RULE PROPOSALS

INTERESTED PERSONS

Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until the date indicated in the proposal. Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

The required minimum period for comment concerning a proposal is 30 days. A proposing agency may extend the 30-day comment period to accommodate public hearings or to elicit greater public response to a proposed new rule or amendment. Most notices of proposal include a 60-day comment period, in order to qualify the notice for an exception to the rulemaking calendar requirements of N.J.S.A. 52:14B-3. An extended comment deadline will be noted in the heading of a proposal or appear in subsequent notice in the Register.

At the close of the period for comments, the proposing agency may thereafter adopt a proposal, without change, or with changes not in violation of the rulemaking procedures at N.J.A.C. 1:30-6.3. The adoption becomes effective upon publication in the Register of a notice of adoption, unless otherwise indicated in the adoption notice. Promulgation in the New Jersey Register establishes a new or amended rule as an official part of the New Jersey Administrative Code.

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

The County Option Hospital Fee Pilot Program

Proposed New Rules: N.J.A.C. 10:52B

Authorized By: Carole Johnson, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-1 et seq., 30:4D-7r through 7x, and 30:4J-8 et seq.; and P.L. 2018, c. 136.

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

Agency Control Number: 19-P-03.

Proposal Number: PRN 2019-135.

Submit comments by December 6, 2019, to:

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Division of Medical Assistance and Health Services
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The agency proposal follows:

Summary

The Department of Human Services (Department) is proposing a new chapter, N.J.A.C. 10:52B, to implement The County Option Hospital Fee Pilot Program.

The new chapter will establish The County Option Hospital Fee Pilot Program (the pilot program) pursuant to P.L. 2018, c. 136 (the Act). The purpose of the pilot program is to increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals in providing necessary services to low-income residents. The pilot program shall be in effect for a period of five years from the effective date of P.L. 2018, c. 136, April 30, 2019, therefore, the pilot program will end on April 30, 2024.

The Act limits eligibility to participate to a maximum of seven counties and delineates criteria for eligibility. The Act authorizes each participating county to impose a local health care-related fee on hospitals within its borders. Should the county choose to transfer fee proceeds to the Department, those fee proceeds will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the participating counties that serve these residents. A small portion of the funding transferred to the Department will be used to cover the direct costs of administering the program. Funds generated under the pilot program and transferred to the Department will be combined with matching Federal Medicaid dollars and distributed to hospitals in participating counties through the existing Medicaid/NJ FamilyCare managed care organizations (MCOs) or directly to hospitals using fee-for-service payments, or a combination of the two mechanisms, at the Department's discretion. County participation in the pilot program is dependent on receiving all necessary State and Federal approvals and can be for one or more years. As this is a pilot program, a participating county can determine to change its plan, as described in a document entitled the "fee and expenditure report," from year-to-year based on experience. However, if it wishes to do so, it must repeat the process related to receiving State and Federal approval.

The fees must be applied broadly to hospital providers in the county in a uniform manner subject to a maximum dollar amount, and proposed funding enhancements must not directly or indirectly guarantee to hold hospitals harmless for all or any portion of the fee amount, in accordance with the complex regulatory and statutory provisions that govern these fees as outlined at 42 U.S.C. § 1396b and 42 CFR 433.68.

The county's proposed fee and expenditure report must include the financial calculations necessary for the Department to determine whether payments to any hospital under the proposed plan, when combined with other Medicaid and disproportionate share hospital (DSH) payments, such as Charity Care funding, can be reasonably expected to exceed the Federal maximum hospital-specific disproportionate share (DSH) limit as outlined in 42 U.S.C. § 1396r-4. County proposals that generate payments in excess of these limits must include certain additional documentation from affected hospitals that authorize payment reductions necessary to mitigate the risk of non-compliance with the Federal DSH limit.

The proposed rules lay out the steps that eligible counties must take in order to qualify to participate in the pilot program and explain how the Department proposes to exercise its authority to approve or deny a county's proposal to participate. Additionally, the rulemaking outlines the procedure the Department would follow in implementing the pilot program.

New Jersey is among the first states in the country to launch a County Option Hospital Fee Pilot Program. The Department acknowledges that the implementation of any new program may present unanticipated situations. The Department will maintain communication regarding this program with the counties and the hospitals and if the need for additional guidance is identified, that guidance will be provided in a timely manner and additional rules will be promulgated as necessary. For example, the Department plans to provide examples of a fee and expenditure report that will outline the key program parameters that will need to be defined by each county fee and expenditure report.

New N.J.A.C. 10:52B, The County Option Hospital Fee Pilot Program, is proposed to be organized into three subchapters: N.J.A.C. 10:52B-1,

General Provisions, 10:52B-2, Participation Requirements, and 10:52B-3, Financial Requirements.

Proposed N.J.A.C. 10:52B-1.1(a) and (b) describe the scope and purpose of the chapter as setting forth the policies and procedures for eligible counties that wish to participate in the pilot program and explain that the pilot program will increase resources available to hospitals within those counties through the Medicaid/NJ FamilyCare programs to serve residents with lower incomes.

Proposed N.J.A.C. 10:52B-1.2 defines the following terms used in the chapter: "Act," "affected hospital," "Centers for Medicare and Medicaid Services (CMS)," "Commissioner," "Department," "days," "eligible county," "fee," "hospital," "intergovernmental transfer (IGT)," "intergovernmental agreement (IGA)," "Medicaid/NJ FamilyCare program," "non-Federal share," "participating county," "pilot program," and "proposed fee and expenditure report."

Proposed N.J.A.C. 10:52B-2.1 contains the requirements for the authorization and implementation of a hospital fee by a county.

Proposed N.J.A.C. 10:52B-2.1(a) sets forth the conditions under which a county may be authorized to implement a pilot program. These conditions include: (1) submitting a fee and expenditure report to the Department for approval; (2) the Department making the report available for review and comment for a period of 21 days; and (3) a provision that the Department may request the county to make amendments to the proposed report to comply with State requirements or to address comments received during the comment period.

Proposed N.J.A.C. 10:52B-2.1(b) lists all of the conditions that must be met in order for the proposed fee and expenditure report to be eligible for approval. These conditions are: (1) the plan described in the fee and expenditure report must increase financial resources to support local hospitals; (2) the proposed fee must comply with 42 U.S.C. § 1396b(w)(3)(A); (3) the plan described in the fee and expenditure report will not create a direct or indirect guarantee to hold affected hospitals harmless as those terms are used in 42 CFR 433.68(f); (4) the fee will not exceed the maximum revenue amount specified at 42 CFR 433.68(f)(3) minus three and one-half percent of total net patient revenues as defined therein; (5) the revenues collected shall qualify as the non-Federal share of the Medicaid/NJ FamilyCare program expenditures; (6) the financial impact of the plan described in the fee and expenditure report shall not reduce access to Medicaid/NJ FamilyCare services or threaten critical care services at any hospital within the county; (7) the fee and expenditure report must meet all provisions of this chapter; and (8) all good faith efforts will be made by the county to ensure that payments to be made under the proposed report will not result in any hospital exceeding its hospital-specific disproportionate share (DSH) limit, consistent with Federal statutes and regulations.

Proposed N.J.A.C. 10:52B-2.1(c) states that the Department shall make an approval determination after review of the fee and expenditure report and consideration of any comments received.

Proposed N.J.A.C. 10:52B-2.1(d) requires the county board of chosen freeholders in the participating county to enact an ordinance or resolution, as appropriate to the county's form of government, imposing the fee.

Proposed N.J.A.C. 10:52B-2.1(e) states that if a waiver is required due to Federal regulations at 42 CFR 433.68(e), the Department will notify the county if, and when, CMS approval is received.

Proposed N.J.A.C. 10:52B-2.1(f) states that the Department will notify the county that it has received CMS approval for the collected fee to be used as the non-Federal share of expenditures for new provider payments.

Proposed N.J.A.C. 10:52B-2.1(g) states that the fee may only be collected from the assessed hospitals to the extent that the Department determines that the fee proceeds qualify as the non-Federal share of the expenditures pursuant to Federal regulations at 42 CFR 433.68.

Proposed N.J.A.C. 10:52B-2.1(h) requires that the fee shall be collected, and the proceeds used in accordance with the approved report, unless an amendment to the report is approved by the Department's Commissioner prior to the implementation of any changes. A county's fee and expenditure report may be approved for one or more years until the end of the five-year pilot program and can be amended annually by the county during that time; however, all changes must be approved by the Department and CMS prior to implementation.

Proposed N.J.A.C. 10:52B-2.2(a) lists the required elements of the county ordinance or resolution, which must include: (1) the process for communicating with affected hospitals and collecting feedback and comments on the county proposal; (2) identification of the hospitals subject to the proposed fee; (3) identification of the revenue or other metric that the county will use as the basis for assessing the fee and the rate that will be used to assess the hospital fee; (4) an explanation of the notice and collection process; (5) identification of the penalties that may be imposed on affected hospitals for non-payment or late payments; (6) an explanation of the appeals process for hospitals; (7) the uses of the proceeds of the fees; (8) a statement that the fee shall not impact patients or payors; and (9) affirmation that the payments shall not supplant or otherwise offset payments made to hospitals from other sources, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share (DSH) limit consistent with Federal statute and regulations.

Proposed N.J.A.C. 10:52B-3.1(a) requires counties to submit their proposed fee and expenditure report in accordance with instructions specified by the Department and to provide additional information as requested.

Proposed N.J.A.C. 10:52B-3.1(b) requires the county to consult with the affected hospitals in the county before the county submits its report to the Department for review.

Proposed N.J.A.C. 10:52B-3.1(c) contains a list of the required items that must be included in the proposed fee and expenditure reports: (1) an overview of the proposed plan described in the fee and expenditure report; (2) a list of all hospitals in the county and their facility type; (3) the proposed fee methodology; (4) the proposed expenditure methodology; (5) documentation of the data used to develop the plan described in the fee and expenditure report; (6) any proposed exclusions and rationale for those exclusions; (7) a delineation of the percentages of the fee proceeds that the county proposes to transfer to the Department; (8) a prospective hospital-specific disproportionate share payment limit (DSH limit) calculation for each affected hospital; and (8ii) where necessary, an attestation from a hospital's chief executive officer confirming that the hospital agrees to a reduction to the hospital's Medicaid DSH payments, including Charity Care payments, to the extent necessary to comply with payment limits outlined in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

Proposed N.J.A.C. 10:52B-3.1(d) requires that the methodology used to develop the fee must be permitted under applicable Federal regulations. Additionally, paragraphs (d)1, 2, and 3 list the minimum criteria the fee methodology must meet, including that: (1) the county must determine how to apply the fee; the fee may be applied to inpatient and/or outpatient services; (2) the fee must be applied to all hospitals in the county unless the county provides an exemption in compliance with Federal regulations and the Department receives approval of such a waiver or exemption from CMS; and (3) the fee shall be assessed consistent with Federal rules.

Proposed N.J.A.C. 10:52B-3.2 requires that the cost of the fee shall not be passed on to, or listed separately for, any patient or insurer or other responsible party.

Proposed N.J.A.C. 10:52B-3.3(a) describes the permissible uses of the funds by the county.

Proposed N.J.A.C. 10:52B-3.3(a)1 requires that the participating county use at least 90 percent of the fee proceeds to benefit hospitals within the county's borders and describes the procedures that must be followed to make payments to the local hospitals as authorized in the approved fee and expenditure report.

Proposed N.J.A.C. 10:52B-3.3(a)2 states that the county can retain not more than nine percent of the fee proceeds.

Proposed N.J.A.C. 10:52B-3.3(a)3 requires that one percent of the fee proceeds be transferred to the Department for the administration of the pilot program. In addition, if any additional administrative funding is needed for the pilot program, such funding shall be subtracted from the amounts otherwise available as the non-Federal share of payments to the hospitals in the participating county.

Proposed N.J.A.C. 10:52B-3.3(a)4 defines the schedule to be followed regarding the transfer of the collected funds to the State and states that failure to adhere to the timeframe as described may result in penalties imposed by the Department.

Proposed N.J.A.C. 10:52B-3.3(b) lists the purposes for which the Department will use the proceeds transferred from the county and any Federal funding generated. These are: (1) increase Medicaid/NJ FamilyCare payments to hospitals in the participating county; (2) make payments to managed care organizations in the participating county for increased hospital related payments; and (3) administer the pilot program.

Proposed N.J.A.C. 10:52B-3.3(c) prohibits the Department from using the proceeds to supplant or offset current or future State funds allocated to a participating county, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share (DSH) limit.

Proposed N.J.A.C. 10:52B-3.3(d) requires all hospitals to maintain records regarding expenditure of funds and make such records available to the Department, the Department's designated representative, or other authorized agent, upon request.

Proposed N.J.A.C. 10:52B-3.4(a) requires that a county that wishes to participate in the pilot program develop a process for calculating the fee. The process must use either financial data requested from the hospitals or data that is publicly available.

Proposed N.J.A.C. 10:52B-3.4(b) requires that a county that wishes to participate in the pilot program specify the frequency of the collection of fees.

Proposed N.J.A.C. 10:52B-3.4(c) requires that a county that wishes to participate in the pilot program provide written notice of the fee amount at least 20 days in advance of the due date or otherwise define the due dates in the ordinance or resolution.

Proposed N.J.A.C. 10:52B-3.4(d) requires the participating hospital to pay the fee amount by the due date.

Proposed N.J.A.C. 10:52B-3.4(e) and (f) describe the process for how refunds of overpayments shall be returned to the participating hospitals by the counties.

Proposed N.J.A.C. 10:52B-3.5 allows a participating county to impose reasonable penalties or interest if the hospital fails to remit the full amount of the payment owed by the due date. These enforcement provisions must be defined in the county ordinance or resolution and the hospitals must be notified in writing of the appeal process.

Proposed N.J.A.C. 10:52B-3.6(a) requires a participating county to have an appeal process for the hospital to object to the fee amount and that the appeal process must afford the hospital 15 days from the date the notice is received to file an appeal.

Proposed N.J.A.C. 10:52B-3.6(b) requires the participating county to have a process for appeal of the decision of the county to impose penalties.

Proposed N.J.A.C. 10:52B-3.6(c) requires the hospital filing the appeal of either the amount of the fee or the penalty imposed by the county (or both) to provide additional information requested by the county.

Proposed N.J.A.C. 10:52B-3.7(a) requires participating counties, affected hospitals, and managed care organizations to retain supporting documents related to costs and provide them to the Department to assist the Department in: (1) determining the amount of the assessment required to be paid by the managed care organization (MCO) to the hospitals; (2) verifying that the MCO has calculated and paid the correct amount; and/or (3) responding to inquiries from governmental agencies with oversight of the program.

Proposed N.J.A.C. 10:52B-3.7(b) prohibits information and records submitted to the Department to be used for purposes other than those specified in this section.

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

Social Impact

The proposed rules will have a positive social impact on the affected hospitals that treat Medicaid/NJ FamilyCare beneficiaries in the participating counties because the increase in financial resources that will be realized from participation in the pilot program will enable them to continue to provide, and expand, needed medical services to the communities they serve.

The proposed rules will have a positive social impact on Medicaid/NJ FamilyCare beneficiaries who are served by the hospitals in the participating counties because the increase in funding will help to ensure that hospitals will continue to be able to provide services to the beneficiaries. The proposed rules will have no negative social impact on non-Medicaid/NJ FamilyCare patients or payers.

Economic Impact

The proposed rules will have a positive economic impact on the affected hospitals in the participating counties because of the increase in financial resources available since each participating county shall be required to use at least 90 percent of the fee proceeds for the benefit of local hospitals.

Medicaid/NJ FamilyCare beneficiaries will experience a positive economic impact because the affected hospitals will have additional resources to continue to be able to provide, and potentially expand, medical services for residents with low incomes.

The participating counties will experience a positive economic impact because they will receive up to nine percent of the fee proceeds.

There will be no negative economic impact to the State because fee proceeds will be available to the Department to cover all direct costs of administering the pilot program.

Federal Standards Statement

42 U.S.C. § 1396b allows governmental jurisdictions to apply an assessment on health care services and Federal regulations at 42 CFR 433.68 define permissible health care related taxes.

42 U.S.C. § 1396d(a) requires a state Title XIX program to provide inpatient and outpatient hospital services to most eligibility groups. Inpatient and outpatient hospital services are optional services for the medically needy population; however, New Jersey has elected to provide these services to medically needy beneficiaries. Federal regulations at 42 CFR 440.2, 440.10, and 440.20, provide definitions of inpatient and outpatient hospital services.

Title XXI of the Social Security Act (SS 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. Section 2110 of the SS Act, 42 U.S.C. § 1397jj, defines hospital services for the children's health insurance program.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the proposed rules falls within Federal standards. Moreover, the county fee and expenditure reports, and the pilot program more broadly, will require approval by the Federal government before implementation. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department anticipates that the proposed rules will not cause the generation or loss of jobs in the State of New Jersey, for the Department, the counties, or the hospitals.

Agriculture Industry Impact

Since the proposed rules concerns hospital reimbursement, the Department anticipates that there will be no impact on the agriculture industry in the State of New Jersey.

Regulatory Flexibility Statement

The providers affected by the proposed amendments are all hospitals that have more than 100 full-time employees. Therefore, they are not considered small businesses, as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and a regulatory flexibility analysis is not required.

Housing Affordability Impact Analysis

Since the proposed rules concern hospital reimbursement, the Department anticipates that the proposed rules will have no impact on the affordability of housing in New Jersey or on the average cost of housing.

Smart Growth Development Impact Analysis

Since the proposed rules concern hospital reimbursement, the Department anticipates that the proposed rules will have no impact on smart growth or housing production within Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated the proposed rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the proposed new rules follows:

CHAPTER 52B
THE COUNTY OPTION HOSPITAL FEE PILOT PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

10:52B-1.1 Scope and purpose

(a) This chapter sets forth the policies and procedures for eligible counties to participate in The County Option Hospital Fee Pilot Program.

(b) The County Option Hospital Fee Pilot Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ FamilyCare program to support local hospitals and to ensure that they continue to provide the necessary services to residents with low incomes.

10:52B-1.2 Definitions

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

"Act" means The County Option Hospital Fee Pilot Program Act, N.J.S.A. 30:4D-7r et seq.

"Affected hospital" means a hospital that is assessed a fee imposed by a participating county.

"Centers for Medicare and Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services that is responsible for the administration of the Title XIX Medicaid program and the Title XXI Children's Health Insurance Program (CHIP), known in New Jersey as the Medicaid/NJ FamilyCare program.

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

"Days" mean calendar days.

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

"Eligible county" means a county with a population greater than 250,000, according to the 2010 Federal decennial census, that contains a municipality that:

1. Is classified, pursuant to N.J.S.A. 40A:6-4, as a First or Second Class municipality, or a Fourth Class municipality whose population exceeds 20,000; and

2. Has a Municipal Revitalization Index score, as last calculated by the New Jersey Department of Community Affairs prior to April 27, 2019, that exceeds 60.

"Fee" means the local health care-related fee authorized by the Act.

"Hospital" means a hospital that is licensed pursuant to P.L. 1971, c. 136 (N.J.S.A. 26:2H-1 et seq.) and is located within the borders of the participating county.

"Intergovernmental agreement (IGA)" means the agreement between a participating county and the Department through which a transfer of funds is made by the participating county to the Department.

"Intergovernmental transfer (IGT)" means the transfer of funds meeting the requirements of 42 U.S.C. §1396b(w) to the Department by a participating county pursuant to an intergovernmental transfer agreement.

"Medicaid/NJ FamilyCare program" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L. 1968, c. 413 (N.J.S.A. 30:4D-1 et seq.) and P.L. 1997, c. 2 (N.J.S.A. 30:4J-8 et seq.).

"Non-Federal share" means the portion of a Medicaid/NJ FamilyCare expenditure that is financed by State or local funds.

"Participating county" means an eligible county that chooses to participate in the pilot program.

"Pilot program" means The County Option Hospital Fee Pilot Program established by a participating county.

"Proposed fee and expenditure report" means a written report by a participating county that describes how the local health care-related fee authorized pursuant to the Act will be imposed in the participating county; how the funds collected from the fee will be used by the participating county; and how the plan described in the fee and expenditure report satisfies the purposes of the pilot program specified at N.J.A.C. 10:52B-1.1(b).

SUBCHAPTER 2. PARTICIPATION REQUIREMENTS

10:52B-2.1 Authorization and implementation of a county option hospital fee

(a) The Department of Human Services may authorize a county to become a participating county by approving its implementation of a pilot program imposing a fee on hospitals located within the county. Approval is subject to the following procedures:

1. The county shall submit a proposed fee and expenditure report to the Department for review and approval as specified in N.J.A.C. 10:52B-3.1;

2. The Department will make a participating county's proposed fee and expenditure report available for review and comment by affected hospitals and other interested parties for a period of 21 days and will consider the comments received in its review of the proposed report; and

3. The Department may request that a participating county amend its proposed fee and expenditure report if the Department determines that the county's proposal does not meet Federal or State requirements or address comments received during the comment period.

(b) As part of the Department's process to decide whether to approve the proposed fee and expenditure report, the Department shall determine whether the report meets the following requirements, whether:

1. The county's proposed fee and expenditure report will increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals and to ensure that they continue to provide the necessary services to residents with low-income;

2. The county's proposed fee complies with 42 U.S.C. § 1396b(w)(3)(A);

3. The county's proposed fee and expenditure plan described in the fee and expenditure report will not create a direct or indirect guarantee to hold affected hospitals harmless, consistent with 42 CFR 433.68(f);

4. The county's proposed fee will not exceed the aggregate amount specified in 42 CFR 433.68(f)(3) minus three and one-half percent of total net patient revenues, as defined therein;

5. The revenues collected from the fee will qualify as the non-Federal share of Medicaid/NJ FamilyCare program expenditures;

6. The financial impact of the county's proposed fee and expenditure report will reduce access to Medicaid/NJ FamilyCare services, reduce services to the uninsured, or otherwise threaten critical health care services at any hospital within the county, as determined by the Commissioner; and

7. The county's proposed plan described in the fee and expenditure report demonstrates that all good faith efforts will be made by the county to ensure that payments to be made under its proposal will not result in any hospital in the county exceeding its hospital-specific disproportionate share (DSH) limit as outlined in 42 U.S.C. § 1396r-4.

(c) After review of each county's proposed fee and expenditure report and consideration of any comments received during the 21-day public review period, the Department shall make a determination regarding approval for each county's proposed fee and expenditure report.

(d) Once a county's fee and expenditure report is approved, the board of chosen freeholders of the participating county may enact an ordinance or resolution, as appropriate to the county's form of government, imposing the fee and containing the elements specified at N.J.A.C. 10:52B-2.2.

(e) If a waiver is required pursuant to 42 CFR 433.68(e) to implement the county's approved fee and expenditure report, the Department will notify the county when the approval of such waiver is received from CMS.

(f) If revenue collected from the fee will be used as the non-Federal share of expenditures for new Medicaid/NJ FamilyCare provider payments, the Department will notify the county that it has received CMS approval for new Medicaid/NJ FamilyCare provider payments.

(g) A fee may only be collected from assessed hospitals to the extent, and for the period that, the Department determines that the fee proceeds qualify as the non-Federal share of Medicaid/NJ FamilyCare program expenditures pursuant to 42 CFR 433.68.

(h) A fee shall be collected and the proceeds from the fee shall be used in accordance with a participating county's approved fee and expenditure report.

1. A participating county may propose to amend its approved fee and expenditure report annually by submitting a proposed amendment to its fee and expenditure report to the Commissioner for review and approval. Any amendments must be approved by the Commissioner and have received any required Federal approvals before any changes are implemented.

2. Any amendment to a participating county's approved fee and expenditure report shall be subject to the requirements and process specified in this chapter.

3. Revenues from the imposition of a fee must be used as specified at N.J.A.C. 10:52B-3.3.

10:52B-2.2 Required elements of county ordinance or resolution

(a) In order for an eligible county to participate in the pilot program, the county may enact a county ordinance or resolution, as appropriate to the county's form of government, that clearly defines the following:

1. The process for communicating with affected hospitals and collecting feedback and comments on the county proposal;

2. Which hospitals are subject to the fee;

3. The revenue or other metric that will be used as the basis for the fee and the rate that will be used to assess the hospital fee;

4. The notice and collection process;

5. Penalties that may be imposed for nonpayment or late payment;

6. The appeals process;

7. Use of fees for administrative costs, transfers for State administrative costs, and transfers to finance Medicaid/NJ FamilyCare payments to county providers;

8. A statement that there will be no impact on patients or payers; and

9. Affirmation that payments made under the pilot program will not supplant or otherwise offset payments made to hospitals from other sources, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share (DSH) limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

SUBCHAPTER 3. FINANCIAL REQUIREMENTS

10:52B-3.1 Fee and expenditure report; appropriate fee methodology

(a) A participating county must submit a proposed fee and expenditure report to the Department for review in accordance with instructions specified by the Department. The fee and expenditure report shall describe the county's plan for imposing fees and making expenditures from those fees and include such information as may be required by the Department to determine whether the county's report satisfies the requirements at N.J.A.C. 10:52B-2.2.

(b) A participating county shall consult with affected hospitals located in the county to develop its proposed fee and expenditure report prior to submission to the Department.

(c) A participating county's proposed fee and expenditure report must include, at a minimum, the following:

1. An overview of the fee and expenditure plan described in the fee and expenditure report;

2. A list of all the hospitals within the jurisdiction and their facility type (acute care, psychiatric, rehabilitation, long-term acute care hospital, etc.);

3. The proposed fee methodology;

4. The proposed expenditure methodology;

5. Source documentation for the data used to create the fee and expenditure report (for example, Medicare or Medicaid/NJ FamilyCare cost report, survey data, etc.);

6. Any and all facilities the county requests to exclude from the fee with the rationale for those exclusions;

7. A delineation of the percentage of the fee proceeds that the county proposes to:

i. Transfer to the Department to cover State administrative costs; and

ii. Transfer to the Department to be used as non-Federal share of Medicaid/NJ FamilyCare payments to hospitals in the participating county; and

8. A submission of the county's prospective hospital specific disproportionate share payment limit (DSH limit) calculation with supporting documentation for each hospital subject to the hospital fee. The DSH limit is the difference between a hospital's costs for treating Medicaid and uninsured individuals minus Medicaid payments and minus any payments received on behalf of the uninsured.

i. The DSH limit must:

(1) Be calculated in a form and in accordance with instructions specified by the Department;

(2) Be based on the data from the most recent Federal DSH audit;

(3) Use the Inpatient Prospective Payment System (IPPS) Hospital Market Basket as published by CMS to trend costs to the current fiscal year, unless hospital documentation verifies a different cost inflation for the hospital;

(4) Exclude any proposed payments to be made under the pilot program;

(5) Adjust for any changes in Federally matched State subsidy payments since the time of the finalized DSH audit used in the calculation (that is, Charity Care, Graduate Medical Education); and

(6) Be approved by the Department. The Department reserves the right to discount any values included in the calculation that are not supported by appropriate documentation.

ii. Should the county's fee and expenditure report include provisions that would result in increased Medicaid/NJ FamilyCare payments for any hospital that exceed the calculated value of the hospital's DSH limit, the county's proposed fee and expenditure report must include an attestation from the specific hospital's chief executive officer confirming that the hospital is agreeing to a reduction to the hospital's Medicaid DSH payments, including Charity Care payments, to the extent necessary to comply with payment limits outlined in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4). The Department reserves the right to take all appropriate action to comply with Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(d) A participating county's proposed fee and expenditure report must describe the fee methodology that the county is proposing to adopt. An appropriate fee methodology is any methodology that is permitted under applicable Federal regulations and that meets the following criteria:

1. The county must determine how to apply the fee; the fee may be applied to inpatient hospital services, outpatient hospital services, or both;

2. The fee must be applied to all hospitals uniformly, except that the participating county may exempt hospitals within the county that provide the assessed service from the fee, provided that the exemption complies with the requirements of 42 CFR 433.68(c) and (d), and the Department requests and receives approval of the waiver of the broad-based and/or uniform requirements from CMS; and

3. The fee shall be assessed consistent with Federal rules, with the basis of the assessment being: net or gross revenues, discharges, encounters, days, beds, or visits, and may exclude revenue or utilization attributable to Medicaid/NJ FamilyCare, Medicare, or both.

10:52B-3.2 No impact on patients or payers

The chief executive officer of each hospital subject to the fee shall certify that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

10:52B-3.3 Permissible use of funds

(a) A participating county shall use funds collected from the imposition of a fee as follows:

1. The participating county shall use at least 90 percent of the fee proceeds for the benefit of hospitals located in the county, as follows:

i. The participating county shall make an intergovernmental transfer (IGT) of the funds under an intergovernmental agreement (IGA) with the Department authorizing the Department's use of the funds as the non-Federal share of Medicaid/NJ FamilyCare payments to the local hospitals; or

ii. The participating county may retain the funds and use the funds to make payments to local hospitals as authorized in its approved fee and expenditure report. However, the Commissioner shall only approve a participating county's proposal to retain funds collected from the imposition of a fee provided that the participating county demonstrates, to the satisfaction of the Commissioner, that the county has sufficient funds

to make payments to local hospitals in the amount of the fee proceeds that would otherwise have been transferred to the Department, plus an amount equal to the Federal matching funds that would have been paid to the Department had the fee proceeds been used as the non-Federal share Medicaid/NJ FamilyCare payments;

2. A participating county may retain no more than nine percent of the proceeds for its own use;

3. The county shall transfer at least one percent of assessment proceeds to the Department for the cost of administering the program. Should the State's administrative costs for the program exceed the total value of funding transferred by the participating counties for this purpose, remaining costs shall be subtracted from amounts otherwise available as the non-Federal share of payments to hospitals in the participating counties; and

4. Unless the county has received approval to retain funds pursuant to (a)1ii above, the county shall transfer all funds to the State on a quarterly basis, not later than 15 days after the close of each quarter of the State fiscal year. Failure to transfer the funds within this timeframe shall result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding transfer amount per month and/or removal from the pilot program.

(b) The Department shall use the fee proceeds transferred from a participating county, and any Federal matching funds or other Federal funds generated therefrom, for the following purposes, the Department may:

1. Increase Medicaid/NJ FamilyCare payments to hospitals located in the participating county;

2. Make payments to Medicaid/NJ FamilyCare managed care organizations operating in the participating county for increased hospital or hospital-related payments; or

3. Use the funds for costs directly related to the administration of the pilot program.

(c) The Department shall not use the transferred fee proceeds to supplant or offset any current or future State funds allocated to a participating county, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share (DSH) limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C § 1394r-4).

(d) All hospitals shall maintain records regarding expenditure of funds and make such records available to the Department, the Department's designated representative, or other authorized agent, upon request.

10:52B-3.4 Notice, collection, and return of fee proceeds

(a) Each participating county must develop a process to calculate the amount of the fee to be applied to each participating hospital in compliance with this chapter and Federal rules. The county may require submission of necessary financial data by the participating hospitals, or the county can choose to use other publicly available data sources.

(b) A participating county must specify in its ordinance or resolution, the frequency of collection of the fee (for example, quarterly, monthly, biannually, etc.).

(c) The participating county must provide written notice of the fee amount to each participating hospital postmarked at least 20 days in advance of the due date or define the due date in its ordinance or resolution.

(d) Each participating hospital will pay the fee amount indicated by the county on the specified due date.

(e) Each participating county will provide for refunding of overpayments, or amounts otherwise in error, to the participating hospitals within 15 days of identifying the overpayment or error. The participating county shall specify in its ordinance or resolution the maximum time limit by which a hospital must identify overpayments or amounts otherwise in error.

(f) In the event the Department returns to the participating county any of the transferred funds, the participating county will refund the full amount returned by the Department to the participating hospitals based on the pro rata share of the total fees paid, within 15 days after receipt by the county of the funds from the Department.

10:52B-3.5 Penalties

A participating county may impose reasonable penalties or interest if an affected hospital fails to remit the full amount of the payment owed by the due date specified, not to exceed 1.5 percent of the outstanding payment amount per month. Any enforcement provision must be defined in the county's ordinance or resolution enacting the Department-approved fee and expenditure reports and include provisions for written notice to the participating hospitals and intended use of the funds consistent with the purpose of this chapter.

10:52B-3.6 Appeal of assessment or enforcement action

(a) A participating county must specify a process for an appeal of the fee amount. The appeal shall be filed with the county within 15 days after the participating hospital receives notice of the fee amount due.

(b) A participating county must specify a process for an appeal of the decision to impose penalties and/or the amount of the penalties assessed pursuant to N.J.A.C. 10:52B-3.5.

(c) A hospital filing an appeal of either the amount of the fee or the penalty imposed by the county, or both, must provide any additional information requested by the county as part of the appeal process.

10:52B-3.7 Reports and access

(a) Participating counties, affected hospitals, and managed care organizations are required to retain supporting documents and shall provide access to and shall furnish such reports to the Department, without charge, as the Department may specify, in order for the Department to:

1. Determine the amount of increased funding required to be paid by the managed care organizations to the hospitals;

2. Verify that the managed care organization has calculated and paid the correct amount due; or

3. Respond to inquiries from governmental entities with oversight of the pilot program, including CMS.

(b) Information and records submitted to the Department under this section shall be used only for the purposes specified in this section.