Citation	Rule Summary	Type of Violation	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-31.4(g)	Failure to retain records as required at 13 CCR § 1963.4(d)	M	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-31.4(g)	Failure to make records available as required at 13 CCR § 1963.4(c)	M	$500	$1,000	$2,500	$7,500

32. (No change.

33. [(Reserved)] **The violations of N.J.A.C. 7:27-33, Fleet Reporting Requirements, and the civil administrative penalty amounts for each violation are as set forth in the following table:**

Citation	Class	Type of Violation	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-33.4(a)	Failure to submit	NM	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-33.4(a)	Omission of required information specified at N.J.A.C. 7:27-33.6 and 33.7	M	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-33.4(b)	Failure to certify	M	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-33.5(a)1 through 4	Failure to maintain records	M	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-33.5(a)	Failure to make records readily available	M	$500	$1,000	$2,500	$7,500
N.J.A.C. 7:27-33.5(b)	Failure to respond to an information request from the Department in a timely manner	M	$500	$1,000	$2,500	$7,500

(n)-(u) (No change.)

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Nursing Facility Patient Care Ratio Requirements

Proposed New Rules: N.J.A.C. 10:49A

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

Authority: N.J.S.A. 30:4D-1 et seq., and 30:4J-8 et seq.; and P.L. 2020, c. 89.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Agency Control Number: 21-P-01.

Proposal Number: PRN 2021-040.

Submit comments by June 18, 2021, to:

Margaret M. Rose Attn: 21-P-01.
Email: Margaret.Rose@dhs.state.nj.us
Mail: Division of Medical Assistance and Health Services
Office of Legal and Regulatory Affairs
PO Box 712 Mail Code #26
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The agency proposal follows:

Summary

The Department of Human Services (Department) is proposing new N.J.A.C. 10:49A, Nursing Facility Patient Care Ratio Requirements. The purpose of the chapter is to implement P.L. 2020, c. 89, which established expense ratio reporting and rebate requirements for nursing facilities. Under the proposed new rules, nursing facilities will pay a rebate to the Department, if less than 90 percent of the revenue received from the Department and its contracted managed care organizations is expended on the care of individual beneficiaries. State Fiscal Year 2022 will be the first reporting period upon which a rebate would be calculated.

The COVID-19 pandemic demonstrated a profound need for focus on the resiliency of the State's nursing facilities and for accountability in the use of revenue to ensure high-quality resident care. In response to a comprehensive review commissioned by the State, the Governor, Legislature, Department of Health, and Department of Human Services took significant action to enhance the care delivered at nursing facilities. Several laws and directives mandated new facility standards, including minimum wage levels for certified nurse aides (P.L. 2020, c. 89), required staffing ratios (P.L. 2020, c. 112), stockpiling of personal protective equipment, and additional reporting and COVID-19 testing requirements. To support these ongoing activities, Medicaid daily rates were increased by 10 percent, with receipt of the funds contingent on facility implementation of staff wage increases and infection control and preparedness measures (P.L. 2020, c. 90).

The patient care ratio (PCR) reporting and rebate requirement at P.L. 2020, c. 89, is an additional tool to ensure that State resources are expended in support of quality care for individuals receiving services. Nursing facilities will be required to report information concerning total revenues. Additional measures will be used to determine the aggregate revenue subject to the rebate calculation and whether the amount expended on permitted costs meets or exceeds the percentage established at P.L. 2020, c. 89. The PCR will require that 90 percent of a facility's State revenue, aggregated from all Medicaid/NJ FamilyCare fee-for-service payments and Managed Care payers, in a State fiscal year is expended on the care of residents. If a facility's PCR is less than 90 percent, the facility will be required to rebate a portion of this reimbursement to the Department. The Department, other defined entities, and their authorized designees may conduct an audit of the financial information reported by the nursing facilities to ensure the accuracy of the information reported and compliance with the requirements of the rule.

Proposed new N.J.A.C. 10:49A, Nursing Facility Patient Care Ratio Requirements, will be organized into three subchapters, which are described below.

Proposed N.J.A.C. 10A:49-1, General Information, will have two sections, as described below.

Proposed new N.J.A.C. 10:49A-1.1, Scope and purpose, delineates the scope of the chapter; explains that the chapter shall apply to all nursing facilities providing services to Medicaid/NJ FamilyCare beneficiaries; and describes the purpose as establishing the requirements for defined nursing facilities to report revenue and the uses of that revenue in order to calculate a patient care ratio and any rebate obligation for the reporting year.

Proposed new N.J.A.C. 10:49A-1.2, Definitions, contains definitions of the following terms as used in the chapter: "Department," "facility," "GAAP," "patient care ratio," "patient care ratio (PCR) reporting year," "related party," "resident," "revenue," and "State audit entity."

Proposed new N.J.A.C. 10:49A-2, Disclosure and Reporting Requirements, will have seven sections, as described below.

Proposed new N.J.A.C. 10:49A-2.1, General requirements, contains five subsections on general reporting requirements to be met by all facilities, separate reporting by owners of multiple facilities, reporting responsibility for closed and transferred facilities, and the treatment of related-party transactions.

Proposed new N.J.A.C. 10:49A-2.1(a) requires all facilities to provide the Department a report of revenue and expenses for each PCR reporting year by the first day of the fourth month after the end of the reporting year.

Proposed new N.J.A.C. 10:49A-2.1(b) requires that an owner of more than one facility must submit a separate annual report for each facility owned and operated during the reporting year because each facility is considered separately for payment, compliance, and rebate calculations.

Proposed new N.J.A.C. 10:49A-2.1(c) requires that an owner who purchases or transfers ownership during a PCR reporting year shall be responsible for completing the annual report for the entire PCR reporting year, including the part of the year prior to the purchase or transfer and that the new owner shall be responsible for the payment of any required rebates.

Proposed new N.J.A.C. 10:49A-2.1(d) requires facilities that cease operation during a PCR reporting year to submit the annual report for any and all closed facilities and to be responsible for the payment of any rebates due for those facilities.

Proposed new N.J.A.C. 10:49A-2.1(e) requires that the costs of services, facilities, and supplies purchased from related parties are permitted to be reported to the extent that they do not exceed the competitive price of comparable services, facilities, and supplies purchased elsewhere. A schedule of the included expenses is required to be submitted to the Department and paragraphs (e)1 through 5 lists the minimum required elements of the report.

Proposed new N.J.A.C. 10:49A-2.2, Revenue reporting requirements, contains two subsections defining required revenue measures.

Proposed new N.J.A.C. 10:49A-2.2(a) requires a facility to report its revenue in accordance with Generally Accepted Accounting Principles (GAAP) for each PCR reporting year and requires that revenue for services provided by a facility that is later assumed by another facility to be reported by the assuming facility for that PCR reporting year.

Proposed new N.J.A.C. 10:49A-2.2(b) requires that the facility report certain measures of revenue, and paragraphs (b)1, 2, and 3 list required elements for bed days and Medicaid revenue amounts.

Proposed new N.J.A.C. 10:49A-2.3, Required reported expenses: personnel and facility management, requires the facility to report gross salaries, wages, consultant fees, fringe benefits, other compensation, and employer taxes paid or accrued during the PCR reporting year. Paragraphs (a)1 through 6 list specific staff categories by which aggregate amounts are to reported and what amounts shall not be included in the report.

Proposed new N.J.A.C. 10:49A-2.4, Required reported expenses: materials and supplies, requires the facility to 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. Subsection (a) lists the specific aggregate amounts to be included in the report and what amounts shall not be included in the report.

Proposed new N.J.A.C. 10:49A-2.5, Required reported expenses: facility operating expenses, requires the facility to report amounts paid or accrued during the PCR reporting year in order to secure facility space and maintain it in habitable condition. Subsection (a) lists the specific aggregate operating expense amounts to be included in the report, criteria for depreciation, and what amounts shall not be included in the report.

Proposed new N.J.A.C. 10:49A-2.6, Required reported expenses: other operating expenses, requires the facility to report amounts paid or accrued during the PCR reporting year in order to support operations. N.J.A.C. 10:49A-2.6(a) lists the specific aggregate amounts to be included in the report. N.J.A.C. 10:49A-2.6(b) lists the specific fees and taxes that must be included in the report. N.J.A.C. 10:49A-2.6(c) allows for a single aggregate amount to be reported by an owner of multiple facilities if the owner uses revenue from some facilities to offset operating losses at other facilities. This subsection describes the requirements the owner must follow when choosing this option. N.J.A.C. 10:49A-2.6(d) requires that expenses not specifically listed in this section are not to be included in the report and includes a non-exhaustive list of examples.

Proposed new N.J.A.C. 10:49A-2.7, Allocation of expenses, describes the requirements related to the classification of expenses within the report. N.J.A.C. 10:49A-2.7(a) requires that each expense be reported in only one category, unless the expense incurred by the facility includes costs that fall into multiple categories, in which case, the expense should be allocated among the appropriate categories. N.J.A.C. 10:49A-2.7(b) requires that expense allocations must be based on a generally accepted accounting principles (GAAP) method consistent with GAAP that is expected to yield the most accurate results and that the report must include a detailed description of the methods used to achieve this requirement. N.J.A.C. 10:49A-2.7(c) explains how to address reporting shared expenses between facilities. N.J.A.C. 10:49A-2.7(e) requires the facility to maintain the data and supporting information used to allocate expenses and to make such data and information available to the Department, upon request.

Proposed N.J.A.C. 10:49A-3, Rebate and Audit Requirements, has four sections, as described below.

Proposed new N.J.A.C. 10:49A-3.1, Calculating and providing the rebate, describes the calculation of the rebate using the reported revenue and expenses. N.J.A.C. 10:49A-3.1(a) requires the facility to provide a rebate to the Department if the facility has a PCR of less than 90 percent and defines the Department as the "payer" for purposes of the rebate calculation. N.J.A.C. 10:49A-3.1(b) requires that all percentage calculations be rounded to three decimal places and describes the process. N.J.A.C. 10:49A-3.1(c) requires that all dollar amount calculations be rounded to two decimal places and describes the process. N.J.A.C. 10:49A-3.1(d) describes how to determine the payer's cost share percentage and requires the percentage to be rounded as described at subsection (b). N.J.A.C. 10:49A-3.1(e) describes how to determine the payer's share of expenses and requires the result to be rounded as described at subsection (b). N.J.A.C. 10:49A-3.1(f) describes how to determine the facility's PCR and requires the PCR to be rounded as described at subsection (b). N.J.A.C. 10:49A-3.1(g) restates the requirement that a facility provide a rebate to the payer if the facility's PCR does not meet or exceed 90 percent and describes how the rebate percentage is calculated.

Proposed new N.J.A.C. 10:49A-3.1(h) describes the formula for calculating the dollar amount of the rebate to be provided. There are five paragraphs that describe rounding the amounts of the payment: that 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, payment method of the rebate, how State payments to facility owners will be withheld to collected unremitted rebates, and a *de minimis* exception if the calculated rebate is less than $1,000.00. N.J.A.C. 10:49A-3.1(i) provides an example calculation. N.J.A.C. 10:49A-3.1(j) allows the facility to request of the Department permission to defer some or all of the rebate payments due if a State entity with a financial audit and/or investigatory authority determines that the payment of the rebates owed shall result in the facility having an insufficient cash balance to continue to operate. N.J.A.C. 10:49A-3.1(k) affirms that, at a minimum, the Department requires all reports to be submitted timely and in compliance with the proposed rules and explains that, 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 these requirements.

Proposed new N.J.A.C. 10:49A-3.2, Audits of a facility, describes the requirements related to audits of the facility to be conducted by the Department or an authorized representative of the Department. The

section describes the audit process, including the actions and responsibilities of the Department and the facility concerning the findings, and any corrective action that may be needed as a result of the audit findings.

Proposed new N.J.A.C. 10:49A-3.3, Access to facilities, addresses the requirements of facilities to allow access to their locations and records. N.J.A.C. 10:49A-3.3(a) requires facilities to allow 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 access to the facility and all records and data for legitimate purposes such as evaluations, inspections, or audits. N.J.A.C. 10:49A-3.3(b) requires that each facility guarantee and allow the same access and entry to the computer and other electronic systems of its parent organization, subsidiaries, related parties, contractors, subcontractors, agents, or a transferee that pertains to the data required to be maintained and reported in accordance with this chapter. N.J.A.C. 10:49A-3.3(c) describes the required timeframes related to audits. A State audit entity may inspect or audit a facility up to six years from the date of facility filing the report, as determined by the timestamped confirmation that the Department provides, or up to three years after completion of the original audit. Subsection (c) also states the reasons that may result in extended time periods for audits.

Proposed new N.J.A.C. 10:49A-3.4, Recordkeeping, contains the recordkeeping requirements of the chapter.

Proposed new N.J.A.C. 10:49A-3.4(a) describes, in detail, the type of documentation and records that must be maintained by the facility.

As the Department has provided a 60-day comment period on this notice of proposal, this notice is excepted from the rulemaking calendar, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

There are approximately 380 nursing facilities in New Jersey that accept at least some Medicaid/NJ FamilyCare beneficiaries. The proposed new rules seek to ensure that facilities are accountable for using State and Federal Medicaid funds in support of quality resident care and appropriate facility management.

Economic Impact

The proposed new rules may result in a small amount of General Fund revenue depending on the volume and number of rebates received from facilities that do not meet the required 90 percent or higher patient care ratio. There is no anticipated change in the volume or cost of services provided. Facilities may incur an economic impact dependent on whether, and by how much, their patient care ratio is below 90 percent.

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 proposed new rules do not exceed Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the proposed new rules will result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

Since the proposed new rules concern patient care ratio reporting and rebate requirements for nursing facilities that provide services to eligible Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that the proposed new rules will have no impact on the agriculture industry in the State of New Jersey.

Regulatory Flexibility Analysis

There are approximately 380 nursing facilities in New Jersey affected by the proposed new rules, some of which may be considered small businesses within the meaning of the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., because they employ fewer than 100 full-time employees.

Medicaid/NJ FamilyCare providers are currently required by law to maintain records necessary to fully document the name of the recipient to whom the service was rendered, the date of the services rendered, the nature and extent of each service rendered, and any additional information that the Department may require by rule. See N.J.S.A. 30:4D-12. The Department anticipates an increase in the existing reporting and recordkeeping requirements for nursing facilities because the proposed new rules require that a facility keep such records as needed to allow that facility to report and calculate its patient care ratio, as described in the Summary above, as well as to support any associated rebate made to the Medicaid/NJ FamilyCare program.

The Department has attempted to minimize any adverse economic impact on small businesses by requiring only the level of recordkeeping, compliance, and reporting requirements necessary to ensure the safety of the beneficiaries and to comply with P.L. 2020, c. 89. In general, providers will only need to compile information that is already maintained in the normal course of business.

The Department has determined that there should be no differentiation based on business size for the proposed new rules, in light of the need to protect nursing facility residents and ensure consistent quality of care and consistent standards in all facilities throughout the State.

Housing Affordability Impact Analysis

Since the new rules concern patient care ratio reporting and rebate requirements for nursing facilities that provide services to eligible Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that the proposed new rules will have no impact on the affordability of housing nor will it have an impact on average costs associated with housing.

Smart Growth Development Impact Analysis

Since the proposed new rules concern patient care ratio reporting and rebate requirements for nursing facilities that provide services to eligible Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that the proposed rulemaking will have no impact on housing production within Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan and will have no impact on smart growth.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

Since the proposed new rules concern patient care ratio reporting and rebate requirements for nursing facilities that provide services to eligible Medicaid/NJ FamilyCare beneficiaries, the Department anticipates that the proposed new rules will have no impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State.

Full text of the proposed new rules follows:

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, 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 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 each transaction 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 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, 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 residents;

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;

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.

(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 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 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.

INSURANCE

(a)

DEPARTMENT OF BANKING AND INSURANCE

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Individual Health Benefits Plans

Proposed Amendments: N.J.A.C. 11:20 Appendix Exhibits A and B

Authorized By: New Jersey Individual Health Coverage Program Board, Ellen DeRosa, Executive Director.

Authority: N.J.S.A. 17B:27A-2 through 16.5.

Calendar Reference: See Summary below for explanation of inapplicability of calendar requirement.

Proposal Number: PRN 2021-039.

As required at N.J.S.A. 17B:27A-16.1, interested parties may testify with respect to the standard health benefits plans set forth at N.J.A.C. 11:20 Appendix Exhibits A and B at a **public hearing** to be held at 10:00 A.M. on Wednesday, March 31, 2021, by teleconference in accordance with P.L. 2020, c. 11, using the following teleconference information: Dial-in number 888-204-5984; Access Code: 3649940#.

Submit comments by April 7, 2021, to:

Ellen DeRosa
Executive Director
New Jersey Individual Health Coverage Program Board
PO Box 325
Trenton, NJ 08625-0325
Email: ellen.derosa@dobi.nj.gov

The agency proposal follows:

Summary

The Individual Health Coverage (IHC) Program was established in accordance with P.L. 1992, c. 161. The IHC Program is administered through a Board of Directors (Board or IHC Board). The primary functions of the IHC Program and its Board are the creation of standard health benefits plans (standard plans) to be offered in the individual market in New Jersey and the regulation of the individual health coverage market. There are five standard plans, which have been established through rule, and are set forth at Exhibits A and B of the Appendix of N.J.A.C. 11:20. The rules for the IHC Program, along with Exhibit C, provide explanations of how certain variables in the standard plans may be used by carriers.

The IHC Board proposes the following amendments to the standard plans at N.J.A.C. 11:20 Appendix Exhibits A and B.

To comply with the requirements of P.L. 2019, c. 472, which requires carriers to limit the cost sharing liability for prescription drugs under certain plans, the Board proposes amendments to the specimen schedule pages to illustrate the maximum amount a covered person can be required to pay for a 30-day supply of a covered prescription drug.

To comply with the requirements of P.L. 2019, c. 58, the Board proposes the following amendments to the definitions section:

- The definition of developmental disability, which is also referred to as neurodevelopmental disability is amended to refer to a neurodevelopmental disorder as referenced by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), and any subsequent editions. The IHC Board notes that the replaced definition was taken from a 1985 law and assumed a distinction between mental and physical impairments. Pursuant to P.L. 2019, c. 58, and the DSM-5, such a distinction does not exist for developmental disability.
- A definition of Mental Health Condition consistent with the definition in P.L. 2019, c. 58, is added and replaces the previously defined term Mental Illness.
- The term Mental Health Conditions replaces Mental Illness in various definitions and wherever the term appears throughout the forms.
- A definition of Same Terms and Conditions consistent with the definition in P.L. 2019, c. 58, is added.

The definition of Generic Drug is amended to include variable text a carrier may elect to include stating that an "authorized generic drug" is not a generic drug. The U.S. Food and Drug Administration uses the term authorized generic drug to identify an approved brand name drug that is marketed without the brand name on the label. Although the term includes the word generic, an authorized generic drug is not a generic drug, and the cost sharing a carrier applies to an authorized generic drug will not necessarily be generic drug cost sharing.

To address the requirements of P.L. 2019, c. 343, regarding breastfeeding support, the definition of practitioner is expanded to include lactation consultants and lactation counselors.