, Line 1, Column E.)

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ii) The nine hospitals with the highest RCCPs shall receive a charity care payment equal to 96 percent of each hospital's hospital-specific documented charity care. The hospital ranked number 10 shall receive a charity care payment equal to 94 percent of its hospital-specific documented charity care, and each hospital ranked number 11 and below shall receive two percentage points less than the hospital ranked immediately above that hospital.

iii) Notwithstanding the provisions of ii) above to the contrary, each of the hospitals located in the 10 municipalities in the State with the lowest median annual household income according to the most recent census data, shall be ranked from the hospital with the highest hospital-specific documented charity care to the hospital with the lowest hospital-specific documented charity care. The hospital located in each of the municipalities, if any, with the highest documented hospital-specific charity care shall receive a charity care payment equal to 96 percent of its hospital-specific documented charity care. This establishes an override of the 2% decrements for hospitals located in the top 10 poorest municipalities and elevates them to 96%, except it applies to only one hospital in each poor municipality – the one with the highest documented charity care. This can effectively result in none or only a few additional hospitals receiving 96% if many low-income municipalities do not have a hospital located within their boundaries or if more than one hospital is located within the a municipal boundary.

iv) Notwithstanding the provisions of ii) and iii) above to the contrary, no hospital shall receive less than 43 percent of its hospital-specific documented charity care. This establishes a floor or lower limit of 43% for any hospital, and at which the 2% decrements must stop.

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4) Effective July 1, 2010, each eligible hospital shall be:

i) assigned to one of two tiers based on its initial Relative Charity Care Percentage (RCCP) as calculated in paragraph 3 above with Tier 1 hospitals having an initial RCCP greater than 5%, and Tier 2 hospitals having an initial RCCP less than Tier 1.

ii) The hospital-specific subsidy initially calculated in accordance with the charity care subsidy determination and methodology in paragraph 3 for each eligible hospital shall not be reduced for Tier 1 hospitals, and shall be reduced by 50% for Tier 2 hospitals;

iii) For each eligible hospital the difference shall be calculated between its initial calculated SFY 2011 charity care subsidy and its total SFY 2010 charity care allocation including any reallocations.

iv) If an eligible hospital's initial calculated SFY 2011 charity care subsidy is more than its total SFY 2010 subsidy allocation including any reallocations, the hospital-specific subsidy calculation for each eligible hospital shall be its total SFY 2010 subsidy allocation including any reallocations plus 55% of the difference calculated in iii above.

v) If an eligible hospital's initial calculated SFY 2011 charity care subsidy is less than its total SFY 2010 subsidy allocation including any reallocations, the hospital-specific subsidy calculation for each eligible hospital shall be its total SFY 2010 subsidy allocation including any reallocations minus 55% of the difference calculated in iii above.

vi) If the hospital-specific subsidy calculated thus far for an eligible hospital is calculated to be more than 98% of its documented charity care for calendar year 2009, the hospital-specific subsidy for each hospital shall be reduced to 98% of its documented charity care.

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vii) The hospital-specific subsidy for an eligible hospital assigned to Tier 2 shall not be less than 15% of its documented charity care for calendar year 2009. The resulting number will constitute each eligible hospital's SFY 2011 Charity Care subsidy allocation.

viii) A proportionate increase or decrease will be applied to Tier 1 hospitals if necessary such that the calculated SFY charity care subsidy allocation for all hospitals totaled shall be equal to $665,000,000 and the 98 percent hospital-specific maximum specified in vi) above is maintained and the 15 percent hospital-specific minimum specified in vii) above is maintained. The methodology for proration is based on the weight of the hospital-specific subsidy calculated for each hospital that has not reached its specified minimum or maximum limit.

TN: 10-06-MA (NJ)
Approval Date: JUL 11 2012
Supersedes: NEW
Effective Date: July 1, 2010