

**Date:** 3 / 19 / 2025

**Subject:** New Jersey County Option Hospital Fee Program Fee and Expenditure Report

**County:** Hudson County

## GENERAL

Describe the proposed hospital fee program the county intends to enact by providing details on all of the elements listed below.

## FEE PROGRAM

1. What is the county's proposed effective date of the fee program?

July 1, 2025

2. List of all licensed hospitals located in your county:

Please Include: Name, address, facility ownership (for profit, NFP or government owned) **and** type of facility (acute care, psychiatric, rehabilitation, children's, LTACH, Specialty)

Please see "Attachment A" for full list of hospitals located in Hudson County.

3. Federal law and regulations require all hospitals in a jurisdiction to be taxed, unless a specific process is followed to exempt particular hospitals – a process that includes meeting a statistical test.

Does the county plan on excluding any hospitals from the fee program? ☒ No ☐ Yes

If so, please list name(s) and type of facility:

Please note that Hudson County Meadowview Psychiatric Hospital, a public psychiatric hospital, is not being included in the fee. However, pursuant to 42 CFR 433.68(c)(1), a provider assessment is considered to be "broad based" if it is imposed on all providers of the applicable services "furnished by all non-Federal, non-public providers...". Notwithstanding the exclusion of Meadowview, the county's proposed fee will be imposed on all non-Federal, non-public providers of inpatient hospital services, and therefore no waiver is necessary and the staticstical test is not required.

4. If the county plan **proposes to exempt** particular hospitals/classes of hospitals, please provide a policy justification for excluding those specific hospitals/classes of hospitals from the fee program. (If not, please leave blank)

5. The law creating the County Option Hospital Fee Program requires that counties consult with affected hospitals within their jurisdiction prior to submitting the Fee and Expenditure Report to the Commissioner of Human Services. Please detail when and how county officials consulted with affected hospitals.

Beginning with the first program year, the County through its contractor, Eyman Partners, implemented a comprehensive process of educating, consulting, and gathering feedback from all hospitals within the jurisdiction, and developing criteria used to evaluate potential models. Those criteria continue to inform the process for the current year. For SFY2026 the County has collected updated data from the hospitals to reevaluate the model (both assessment and payment bases) and has involved the hospitals throughout. Due to hospital issues causing delay in the modeling process, we met with hospitals to consider a limited slate of models for the 2026 program year. We shared this information with the hospitals by email and call and gathered feedback to inform the design of the program for SFY26. We also provided support for hospitals in completing all required forms.

6. Please describe the basis of the proposed fee – e.g. net patient revenue, days of care, discharges? (N.J.A.C. 10:52B)

The County proposes to assess a fee on inpatient hospital services, structured as a per diem fee, for services furnished within the County's jurisdiction. The County proposes to use calendar year 2023 data, inflated through SFY2026, as the source for calculating the fes.

7. Will the basis for the proposed fee exclude Medicare and /or Medicaid data?

No.

8. What is the proposed fee rate or fee amount?

Please specify if different fee rates or amounts will be applied to inpatient versus outpatient services and identify respective notes/ amounts.

The proposed assessment rate will be \$329.68 per day.

9. Will the same fee rate or fee amount apply to all hospitals included in the fee program? ☐ No ☒ Yes

If not, please describe which fee rate or amount is proposed to be applied to each hospital and the policy rationale.

10. If the fee program is not uniform or broad based, one or more statistical tests must be passed for the fee to comply with federal regulations. If the proposed fee program is **not broad-based** or **not uniform**, please provide a copy of the federally compliant statistical test(s) in an excel document. ☒ N/A ☐ Attached

Information on federally compliant statistical test (s) can be accessed at 42 CFR § 433.68

- Permissible health care-related taxes.

<https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/xml/CFR-2018-title42-vol4-sec433-68.xml>

11. While the transfers to the state from the county must occur quarterly, what is the planned timing for collecting the fee – quarterly, monthly, biannually?

☒ Quarterly ☐ Monthly ☐ Biannually ☐ Other \_\_\_\_\_

12. What interest and/or penalties will be imposed for failure to pay the fee?

In the event a hospital fails to remit the fee by the due date, the County will add interest to the amount due, not to exceed 1.5% of the outstanding payment amount per month, reflected on to the following quarter's invoice. If a hospital fails to pay for more than 30 days, the County may apply a lien or collect payment by any legally available means.

13. What appeal process will be established to resolve any disputes related to the fee program?

Upon federal approval of the program, the County will officially notify hospitals that the fee program will take effect, and of the amount of the quarterly fee they will be required to pay throughout the program year. The hospitals will have 15 days from receipt of that notice to contest the fee amount, by submitting a letter, including any supporting documents, to the County specifying the basis for the appeal. Hospitals subject to interest penalties will have 15 days from receipt of an assessment notice including such fees to appeal the decision to impose interest and/or the amount of the interest, by the same process.

14. How will hospitals be notified of their fee obligation and any other related operational requirements under the fee program?

The County will distribute annual notice of the fee amounts to each hospital upon CMS approval of the preprint and will send each hospital quarterly invoices notifying them of their fee obligation and the payment deadline at least 20 days in advance of each quarterly due date.

15. Please provide any additional pertinent information that you believe would be helpful in describing the program.

This Fee & Expenditure report was prepared by the County's contractors who have nationwide experience working with these types of programs. The County has relied extensively on their expertise in developing the model, responding to these questions and assuring compliance with state and federal rules. The signed certification below relies in large part on the work and advice of the contractors.

## PROPOSED PAYMENT PROGRAM

As part of the program, counties may submit a proposed payment methodology detailing how program funds will be distributed to hospitals and the basis of the distribution. However, as the single State agency for the Medicaid Program, the Department's role is to review the proposed programs to assure that the assessment design and proposed expenditure methodology, if provided, comply with federal regulations governing such programs. A county's proposed payment method must include details on elements listed below.

### 1. What is the proposed basis for determining the hospital payment amounts?

The County proposes a state directed payment to be implemented as a uniform increase to Medicaid Managed Care payments for inpatient hospital services provided by acute care hospitals in Hudson County. The increase in payments for inpatient hospital services would be implemented as a per discharge add-on of \$22,491.98.

The payments have been calculated using an estimated Federal Medical Assistance Percentage (FMAP) of 68.64%. We began by calculating the FMAP based on the mix of Medicaid, expansion and CHIP patients in the state's CY2023 data.

The payment methodology would be the same for all hospitals, thereby directing the expenditures equally, using the same terms of performance, as required by 42 CFR 438.6(c)(2)(ii)(B). Details of the calculation of this payment methodology are contained in the attached model, prepared by the County's contractors, who can be available to the state to answer any questions about it or provide additional information as needed.

The directed payments would be provided on a quarterly basis, paid to the managed care organizations as a separate payment term (apart from monthly capitation payments to the plans). The four quarterly payments would each be equal to 25% of the projected annual rate increase amount (which is estimated in the attached model, based on the state's CY2023 encounter data forwarded to the County by DMAHS on 9/30/24). A final reconciliation adjustment would be determined after the end of the year, based on actual services provided, keeping the relative distribution of payments across the general acute and specialty hospital classes as modeled. In this way, the payments would meet the federal requirement at 42 CFR 438.6(c)(2)(ii)(A) that directed payments be "based on the utilization and delivery of services."

### 2. The purpose of the County Option Hospital Fee Program is to increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals and to ensure that they continue to provide necessary services to low-income residents. How will the payments be utilized to effectuate this purpose?

The resources generated from the County Option Hospital Fee Program will help to stabilize the hospitals' financial positions, particularly in view of the low base Medicaid rates in the state compared to the average commercial rate, and, consequently, will strengthen their capacity to provide access to quality comprehensive and essential healthcare services to low-income County residents as well as encourage the hospitals to expand their provision of Medicaid services.

## OTHER COUNTY REQUIREMENTS

### CHECK BOX TO CONFIRM COMPLETION AND/OR AGREEMENT

- ☒ The county has provided the state with all calculations for the fee, the proposed payments, and the statistical test.
- ☒ The county understands that the funds created from this program are to increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals in providing necessary services to low-income residents.
- ☒ The county understands that at least 90% of the fee amounts collected will be transferred to the state to be used as the non-federal share for federally matched hospital payments.
- ☒ The county understands that at least 1% of the fee amounts collected will be transferred to the state for the state's administrative costs.
- ☒ The county understands that fees to be collected may not exceed 2.5% of the net patient revenue of hospitals included in the fee program.
- ☒ The following FORMS and ATTESTATION must be submitted with the Fee and Expenditure Report for each hospital located in the county (Include all source documents)
  - ☒ **Data Form for County Option Hospital Fee Program**
  - ☒ **Preliminary DSH Calculation Template**
- ☒ **Attestation**  
Signed by each hospital located in the county.

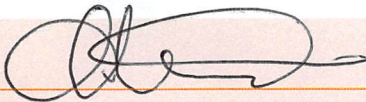
## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM FEE AND EXPENDITURE ATTESTATION

#### CERTIFICATION BY COUNTY OFFICER OR ADMINISTRATOR

I hereby certify that I have examined the Fee & Expenditure Report for the reporting periods specified and that to the best of my knowledge and belief it is true, correct and complete statement prepared from the county option hospital fee state data set created from reports submitted by the hospitals within the county's jurisdiction in accordance with applicable instructions, except as noted. I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.

Signed



County Officer or Administrator

Name: Abraham Antun

Full Name (Printed)

Title: County Administrator

Date: 3 / 19 / 2025

Email Address: aantun@hcnj.us