New Jersey County Option Hospital Fee Program
Operations Manual – SFY24 Program Year
Updated: September 2023

Scope of Manual

This document provides a detailed description of New Jersey's implementation of the NJ County Option Hospital Fee Program within the New Jersey Medicaid program, NJ FamilyCare. As outlined by enabling State statute, the County Program authorizes twelve counties that meet certain criteria to enact a local hospital fee program in their jurisdictions for the purposes of (1) increasing financial resources through the Medicaid program to support local hospitals and ensure that they continue to provide necessary services to low-income citizens, and (2) providing participating counties with new fiscal resources.

This manual describes the Department of Human Services (DHS) and Division of Medical Assistance and Health Services (DMAHS) approach, details the payment methodology and program funding, and provides guidelines for continuing the implementation of the NJ County Option Hospital Fee Program.

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Introduction

On November 1, 2018, Governor Murphy signed the County Option Hospital Fee Pilot Program Act [1]. On July 5, 2022, the County Option Hospital Fee Program Act[2] (Act) was signed into law. The Act removes the sunset provision - making the program permanent - and expands the eligibility criteria for participation in the program. The County Option Hospital Fee Program allows twelve counties meeting certain criteria (Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Hudson, Mercer, Middlesex, Monmouth, Ocean, and Passaic) the option of enacting a local hospital fee program in their jurisdiction for the purposes of (1) increasing Medicaid payments to hospitals by securing additional Federal funding through the NJ FamilyCare Program; and (2) providing participating counties with new fiscal resources.

These counties were deemed eligible to participate in the program, in part, based on the Municipal Revitalization Index rankings of the municipalities within their borders, which measure municipal distress based on indicators of diverse aspects of social, economic, physical, and fiscal conditions. Collection of the local hospital fees is contingent on CMS approval of the Medicaid payments that are funded under the county programs. This legislation follows parameters established by federal authorities as outlined in Section 1903(w) of the Social Security Act,[3] 42 CFR 433.68,[4] and 42 CFR 433.51.[5]

Program Operations

County Process of Submitting Fee & Expenditure Report and Other Materials

Per N.J.A.C. 10:52B-3.1, each eligible county that chooses to participate in the program is required to submit a proposed fee and expenditure (F&E) report to the Department of Human Services ("The Department"). The proposed F&E report should describe the county's proposed hospital fee program. The Department will then conduct a review of the submitted F&E reports to determine whether the proposed programs meet State and Federal regulatory requirements and that the data and methodologies contained within are accurate. These plans are subsequently made available for comment during a 21-day public review period, followed by a careful review by the Department of all submitted plans. If no cause to alter any county plan is found, the Department submits the initial documents authorizing the program payments to CMS for approval.

An eligible county with an approved F&E report, which plans to continue their program unchanged into a subsequent program year, is not required to resubmit a F&E report. Should a county wish to modify their plan at any point, an amended F&E Report must be provided to the Department for approval. As per Rule N.J.A.C. 10:52B-2.1(h)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

[1] S2758/A4212 (Approved P.L.2018, c.136), Rule N.J.A.C. 10:52B, then updated in March 2021 (approved P.L. 2021 c.41/S3252). This legislation follows parameters established by federal authorities as outlined in Section 1903(w) of the Social Security Act (allowing healthcare related taxes on certain classes of health care providers, including Hospitals); 42 CFR 433.68 (defines permissible health care-related taxes); and 42 CFR 433.51 (categorizes public funds as the State share of financial participation).

[2] S2729/A4091 (Approved P.L.2022, c.61./A4091)

[3] Section 1903(w) of the Social Security Act allows states to tax nineteen classes of health care providers, including Hospitals

[4] 42 CFR 433.68 defines permissible health care-related taxes

[5] 42 CFR 433.51 authorizes the use of public funds transferred from local governments as the State share of Medicaid expenditures.

have received any required Federal approvals before any changes are implemented." Amended/updated F&E Reports will undergo a 21-day review and comment period.

On a yearly basis, participating hospitals are required to submit the following documents to the Dmahs.hospcountyfee@dhs.nj.gov email address regardless of whether any changes to the county program are proposed:

1. Hospital Attestation (Appendix C)
2. Completed Disproportionate Share Hospital (DSH) calculation template (Appendix E)
3. Table 2; Impact of State Directed Payment of Payment Level (Appendix F)
4. National Provider Identifier (NPI) List and their correlated Medicare ID number(s) for encounter data (Appendix G)
5. NPI Form (Payment) (Appendix S)

Appendix A provides an exhaustive list of documents counties are required to submit for participation in the program.

Counties and/or their consultants are responsible for coordinating facilities within their jurisdictions to complete and submit these forms on time. Counties may choose to collect the forms from the hospitals and submit them on their behalf or have the hospitals submit them directly to the state. A DSH calculation template is provided by the Department outlining and explaining the data needed for each hospital to calculate their estimated DSH limit.

Due to the size of the Medicaid payments provided under the County Program, these annual DSH projections are needed to identify and limit DSH payments (i.e., Charity Care) that, when combined with other Medicaid payments provided to hospitals, are likely to exceed federal maximum DSH limits and trigger a recoupment of federal DSH funding upon subsequent audit.

The State or its technical contractor will ask participating hospitals to return an updated DSH Calculation Template (See Appendix E for most recent version) and any backup materials by early December prior to every program year. The State or its technical contractor may request further detail based on the hospitals' initial submission.

County Ordinances/Resolutions and Intergovernmental Agreements (IGAs)

As outlined in N.J.A.C. 10:52B-2.2, each eligible county is required to enact a county ordinance or resolution, as appropriate to the county's form of government, to impose the local county fee on hospitals located within the county. Each County Commissioner Board must also enter into an Intergovernmental Agreement (IGA) with the Department of Human Services authorizing and outlining various details of the transfer of fees collected under the county's program to the Department to fund the non-federal share of the County Option hospital payments and Departmental administrative costs. Ordinances or Resolutions are included in Appendix H and approved IGAs are found in Appendix I.

Ordinances/Resolutions remain in effect and do not need to be updated annually unless a participating county introduces an amendment to their previously approved program or if there are changes in the hospital landscape of the county i.e., hospital merger and acquisition or permanent closure (Please see appendix T for proposed language to be included in Ordinances or Resolutions in case of merger/acquisition or closure). IGAs will require revision if a participating county introduces an amendment to their previously approved program or if there are programmatic changes required by the NJ State Legislature or CMS.

Use of Local Fee Proceeds

Subject to CMS approval, the Division of Medical Assistance and Health Services (DMAHS) will use the local hospital fees to fund Medicaid State Directed Payments (SDPs) through the State's Medicaid managed care organizations to hospitals in the participating counties. DMAHS will prepare the annual application (via preprints) for the SDPs for CMS approval, which will include a prior review by DMAHS's actuary**.** DMAHS will share a draft of the preprint with participating counties at least 14 days prior to submission to CMS, with a due date for any comments from counties due no later than 7 days before submission to CMS. DMAHS will submit the preprints to CMS no later than March 31 each year.

The CMS approval documents for the most recent program year are located in Appendix J. Each CMS-approved preprint describes the State's payment methodology for the hospitals in a participating county. The non-federal share of the new Medicaid SDPs identified in the preprints will be funded with the local hospital fees implemented by the participating county. Counties may retain up to nine percent of their local fee proceeds and transfer the remaining minimum of 91% to the NJ Department of Human Services in equal quarterly installments via an intergovernmental transfer (IGT) 15 business days prior to the close of each quarter of the state fiscal year (SFY).

The State or its technical contractors will supply IGT schedules to designees at the Office of Management and Budget and DMAHS on an annual basis to track the non-federal share. New Jersey will retain at least one percent of the fee proceeds transferred by the counties to defray the cost of administering the NJ County Option Hospital Fee Program. The remaining fee amount (after the county share (up to 9%) and State administrative allocation) will be used as the non-federal share of enhanced Medicaid payments to hospitals (see the "Payment Process and Reconciliation: Interim to Final Payment Amounts" section of the Operations Manual for more information on payment design).

Impact on DSH/Charity Care

Like other Medicaid payments, the SDPs funded through the NJ County Option Hospital Fee Program payments will be counted towards a hospital's DSH limit. Broadly speaking, the DSH limit represents the unreimbursed costs incurred by a hospital in serving Medicaid and uninsured clients, and above which the federal government will not provide matching funds for DSH payments. As per guidance from the NJ Department of Health (DOH) disseminated in July 2022:

> "...please note that hospitals currently participating in the New Jersey County Option Hospital Fee Program (County Option) recently implemented by the Department of Human Services (DHS) pursuant to P.L. 2018, c.136 (C.30:4D-7r) and N.J.A.C. 10:52B are more likely to exceed the federal maximum hospital-specific DSH limits in Title 42 United States Code (U.S.C.) s.1396r-4. To ensure compliance with federal regulations, and consistent with attestations signed by participating facilities and submitted to DHS as part of the County Option program, FY 2023 Charity Care payments may be subject to recoupment should hospitals exceed federal maximum limits upon audit."

Specifically, if the additional County Option funded SDPs are projected to cause a specific hospital to exceed its respective annual DSH limit during the SFY, the hospital may need to forgo a portion, or all, of its Charity Care allotment per the most current State Fiscal Year Appropriation's Act language below:

> "Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated from the Health Care Subsidy Fund for Charity Care payments are subject to the following condition: A disproportionate share hospital eligible for funding through the Charity Care program may decline Charity Care payments for the fiscal year by notifying the Commissioner of Health on a form designated by the Department of Health on or before the

> fifteenth day following enactment. If a disproportionate share hospital declines Charity Care payments for the fiscal year the amount declined will be redistributed in accordance with the provisions of section 3 of P.L.2004, c.113 (C.26:2H--18.59i), as modified by this act."

As part of the NJ County Option Hospital Fee Program's approved F&E Reports and reiterated in DOH's guidance above, all participating hospitals in SFY24 attested that they would forgo Charity Care payments if the receipt of County Fee Program payments is projected to generate total payments that exceed their DSH limit.

Non-Compliant Hospitals

To meet the federal standards of no hold harmless,[6] all local hospital fees must be paid. If a hospital does not meet its payment obligations, the counties may institute a penalty or interest as noted in N.J.A.C § 10:52B-3.5.:

> "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."

Additionally, all participating counties have included language in their IGAs[7] (Appendix I) and Ordinances/Resolutions[8] (Appendix H) authorizing the same interest or penalties as noted above.

If necessary, the State's technical contractor will track the financial obligations owed by the delinquent hospitals, as well as the penalties (see "Tracking Transfers and Payments" section below). These penalties and payment obligations will be imposed quarterly until they are fulfilled.

Underpayment of IGT

If an IGT amount is less than what was expected from a specific county as outlined in the annual IGA agreement with the Department, OMB will alert the Department and their technical contractor of the actual amounts transferred. The State will temporarily fund the difference between the expected IGT, and the actual amount received so that DMAHS has sufficient funding to disburse the SDPs as approved by CMS. [9] As specified in each participating county's IGA, any shortfalls in the amount transferred in a given year will be subtracted from the amounts otherwise available to fund the non-federal share of enhanced payments for the particular county, then credited back to the state in the subsequent program year. These details are a mandatory section of the County's IGA with NJ DHS.[10]

Overpayment of IGT

If a transferred amount is greater than what was expected from a specific county, the state or their technical contractor will contact the respective County and/or their consultants to understand why the

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[6] 42 CFR 433.68(f) defines the conditions under which a taxpayer will be considered to be held harmless under a tax program

[7] See Section 5(d) of the Atlantic, Camden, Hudson, Mercer, Middlesex, Passaic County IGAs and Section 6(d) of the Essex County IGA for full details

[8] See Section 8 of the Atlantic, Camden, Hudson, Middlesex, and Passaic County Ordinances/Resolutions; Section 4.08.08 of the Mercer County Ordinance and the Preamble of the Essex County Ordinance for full details

[9] N.J. Stat. § 30:4D-7tg

[10] See Section 5(i) of the Atlantic, Camden, Hudson, Mercer, Middlesex, Passaic County IGAs and Section 6(i) of the Essex County IGA for full details

figures are different. The State may:

- repay to the counties any overpayments received for this Program via IGT. The State or their technical contractor will inform counties of overpayment and process for repayment; or,
- credit the amount towards the next quarterly fee payment.

Payment Process and Reconciliation: Interim to Final Payment Amounts

The interim payments (the quarterly directed payments made by the MCOs to hospitals) made during each year of the County Option program are estimates based on a prior year of utilization data. Counties will be responsible annually for completing and submitting Appendix S that lists the NPI numbers to which payments will be made to ensure timely and accurate receipt of payments to the hospitals. CMS requires that these estimated payments be reconciled to actual Medicaid utilization once the actual utilization data for the year is available. These required settlements will occur annually for all County Option participating hospitals and will generate revised payments amounts based on the following: actual hospital utilization (actual utilization reflected in Encounter data for the current program year, with a claims run out period), the applicable federal Medicaid matching rate (the Federal Medical Assistance Percentage or FMAP) earned based on the eligibility group of Medicaid members receiving services, and the distribution of days or discharges by MCO. Of these factors, the total of all payments made to the hospitals within a county will only change based on the actual FMAP earned based on eligibility group. The reconciliation of other aspects of the utilization data will result in a shift between hospitals based on changes to their relative share of all Medicaid services delivered within the county. Any increase or decrease in payments resulting from the reconciliation of prior year payments will be added to or subtracted from each facility's current year interim payments in the subsequent program year.

See Appendix K for Reconciliation/Payment Visual

Tracking Transfers and Payments

Once fee proceeds that act as the non-federal share of payments have been transferred to DMAHS and after the State provides payment charts to each MCO (which identify hospital-specific payment amounts), the State will provide funding equal to the combined federal and non-federal share of funds to the MCOs (see Appendix L for full schedule) to make the SDPs to the hospitals.

MCOs are required to make the hospital payments within 15 calendar days of receipt of the funds from DMAHS. DMAHS will provide the MCOs with a quarterly payment breakout chart 15 calendar days prior to receipt of the funds from DMAHS. MCOs are required to make the payment to the specific NPI numbers identified by the hospital. If a hospital does not receive an expected payment, they should reach out to the MCO contact below and, if the payment issue is not resolved, to the State's technical contractor. If necessary, the State's technical contractor will work with the State, Counties, and County Consultants to locate payments made to the hospitals. All payments from the MCOs to hospitals are expected to be processed by EFT (see Appendix N for more information).

Other Annual Processes

Measuring Impact

In 2021, representatives from DMAHS and its technical contractor met with CMS to review proposed quality metrics for the Program. County consultants worked with the seven counties participating in the original County Option pilot program and selected two measures (see Table 2) that were mutually agreeable to all stakeholders; hospital performance on these measures for the first year of the program (SFY 2022) will be reported with the SFY24 preprint submissions to capture a full program year of measures (Appendix O). Quality Measures will be collected annually for CMS reporting purposes.

In consultation with CMS and the original counties, the state has chosen two measures to annually assess the success of the program and measure may be altered in future years as necessary:

Table 2: Evaluation Measures

Measure Name	Baseline Year	Baseline Statistic	Performance Target
Average (median) time patients spent in the ED before leaving from the visit	CY 2019	Acute: 142 minutes (national average)	For the acute hospitals with number of minutes above the national average, reduce the gap between hospital actual and national average by 1% per year.
Clostridium difficile (C.diff.) intestinal infections	Long Term: FFY 2019 Rehab: FFY 2019	Long Term: 0.537 Rehab: 0.557 (National Average)	For the LTACH and Rehab hospitals with a CDI ratio above the national average, reduce the gap between hospital actual and national average by 1% per year.
Screening for Metabolic Disorders (SMD)	CY2022	CY2022 Performance will serve as the baseline for the metabolic screening measure.	Improve over baseline statistic by 1% per year.

Evaluation Plan

The impact of the payment arrangement must be reported to CMS within the preprint in the subsequent full program year. By providing data on the evaluation measures in Table 2, the State will be able to understand the impact of the payment arrangement over time. The State or its technical contractor requested the quality measure reporting for program year 1 from the hospitals which was submitted December 9, 2022; the counties may choose to collect this information and submit it on behalf of the hospitals. DMAHS or its technical contractors can provide assistance to the hospitals in order to fulfill this program requirement. Participating hospitals (or counties on their behalf) may submit their quality

reports to the Dmahs.hospcountyfee@dhs.nj.gov email address. The State's technical contractor is responsible for evaluating the quality data annually using the CMS Evaluation Findings Template. The evaluations will be shared with each participating county in conjunction with their review of the draft preprint.

CMS requires all directed payments to demonstrate that the payments are intended to advance at least one of the goals in the State quality strategy.[11] The following goals and objectives were chosen:

1. *Serve people the best way possible through benefits, service delivery, quality, and equity*
    a. Help members with physical, cognitive, or behavioral health challenges get better coordinated care
    b. Monitor fiscal accountability and manage risk
    c. Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers

2. *Focus on integrity and real outcomes through accountability, compliance, metrics, and management*
    a. Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers

Future Program Years

F&E Reports Submission

For future years, participating counties who wish to amend their F&E reports (Appendix B) may submit their amended reports to the Dmahs.hospcountyfee@dhs.nj.gov email address. Due dates will be provided on the NJ County Hospital Fee Program website.

Use and dissemination of historical encounter data

For SFY22, the State provided CY19 MCO Encounter data (See Appendix P) for the counties to create their estimated models and to make interim quarterly payments. For SFY24, the State plans to continue to utilize CY19 MCO Encounter data to make interim payments.

Contacts

State Contacts

If you have questions about the NJ County Option Hospital Fee Program, please direct your questions to the County Option email at Dmahs.hospcountyfee@dhs.nj.gov.

MCO Contacts

Each MCO has designated a contact for any questions related to the NJ County Option Hospital Fee Program:

Aetna	Sonia Barbosa Alex McLean	BarbosaS1@cvshealth.com McleanA2@aetna.com
Amerigroup	Van Chang	van.chang@anthem.com

[11] Department of Health and Human Services, Centers for Medicare & Medicaid Services: Section 42 C.F.R. § 438.6(c) Preprint January 2021, pg. 19

Horizon	James Dalessio Mike Leon Rich Garzon	James_Dalessio@horizonblue.com Michael_Leon@horizonblue.com Richard_Garzon@horizonblue.com
United Healthcare	Joseph Dicks	joseph_m_dicks@uhc.com
WellCare	Sean McBride	Sean.McBride@wellcare.com

County Administrators

Each county has designated a contact for any questions related to the NJ County Option Hospital Fee Program. The following contacts signed their counties' respective Fee and Expenditure Reports:

Atlantic County	Jerry DelRosso	Dewees_jacqueline@aclink.org Delrosso_jerry@aclink.org
Bergen County	James Tedesco	JTedesco@co.bergen.nj.us
Burlington County	Eve Cullinan	ecullinan@co.burlington.nj.us
Camden County	Ross Angilella	rossa@camdencounty.com
Cumberland County	Jeff Ridgway	JEFFRI@CumberlandCountyNJ.gov
Essex County	Joseph Divincenzo	JoeDi@admin.essexcountynj.org
Hudson County	Abraham Antun	aantun@hcnj.us
Mercer County	Lillian Nazzaro	lnazzaro@mercercounty.org
Middlesex County	John Pulomena	John.pulomena@co.middlesex.nj.us
Monmouth County	Teri O'Connor	Teri.O'Connor@co.monmouth.nj.us
Ocean County	Michael Fiure	MFiure@co.ocean.nj.us
Passaic County	Richard Cahill	rcahill@passaiccountynj.org

Appendices

A. Required Documents
B. Fee and Expenditure Report template
C. Attestation template
D. Data Form template
E. Preliminary DSH Calculation template ()
F. Table 2; Impact of State Directed Payment of Payment Level
G. NPI List and their correlated Medicare ID number(s) for encounter data
H. Approved Ordinances/Resolutions
I. Approved IGAs
J. SFY23 Approved Preprints
K. SFY23 Reconciliation/Payment Visual
L. List of Key Dates for SFY24
M. MCO Contract Language

N. MCO Briefing Slides with Sample MCO Payment Schedule
O. NJ County Option Quality Evaluation Template
P. CY19 MCO Encounter Data Criteria
Q. Adopted Rules and Summary of Public Comments
R. SFY24 List of Counties and Hospitals
S. NPI Form (payments)
T. Proposed Language for Merger/Acquisition or Closure