(i)-(l) (No change.)

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Nursing Facility Patient Care Ratio Requirements
Adopted New Rules: N.J.A.C. 10:49A

Proposed: April 19, 2021, at 53 N.J.R. 605(a).
Adopted: September 14, 2021, by Sarah Adelman, Acting Commissioner, Department of Human Services.
Filed: September 14, 2021, as R.2021 d.120, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).
Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.; and P.L. 2020, c. 89.
Agency Control Number: 21-A-01.
Effective Date: October 18, 2021.
Expiration Date: October 18, 2028.

Summary of Public Comments and Agency Responses:

Comments were received from the following agencies/individuals:
Martin Friedman CPA, PC (Abi Goldenberg)
Health Care Resources (A. Katherine Blissit)
One letter signed by the three Trade Organizations listed below:
- NJ Hospital Association (Theresa Edelstein, Senior Vice President)
- Health Care Association of NJ (Andrew Aronson, President & CEO)
- LeadingAge NJ & DE (James W. McCracken, President & CEO)

NJ National Academy of Elder Law Attorneys (NJ NAELA) (Laura L. Ergood, President)
AARP NJ (Evelyn Liebman, Director of Advocacy)
Disability Rights NJ (DRNJ) (Mary Ciccone, Director of Policy)
Office of the State Comptroller (OSC) (Joshua Lichtblau, Director, Medicaid Fraud Division)

N.J.A.C. 10:49A-1.2, Definitions

1. COMMENT: One commenter asked how "care of individual beneficiaries" is defined.

RESPONSE: This phrase is not defined because it appears only in the notice of proposal Summary and is not a term used in the actual rules.

2. COMMENT: Patient care ratio (PCR) reporting year. Three commenters requested that the reporting year change from the State fiscal year to the calendar year. This would align the PCR reporting year with most facility fiscal/tax years and avoid a burdensome mid-year accrual and reconciliation process. One commenter noted that Medicare reporting to the Federal Centers for Medicare and Medicaid Services (CMS) is on the calendar year. Another commenter noted that Medicaid began requiring calendar year cost reporting in 2010.

RESPONSE: The Department of Human Services (Department) agrees with the comment and will incorporate the change upon adoption. This revision is not considered too substantial to make upon adoption because the total number of months to be reported per reporting year remains as 12. The change from State fiscal year to calendar year aligns the reporting period for the PCR with the reporting periods for other Medicare and Medicaid financial reporting, which means that the first reporting period will start on January 1, 2022.

3. COMMENT: Related party. One commenter requested that the definition of related party align with the Federal Medicare definition and disclosure threshold found at 42 CFR 455.104. The Federal definition quoted in the letter has several standards for the disclosing Medicaid entity.

RESPONSE: This change will not be incorporated upon adoption because the proposed language is already consistent with the Federal definition.

4. COMMENT: Revenue. One commenter requested that the definition state that only Medicaid/NJ FamilyCare Revenue will be used in calculating a nursing facility's PCR and rebate.

RESPONSE: This change will not be incorporated upon adoption because the comment is about the calculation proposed in the rule, rather than the substance of the definition.

N.J.A.C. 10:49-2.1, General Requirements

5. COMMENT: Regarding paragraph (a)1, two commenters requested that the due date of the report be lengthened from three months after the close of the PCR reporting year to the longer time period permitted by CMS for Medicare cost reports. One commenter requested five months and another requested four months.

RESPONSE: The Department agrees with the commenters and will change the regulation upon adoption to require submission by the sixth month following the end of the PCR reporting year, rather than the fourth month. This revision is not considered too substantial to make upon adoption because the requirement to submit the information is not changing, only the month in which the information is to be submitted, to allow more time for submission.

6. COMMENT: Regarding subsection (e), two commenters requested that the reporting of detailed transactions change to a summary by vendor, which is what CMS allows for Medicare cost reports, because there are hundreds of transactions. One of the two commenters also noted a typographical error with the word "transition" at N.J.A.C. 10:49A-2.11(e)5. Another commenter noted their support for related party reporting.

RESPONSE: The Department will correct the noted typographical error and clarify that the substantive analysis is intended to be a summary by vendor, although a detailed report of each transaction is required. This revision is not considered too substantial to make upon adoption because it is clarifying that the substantive analysis is performed in summary for each related party, with no change to reporting the transaction detail.

7. COMMENT: Regarding paragraph (e)5, one commenter requested that the substantive analysis be worded as optional, with facilities alternatively noting the methodology for setting the price. The commenter also noted that substantive analysis is not defined or used in other healthcare contexts.

RESPONSE: The change will not be incorporated upon adoption because the analysis is required for the rule to serve its intended purpose, which is to accurately report the cost of patient care. The outcome of the analysis is defined, which is that a facility must demonstrate a fair market price. The form of analysis is necessarily flexible so that, as requested, facilities can choose a methodology appropriate to the transaction type.

N.J.A.C. 10:49A-2.2, Revenue Reporting Requirements

8. COMMENT: Three commenters noted the legislative distinction between total revenues and aggregate revenues and requested that the rule use aggregate revenue from all payers in determining the reporting and rebate requirements of the PCR.

RESPONSE: This change will not be incorporated upon adoption because the proposed rule requires reporting of total revenue and calculates the rebate on all revenue, as is permissible under the Department's regulatory authority.

9. COMMENT: One commenter asserted that Medicaid services are loss leaders and asked about the treatment of non-Medicaid funds and incentives to either create additional ancillary companies or discourage acceptance of Medicaid residents.

RESPONSE: The Department does not believe that the rule will discourage the acceptance of Medicaid beneficiaries into the nursing facilities.

10. COMMENT: One commenter requested that, in addition to Generally Accepted Accounting Principles (GAAP), facilities could elect to report revenue consistent with Other Comprehensive Basis of Accounting (OCBA), which collectively refers to several non-GAAP accounting systems. This is because not all facilities use GAAP and requiring GAAP as the only standard may result in increased costs to facilities, particularly for individual or small facilities.

RESPONSE: This change will not be incorporated upon adoption because the rule's application of GAAP is limited to revenue reporting, rather than all aspects of a facility's financial statements. Alignment with GAAP revenue recognition and accrual is necessary for consistency in reporting (that is, matching revenue with service dates) and equitable treatment across facilities when calculating rebates. In general, this means that facilities report revenue based on days billed in the reporting period and the likelihood of collection, rather than when cash payments are received.

N.J.A.C. 10:49A-2.3, Workers' Compensation Insurance

11. COMMENT: Regarding subsection (a) and N.J.A.C. 10:49A-2.6(a)2, one commenter requested that, for clarity, compensation expenses explicitly include workers' compensation insurance, which is consistent with current facility accounting for staff benefits. This change also requires clarification to the section on insurance reporting.

RESPONSE: The Department agrees that the proposed rule would be clearer if the expense type for reporting workers' compensation insurance was explicitly defined. These changes will be incorporated upon adoption to clarify that the personnel type for all staff compensation expenses includes workers' compensation insurance. The language will be incorporated at N.J.A.C. 10:49A-2.3(a) and 2.6(a). This revision is not considered too substantial to make upon adoption because it is not changing the reporting of workers' compensation insurance, only defining which expense type it should be reported within.

12. COMMENT: Regarding paragraph (a)2, one commenter requested that the reporting of non-certified nurse aide (CNA) Direct Care compensation be modified to include all nursing staff that do not work solely in an administrative capacity because facilities do not have the capability to track the proposed standard of greater than 90 percent face-to-face time with residents. In contrast, another commenter requested that the proposed rule include any health care professional licensed or certified pursuant to Title 26 or Title 45 of the Revised Statutes to show what type of care is being delivered.

RESPONSE: The Department will clarify that other professionals who primarily provide hands-on care to residents as part of their daily job duties can be included in the reporting of non-CNA Direct Care compensation. This revision is not considered too substantial to make upon adoption because it does not change the intent of the language, which is to provide a flexible standard of non-CNA Direct Care that can be simply administered by all facilities and is not narrowly limited to nursing staff or similar titles.

13. COMMENT: Regarding paragraph (a)3, one commenter requested that nursing and rehabilitation therapy be added to the non-exhaustive list of other compensation.

RESPONSE: This change will not be incorporated upon adoption because the reporting of these staff titles may vary by facility depending on the extent to which their work involves Direct Care.

14. COMMENT: Regarding paragraphs (a)4 and 5, one commenter does not support including administrative costs, such as accounting, salaries, and benefits for executive staff. Another commenter noted that the reporting does not distinguish between the gross fee the facility paid to the management company from the portion of that fee that was attributable to the profit of the management company.

In contrast, another commenter asked about the interaction between related-party transaction reporting pursuant to N.J.A.C. 10:49A-2.1(a)1v and management fees that may be reported under this provision. The commenter asked specifically if this provision refers to all management fees or only related-party transactions and what effect this provision has on a single-facility management company. The commenter requested that a percentage of revenue and accumulated costs be added to the listing of acceptable allocation methods.

RESPONSE: These changes will not be incorporated upon adoption because the intent of the law is to include expenses in the ratio if they are related to the cost incurred by a facility. The accumulated cost change is unnecessary because the concept is already incorporated into the rule, where the total accumulated cost would be allocated using one of the defined allocation bases.

Additionally, there is no conflict between the two sections. N.J.A.C. 10:49A-2.1(a)1v applies to all related-party transactions, including management fees. N.J.A.C. 10:49A-2.3 adds additional requirements because management fee pricing is less standardized than costs of other goods and services (for example, professional services billed at a rate based on actual time spent engaged on a matter). In the case of a single-entity management company, the fee is reportable if it complies with the other regulatory requirements on competitive pricing and allocation methods.

N.J.A.C. 10:49-2.6, Interest Payments

15. COMMENT: Regarding paragraph (a)4, one commenter requested that this paragraph be revised to state that interest on routine borrowing secured in the normal course of business, such as lines of credit, mortgages, and other similar loans, is considered an expense that is for resident care.

RESPONSE: This change will not be incorporated upon adoption because the rule does not broadly assume that all borrowings are for resident care. This provision already permits full reporting of the interest if the borrowings are for resident care.

16. COMMENT: Regarding paragraph (d)3, one commenter requested that bad debt expense related to resident care charges be removed from the list of exclusions because facilities often experience changes in residents' Medicaid status, denials of eligibility, or penalty periods, despite having provided care and services to the residents.

RESPONSE: This change will not be incorporated upon adoption because bad debt related to unpaid resident care charges will already factor into total revenue recognition for the reporting period.

17. COMMENT: Regarding paragraph (d)7, one commenter requested that income taxes, except for LLCs, be reported as an expense. In contrast, another commenter supports the exclusion of profits, from which income taxes are paid, as a reportable expense.

RESPONSE: This change will not be incorporated upon adoption because income taxes are paid from gross profits, which is the amount left after payment of expenses. As the second commenter noted, profits are not a reportable expense.

18. COMMENT: Regarding subsection (d), one commenter requested that the proposed rule include a specific reporting exception for overpayments returned to a payer, such as a managed care organization.

RESPONSE: This change will not be incorporated upon adoption because it is already part of the reporting framework. In addition to being similar to the non-exhaustive list of example expenses specifically excluded by the rule, such as legal settlements, overpayments returned to a payer are not a reportable patient care expense under any provision and, therefore, would be excluded from reporting.

N.J.A.C. 10:49A-3.1, Calculating and Providing the Rebate

19. COMMENT: One commenter requested that the proposed rule be amended to include clarity on a plan to update the public on the implementation of PCR and the status of each nursing facility.

RESPONSE: This change will not be incorporated upon adoption because the comment is beyond the scope of the rulemaking. The new rule concerns the standards for facility reporting and PCR calculation and does not include provisions related to educating the general public about the program.

20. COMMENT: One commenter requested revision of the proposed rule to detail specifically how the Department defines and enforces offenses and violations, as well as the method by which the Department will analyze multiple facility owners.

RESPONSE: This change will not be incorporated upon adoption because this information is already included in the new rules. The enforcement mechanisms of debt collection and payment withholding are included at N.J.A.C. 10:49A-3.1(g)4 and (k). Additionally, N.J.A.C. 10:49A-2.1(b) requires that compliance and rebate calculations be determined for each individual facility, and an owner of multiple facilities must submit a separate report for each facility. In the event that an owner elects to offset losses with gains across facilities, N.J.A.C. 10:49A-2.6(c)3 requires that the exact amounts for each facility must be reported on a separate schedule and that no amount can be reflected beyond the amount required to offset operating losses.

21. COMMENT: Regarding subsection (j), two commenters requested more details on the procedure for requesting a deferral and asked whether the request can be made before amounts are withheld.

RESPONSE: The language will be changed upon adoption to provide an address at the Division of Medical Assistance and Health Services for the submission of deferral requests.

N.J.A.C. 10:49A-3.2, Auditing

22. COMMENT: Two commenters requested that additional information be incorporated on the Department's plan to audit facilities, such as certain percentages or audit triggers.

RESPONSE: The Department may conduct audits at any time. No changes will be made to the rule because the 30-day advance notice that will be provided prior to an audit is sufficient.

23. COMMENT: Regarding subsection (a), one commenter noted that the notice period applies to the "Department or by authorized representatives of the Department," which is different than the definition of "State audit entity," and requested changing the reference in this provision to the defined term.

RESPONSE: This change will not be incorporated upon adoption; however, "authorized representatives of the Department" is intended to allow the Department to broadly delegate audit authority, as may be needed, to a "State audit entity," as well as other entities the Department may engage to act on its behalf.

N.J.A.C. 10:49A-3.3, Records Retention

24. COMMENT: Regarding subsection (c), two commenters requested that the time period for record retention be changed from six years to three years, consistent with the time period at N.J.A.C. 8:85-4.1.

RESPONSE: The Department agrees with the commenters and will incorporate the change upon adoption. This change is not too substantive to make upon adoption because the three-year timeframe is consistent with the existing requirements the agencies are already required to comply with at N.J.A.C. 8:85-4.1 and is a reduction of a burden on agencies. The Department notes that this change does not change the six years that applies to disputes or allegations of fraud.

Federal Standards Statement

Section 1902(a)(10) of the Social Security Act, 42 U.S.C. § 1396a(a)(10), regulates program eligibility including the amount, duration and scope of benefits. Section 1905(a) of the Social Security Act, 42 U.S.C. § 1396d(a), governs reimbursement under state medical assistance programs for care recognized under state law that is furnished by licensed practitioners within the scope of their practice, as defined by state law, including those services provided in nursing facilities. Federal regulations at 42 CFR 440.60(a) provide that remedial services rendered to a beneficiary by a licensed practitioner, practicing within the scope defined by state law, are reimbursable.

Title XXI of the Social Security Act allows states to establish a children's health insurance program for targeted low-income children. New Jersey elected this option through implementation of the NJ FamilyCare Children's Program. Section 2103, 42 U.S.C. § 1397cc, provides broad coverage guidelines for the program.

The Department has reviewed the applicable Federal laws and regulations and that review indicates that the adopted new rules do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Full text of the adopted new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 49A
NURSING FACILITY PATIENT CARE RATIO REQUIREMENTS

SUBCHAPTER 1. GENERAL INFORMATION

10:49A-1.1 Scope and purpose

(a) This chapter shall apply to all nursing facilities providing services to Medicaid/NJ FamilyCare beneficiaries.

(b) This chapter establishes the requirements for defined nursing facilities to report information concerning certain revenues and the use of those revenues for the care of the residents.

(c) This chapter describes how this information will be used to determine, with respect to each patient care ratio (PCR) reporting year, whether the amount of reported revenue expended by the facility on permitted costs meets, or exceeds, the percentage established pursuant to P.L. 2020, c. 89, addresses requirements for calculating any rebate amounts that may be due in the event that a facility did not meet the PCR standard during the reporting year, and specifies administrative requirements of the program.

10:49A-1.2 Definitions

The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Department" means the New Jersey Department of Human Services.

"Facility" means a Class I (private), Class II (county), or Class III (special care) nursing facility identified by both a unique Medicaid/NJ FamilyCare provider number and a unique daily payment rate. A facility may be a specific unit co-located with other services (for example, a special care nursing facility floor sharing space with a nursing facility shall be considered a separate facility, if it has a separate Medicaid/NJ FamilyCare provider number and daily rate).

"GAAP" means the U.S. Generally Accepted Accounting Principles, a common set of accounting principles, standards, and procedures issued by the national Financial Accounting Standards Board (FASB). GAAP aims to improve the clarity, consistency, and comparability of the communication of financial information. Any financial concept, measure, metric, or other financial reference used in this chapter, or to meet the requirements of this chapter, must follow U.S. Generally Accepted Accounting Principles.

"Patient care ratio" (PCR) means the percentage of a facility's Medicaid revenue expended on resident care, services, and support that is calculated.

"Patient care ratio (PCR) reporting year" means a *[State fiscal year, as determined by the Annual Appropriations Act]* ***calendar year from January 1 through December 31***, during which Medicaid/NJ FamilyCare-covered services are provided by a facility.

"Related party" means a person or entity that is related to the reporting facility. A related party relationship includes, but is not limited to, relationships between: (1) divisions of an organization; (2) organizations under common control through common officers, directors, or members; (3) an organization and its director, trustee, officer, or key employee, or an immediate family member of those individuals, any of whom holds a controlling interest in the organization either directly or through corporations, trusts, or similar arrangements; and (4) any parties that enable one to control or substantially influence the actions of the other.

"Resident" means an individual who resides at the facility for at least one night at any time during a PCR reporting year.

"Revenue" means all recognized income received from, or on behalf of, a resident as a condition of receiving services from the facility, including any fees or other contributions the facility may require as part of a resident reserving, securing, or receiving services.

"State audit entity" means the Department, the New Jersey Department of Law and Public Safety, the New Jersey Office of the State Comptroller, or any authorized agents of those entities.

SUBCHAPTER 2. DISCLOSURE AND REPORTING REQUIREMENTS

10:49A-2.1 General requirements

(a) For each PCR reporting year, a facility must submit, to the Department, a report, that complies, in all respects, with the requirements of this chapter concerning revenue and expenses related to the services that it provided.

1. The report must be submitted to the Department by the first day of the *[fourth]* ***sixth*** month following the end of a PCR reporting year and must contain the information set forth in this section.

(b) An owner of multiple facilities must submit a separate report for each facility operated during the PCR reporting year. Data for multiple facilities cannot be combined into an aggregate report or reports. Compliance and rebate calculations will be determined by the individual facility.

(c) Owners that purchase another facility, or have ownership of another facility transferred to them, during a PCR reporting year are responsible for submitting the information and reports required by this chapter for the

assumed facilities, including for that part of the PCR reporting year that was prior to the assumption and for the payment of any required rebates.

(d) Owners of facilities that cease operations during a PCR reporting year are responsible for submitting the information and reports required by this chapter for the closed facilities and for the payment of any required rebates.

(e) Costs of services, facilities, and supplies, including management fees and similar payments, furnished by a related party may only be reported to the extent that they are less than, or equal to, the competitive price of comparable services, facilities, or supplies purchased elsewhere. A facility must report all related-party transactions on a form, and in the manner prescribed by the Department, which shall include, but is not limited to, the following information for each transaction:

1. Date;
2. Amount;
3. Description of goods and services provided;
4. Nature of the relationship for each transaction; and
5. Substantive analysis *[of]* ***listed by*** each *[transaction]* ***related party*** showing that the reported cost is equal to, or less than, the cost had the transaction occurred in an arm's length negotiation. If the goods or services are fungible or otherwise available in a ready market, evidence of competitive procurement, or posted prices at the time of the *[transition]* ***transaction*** must also be reported.

10:49A-2.2 Revenue reporting requirements

(a) A facility must report to the Department its revenue in accordance with GAAP, as defined by the Financial Standards Accounting Board for the reporting year.

1. All revenue for services provided by one facility that is later assumed by another facility must be reported by the assuming facility for the entire PCR reporting year during which the services were provided.

(b) A facility must report certain measures of revenue that shall be used to calculate the PCR. Reported revenue shall include, at a minimum:

1. Total bed days, which means that a facility must report the total number of bed days billed to any individual or entity during the PCR reporting year. This must include billed, but not collected, days consistent with GAAP and a facility's Federal tax filing accrual and revenue recognition policies;
2. Medicaid/NJ FamilyCare bed days, which means that a facility must report the number of bed days billed to the Department's Medicaid/NJ FamilyCare fee-for-service and Managed Care programs. This number must include billed, but not collected, days consistent with GAAP and a facility's Federal tax filing accrual and revenue recognition policies; and
3. Medicaid/NJ FamilyCare revenue, which means that the facility must report the amount of revenue reported at (a) above that was recognized from the Department's Medicaid/NJ FamilyCare fee-for-service and Managed Care programs.

10:49A-2.3 Required reported expenses: personnel and facility management

(a) A facility must report gross salaries, wages, consultant fees, fringe benefits, ***workers' compensation insurance,*** other compensation, and employer taxes paid or accrued during the PCR reporting year in order to operate the facility and provide services to residents. Amounts must be reported in the aggregate for each of the following distinct categories:

1. A single aggregate amount must be reported for all Certified Nurse Aide (CNA) compensation paid during the PCR reporting year;
2. A single aggregate amount must be reported for all Non-CNA Direct Care compensation paid during the PCR reporting year. Non-CNA Direct Care compensation means the amount paid to registered professional nurses and licensed practical nurses, as well as other individuals who, *[averaged]* over the course of a PCR reporting year, *[spend 90 percent or more of their time face-to-face with]* ***primarily provide hands-on care to*** residents ***as part of their daily job duties***;
3. A single aggregate amount must be reported for all Other Resident Care and Support compensation paid during the PCR reporting year. Resident Care and Support compensation means the entire amount paid to individuals who provide resident care oversight, planning, quality assurance, support services, and other functions, including, but not limited to, activities, food service, housekeeping, infection control, maintenance, medical services, medical recordkeeping, social services, and transportation;
4. A single aggregate amount must be reported for all other compensation paid to individuals who have general and administrative functions that are common to most businesses, including, but not limited to, administrative, executive, finance, human resources and legal staff, and similar staff that are necessary to ensure safe operation and compliance with all general business laws, rules, and regulations;
5. A single aggregate amount may be reported for all management fees paid, only if the management fee is apportioned or charged to the facility in the same manner that it is charged to all other facilities that the management entity serves and is allocated using a method based on one or more of the following:
   i. A measure of service level;
   ii. Actual hours of services delivered;
   iii. The number of staff per facility;
   iv. The number of residents per facility;
   v. Pricing of actual services delivered; or
   vi. The proportion of total bed days; and
6. No amount shall be reported for all other compensation or management fees paid during the PCR reporting year.

10:49A-2.4 Required reported expenses: materials and supplies

(a) A facility must report amounts paid or accrued during the PCR reporting year for materials and supplies needed in order to operate the facility and provide services to residents. Amounts must be reported in the aggregate for each of the following distinct categories.

1. A single aggregate amount must be reported for all direct care materials and supplies. Direct care materials and supplies means items used by, or for, residents, such as those used for services and other functions, including, but not limited to: activities, food service, housekeeping, infection control, maintenance, medical services, medical recordkeeping, social services, and transportation; and
2. A single aggregate amount is reported for all other materials and supplies. Other materials and supplies means general and administrative items common to most businesses, such as those corresponding to the staff, provided at N.J.A.C. 10:49A-2.3(a)4.

10:49A-2.5 Required reported expenses: facility operating expenses

(a) A facility must report amounts paid, or accrued, during the PCR reporting year in order to secure facility space and maintain it in habitable and licensable condition. Amounts must be reported in the aggregate for each of the following distinct categories:

1. A single aggregate amount must be reported for all equipment, maintenance, telecommunications, and utility expenses attributable to buildings and equipment used for resident living, activities, services, and support functions, including, but not limited to, food service and transportation. If administrative offices are attached to these buildings, expenses for similar items may be included in this total if they are dedicated solely to the operations of the reporting facility. Expenses for areas that are not used solely by, or for, residents may only be reported in this category if the amount is allocated on a pro rata basis, based on the proportion of actual resident use, as calculated over the course of the PCR reporting year;
2. A single aggregate amount must be reported for all depreciation and rent expenses attributable to property, plant, and equipment (PP&E) used for resident living, activities, services, and support functions, such as food service and transportation. PP&E that are not used solely by, or for, residents may only be reported in this category if the amount is allocated on a pro rata basis, based on the proportion of actual resident use, as calculated over the course of the PCR reporting year;
3. Depreciation must match the amount that would be recognized on a facility's income statement in accordance with GAAP, as defined by the Financial Standards Accounting Board for the reporting year. Facilities may not report the total cash outlay or balance sheet asset generated by a capitalized expenditure. Facilities shall not report accelerated depreciation used for internal reporting or tax filing; and
4. No amount shall be reported for all other facility operating expenses. Other facility operating expenses means amounts not allowable under any other category.

10:49A-2.6 Required reported expenses: other operating expenses

(a) A facility must report amounts paid, or accrued, during the PCR reporting year in order to support operations. Amounts shall be reported in the aggregate for each of the following distinct categories.

1. A single aggregate amount must be reported for all staff training;

2. A single aggregate amount must be reported for all insurance policies***, except for workers' compensation insurance, which is reported as part of staff compensation***;

3. A single aggregate amount must be reported for all interest on depreciable property, plant, and equipment (PP&E) used for resident living, activities, services, and support functions, such as food service and transportation. PP&E that are not used solely by, or for, residents may only be reported in this category if the amount is allocated on a pro rata basis, based on the proportion of actual resident use, as calculated over the course of the PCR reporting year; and

4. A single aggregate amount must be reported for all other non-PPE interest payments. Interest on borrowings for expenses that are not used solely by, or for, residents may only be reported in this category if the amount is allocated on a pro rata basis, based on the proportion of actual resident use, as calculated over the course of the PCR reporting year.

(b) The report must include the following fees and taxes:

1. Routine licensing and regulatory fees, such as those imposed by the Department of Health on all facilities. Penalties and similar assessments are not included;

2. Property taxes and similar payments in lieu of taxes;

3. Sales and similar taxes, only if not included with the cost of goods and services reported in other sections; and

4. Any industry-wide assessments paid to the State directly, such as provider taxes.

(c) A single aggregate amount may be included on each individual facility's report if an owner of multiple facilities uses revenue from some facilities to offset operating losses in other facilities.

1. A facility may report a single aggregate expense equal to the amount of support provided to all other facilities.

2. A facility with operating losses may report a single aggregate expense offset equal to the amount of support provided from all other facilities.

3. The owner of the facilities must provide a supplemental schedule of all expenses and expense offsets recorded. The total must net to zero across all facilities.

4. No amount shall be reported for transfers during the PCR reporting year in excess of the amount required to offset operating losses.

(d) In addition to amounts specifically excluded, expenses not specifically authorized in this chapter must not be reported. These non-reportable expenses shall include, but not be limited to, the following examples:

1. Compensation and costs for sales personnel;

2. Agent and broker fees and commissions;

3. Bad debt expenses;

4. Fines, penalties, and similar fees;

5. Legal damages and settlements;

6. Debt principal payments;

7. Profits, losses, and income taxes. Profit is the amount left over after expenses are subtracted from revenues. Therefore, for the purposes of this chapter, profits are not part of the expenses added to patient care expenses. Similarly, income taxes are a percentage of profits and are not added to patient care expenses; and

8. Rebates paid under the requirements of this chapter. Rebates are calculated when reported expenses in a closed reporting period did not meet the PCR requirement. These expenses cannot be used to increase reported expenses in subsequent periods when paid.

10:49A-2.7 Allocation of expenses

(a) Each expense must be reported under only one type of expense, unless a cost incurred by the facility aggregates amounts that must be reported in different categories, in which case the expense must be allocated between expense reporting categories.

(b) Allocation to each category must be based on a generally accepted accounting method consistent with GAAP that is expected to yield the most accurate results. If expenses are allocated, the report must include a detailed description of the methods used to allocate expenses, including how each specific expense meets the criteria for the several categories assigned and why this is more accurate than specific identification with a single category.

(c) Facilities operating within a group where personnel and physical locations are shared, including expenses under the terms of a management contract, must be allocated among the facilities incurring the expense in accordance with the above standards. Expenses that relate solely to the operations of a reporting facility must be borne solely by the reporting entity and shall not be allocated to other entities within a group.

(d) The facility must maintain, and make available to the Department upon request, the data used to allocate expenses reported, along with all supporting information required to determine that the methods identified and reported were accurately implemented in preparing the report.

SUBCHAPTER 3. REBATE AND AUDIT REQUIREMENTS

10:49A-3.1 Calculating and providing the rebate

(a) A facility must provide a rebate to the Department if the facility has a PCR of less than 90 percent.

1. For the sole purpose of determining if the facility has a PCR of less than 90 percent, the Department is entitled to receive a rebate pursuant to this subchapter, the term "payer" means the Department, as the administrator of the New Jersey Medicaid/NJ FamilyCare fee-for-service and Managed Care programs.

(b) Each percentage calculation in this section shall be rounded to three decimal places. The amount shall be rounded up if the number in the fourth decimal place is greater than or equal to five, and otherwise rounded down. For example, 0.79881 shall be rounded up to 0.799 or 79.9 percent, and 0.82549 shall be rounded down to 0.825 or 82.5 percent.

(c) Each dollar amount calculation in this section shall be rounded to two decimal places, except for the final rebate amount, which is defined separately. The amount shall be rounded up if the number in the third decimal place is greater than or equal to five, and otherwise rounded down. For example, $7.9881 shall be rounded up to $7.99, and $8.2549 shall be rounded down to $8.25.

(d) The payer's Cost Share Percentage is the ratio of the reported number of Medicaid/NJ FamilyCare Bed Days (numerator) to the reported number of Total Bed Days (denominator). The payer's Cost Share Percentage shall be rounded as defined at (b) above.

(e) The payer's Share of Expenses is the dollar amount calculated by multiplying the payer's Cost Share Percentage by the sum of all reported expenses, as described in this section. The payer's Share of Expenses shall be rounded as defined at (c) above.

(f) A facility's PCR is the ratio of the payer's Share of Expenses to the payer's reported Medicaid/NJ FamilyCare Revenue (denominator). A facility's PCR shall be rounded as defined at (b) above.

(g) For each PCR reporting year, a facility must provide a rebate to the payer if the facility's PCR does not meet or exceed 90 percent.

1. If a facility's PCR is 90 percent or higher, the Rebate Percentage is zero.

2. If a facility's PCR is below 90 percent, the Rebate Percentage is 90 percent minus the facility's rounded PCR.

(h) If a rebate is required, the amount is calculated by multiplying the facility's Rebate Percentage by the reported Medicaid/NJ FamilyCare Revenue.

1. A facility's final rebate shall be rounded to the one-dollar position. The amount shall be rounded up if the number in the first decimal place is greater than or equal to five. For example, $8,254.91 shall be rounded up to $8,255.00 and $7,988.16 shall be rounded down to $7,988.00.

2. A facility must pay any rebate owing no later than the first day of the seventh month following the end of the PCR reporting year.

3. A facility must provide any rebates owed in the form of a lump-sum check unless the payer provides written instructions for a revenue credit.

4. If a rebate from any facility is not paid by the required date, the amount will be withheld from all other State and Medicaid/NJ FamilyCare fee-for-service and Managed Care payments due to the facility owner, as identified by a Tax Identification Number, including offset against prospective payments, any other amounts due, and referral to the Department of the Treasury's program for debt collection.

5. A facility is not required to provide a rebate to the payer if the calculated rebate owed to the payer is *de minimis*, meaning less than $1,000.

(i) As an example of the calculations in this section, assume a facility reports 100 total bed days, 50 Medicaid/NJ FamilyCare bed days, $1,000 of total expenses, and $570.00 of Medicaid/NJ FamilyCare revenue.

1. The payer's Cost Share Percentage is 50 percent (50/100).

2. The payer's Share of Expenditures is $500.00 (50% * $1,000).

3. The payer's PCR is 87.7 percent ($500/$570).

4. The payer's Rebate Percentage is 2.3 percent (90.0% - 87.7%).

5. The payer's Rebate is $13.00 (2.3% * $570). This example does not apply the *de minimis* rule due to illustrative small dollar amounts.

6. The payer's Share of Expenditures plus Rebate is $513.00, which is 90 percent of the payer's Revenue ($513/$570).

(j) If a State entity with financial audit and/or investigatory authority determines that the payment of rebates by a facility will cause the facility's cash balance to fall below the amount needed to operate as a going concern, the facility may request that the Department defer all, or a portion of, the rebate payments owed by the facility. The Department may permit a deferral of all, or a portion of, the rebates owed, but only for a period determined by the Department in consultation with the auditing entity. ***Upon receipt of notice that a rebate is due, a facility may request a deferral by filing a written request, including a copy of the State entity's finding, with the Division of Medical Assistance and Health Services, Office of Legal and Regulatory Affairs, PO Box 712, Mail Code #26, Trenton, NJ 08625-0712. The written request must be filed within 60 days of receipt of notification of the rebate.***

(k) The Department requires, at a minimum, that all reports shall be submitted timely, as described above, and that all data used in reports shall comply with the definitions, criteria, and other requirements as set forth in this chapter. If a facility fails to submit a timely report, fee-for-service and Managed Care claims will be held in pending status and no payments will be made until the facility is in compliance with the requirements in this chapter.

10:49A-3.2 Audits of a facility

(a) The Department will provide 30 days' advance notice of its intent to conduct an audit of a facility, either by Department staff or by authorized representatives of the Department.

1. All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the audit findings will be discussed.

2. The Department will share its preliminary audit findings with the facility, which will then have 30 days to respond to such findings. The Department may extend, for good cause, the time for a facility to submit such a response.

3. If the facility does not dispute the preliminary findings, the audit findings will become final. Alternatively, if the facility responds to the preliminary findings, the Department will review and consider such response and finalize the audit findings.

4. The Department will send the facility a copy of the final audit findings, including any recommendations the facility must implement as a result of the audit findings. A plan of corrective actions must be submitted to the Department within 90 days of the issuance of the final report.

5. If the Department determines, as the result of an audit, that a facility has failed to pay rebates it is obligated to pay pursuant to this chapter, the Department may order the facility to pay those rebates in accordance with this chapter.

6. If another entity conducts an audit of a facility's PCR reporting and rebate obligations, the Department may, in the exercise of its discretion, accept the findings of that audit if the Department determines the following:

i. The entity's audit reports on the validity of the data regarding expenses and revenue that the facility reported to the Department, including the appropriateness of the allocations of expenses used in such reporting; and

ii. The entity submits final audit reports to the Department within 30 days of finalization.

7. If the Department accepts an audit conducted by another entity, and if the facility makes additional rebate payments as a result of the audit, then the Department shall accept those payments as satisfying the facility's obligation to pay rebates pursuant to this chapter.

10:49A-3.3 Access to facilities

(a) Each facility subject to the reporting requirements of this chapter must allow access and entry to its premises, facilities, and records, including computer and other electronic systems, to the Department, the New Jersey Department of Law and Public Safety, the New Jersey Office of the State Comptroller, or any authorized agents of those entities to evaluate, through inspection, audit, or other means, compliance with the requirements for reporting and calculation of data submitted to the Department, and the timeliness and accuracy of rebate payments made pursuant to this chapter.

(b) Each facility must allow the same access and entry to the facilities and records, including computer and other electronic systems, of its parent organization, subsidiaries, related parties, contractors, subcontractors, agents, or a transferee, that pertain to any aspect of the data reported to the Department or to rebate payments calculated and made pursuant to this chapter. To the extent that the facility does not control access to the facilities and records of its parent organization, related parties, or third parties, it is the responsibility of the facility to contractually obligate any such parent organization, related parties, or third parties to grant said access.

(c) Unless a longer period is required by applicable law, State audit entities may inspect or audit a facility at any time up to *[six]* ***three*** years from the date, determined by the timestamped confirmation that the Department provides, of the facility's filing of a report required by this chapter. The Department may also inspect or audit a facility at any time up to three years after the completion of an audit and for such longer period ***as*** set forth in this subsection, provided that any of the following occur:

1. An entity determines there is a special need to retain a particular record, or group of records, for a longer period and notifies the facility at least 30 days before the record retention disposition date;

2. There has been a dispute or allegation of fraud or similar action by the facility, in which case the retention may be extended to six years from the date of any resulting final resolution of the dispute, fraud, or similar fault; or

3. The entity determines that there is a reasonable possibility of fraud or similar fault, in which case the entity may inspect, evaluate, and audit the facility at any time.

10:49A-3.4 Recordkeeping

Each facility subject to the requirements of this chapter must maintain all documents and other evidence necessary to enable the Department to verify that the data required to be submitted in accordance with this chapter comply with the definitions and criteria set forth in this chapter, and that the PCR is calculated and any rebates owing are calculated and provided in accordance with this chapter. This requirement includes, but is not limited to, all administrative and financial books and records used in compiling data reported, and rebates provided, pursuant to this chapter and in determining what data to report and rebates to provide under this chapter, electronically stored information, and evidence of accounting procedures and practices. This requirement also includes all administrative and financial books and records used by others in assisting a facility with its obligations pursuant to this chapter.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Notice of Readoption
Chiropractic Services

Readoption with Technical Changes: N.J.A.C. 10:68

Authorized By: Sarah Adelman, Acting Commissioner, Department of Human Services.