New Jersey County Option Hospital Fee Program
Operations Manual – SFY23 Program Year
Updated: August 2022

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 SFY23 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. Table 1 lists the dates on which the participating counties enacted Ordinances or Resolutions (see Appendix H for the full text of each Ordinance/Resolution) and approved their IGAs (see Appendix I for the full text of each IGA).

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. 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.

Table 1: County Ordinances/Resolutions and IGA Approvals

County	Date Ordinances/Resolutions Approved by County Commission	Date IGAs Approved by County Commission
Atlantic County	3/2/2021	5/20/2021
Camden County	3/18/2021	6/9/2021
Essex County	7/11/2022	5/18/2022
Hudson County	4/15/2021	5/19/2021
Mercer County	4/22/2021	6/1/2021
Middlesex County	3/4/2021	5/26/2021
Passaic County	2/23/2021	5/18/2021

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 SFY23 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 SFY23 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 SFY23 attested that they would forgo Charity Care payments if the receipt of County Fee Pilot 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 <u>less</u> than what was expected from a specific county as outlined in the annual IGA

[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

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 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

[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

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).

In consultation with CMS and the original counties, the state has chosen two measures to evaluate annually to 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.

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 will request the quality measure reporting for program year 1 from the hospitals be submitted by December 9, 2022; the counties may choose to collect this information and submit it on behalf of the hospitals. Additional details will be provided to the hospitals in the Fall of 2022. 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 SFY24, participating counties may submit their F&E reports or amended reports (Appendix B) to the Dmahs.hospcountyfee@dhs.nj.gov email address by December 9, 2022. For SFY23 counties that wished to amend their program were required to submit their updated F&E report by December 10, 2021**.**

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 SFY23, 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

[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

Amerigroup	Van Chang	van.chang@anthem.com
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
Camden County	Ross Angilella	rossa@camdencounty.com
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
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 (SFY23 version)
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 SFY23
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. SFY23 List of Counties and Hospitals
S. NPI Form (payments)

Appendix A: Required Documents

Form	County Option Progs. Approved before 7/1/2022	County Option Progs. Potentially Eligible by 7/1/2023	Due Date	Notes/Comments
NPI Form- Encounter data	Yes	Yes	08/1/22	Used to pull encounter data Appendix F
F&E Report	No (*Submission is only required for Counties wishing to amend their F&E reports)*	Yes	12/9/22	Describes the county 's proposed hospital fee program Submitted once for approval unless changes are being made to the program Appendix B
Hospital Attestation	Yes	Yes	12/9/22	Certifies that submitted documents are accurate Appendix C
DSH Calculation Template	Yes	Yes	12/9/22	Provides a process through which the hospital can calculate its preliminary DSH limit for the fiscal year Appendix E
Table 2; Impact of State Directed Payment on Payment Levels	Yes	Yes	12/9/22	Utilized in the annual submission to CMS Appendix F
NPI Form-Payments	Yes	Yes	12/9/22	Designates the hospital NPI number that will receive the quarterly payment Appendix S
Draft Preprint	Yes	Yes	12/9/22	Preprint template is the CMS application for program approval. Appendix J
Quality Evaluation Template	Yes	Yes	12/9/22	Quality template is used to collect evaluation data Appendix O

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Date: / /

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

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?

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)

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:

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.

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

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

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.

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?

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

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

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

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?

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?

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: _____
Full Name (Printed)

Title: _____ **Date:** / /

Email Address: _____

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ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: _____

CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of _____ hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- 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.
- I certify that 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.

I am authorized to make this Certification on behalf of _____ hospital.

Signature _____

Name _____
Full Name (Printed)

Title _____ **Date** / /

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DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name _____

Facility address(es) within Authorized County _____

County_

Medicaid Provider Number _____

Medicare Provider Number _____

Hospital Parent Company (if applicable) _____

Contact Person Name _____

Title_____

Phone (____) - _____ - _____ Ext: _____

Email Address_____

Period Covered: _____ **to** _____

INSTRUCTIONS

DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: Dmahs.hospcountyfee@dhs.nj.gov.

SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalant to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0" .

SECTION 2

Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of
the county.

Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

SECTION 1

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records: INPATIENT (Column A)	Amount Verified From Hospital Records: OUTPATIENT (Column B)	SOURCE
1	Total Net Patient Revenue			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1			☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)

SECTION 2

LINE	REVENUE CATEGORY	COLUMN A: MEDICAID	COLUMN B: MEDICARE	COLUMN C: OTHER	SOURCE
9	Days, Inpatient Fee-for-Service				☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care				☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service				☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care				☐ Medicare Cost Report Indicate Wksht(s), Line(s)# ☐ Financials ☐ Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period				

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PRELIMINARY DSH LIMIT CALCULATION TEMPLATE

The DSH Template provides a process through which a hospital can calculate its preliminary hospital specific disproportionate share (DSH) limit for State fiscal year 2023 (July 1 2022 – June 30 2023). The hospital specific DSH limit as specified in 1923(g)(1)(A) of the Social Security Act prohibits federal matching funds for any Medicaid disproportionate share payments made in excess of a hospital's DSH limit.

The attached template is intended as guidance in calculating a hospital's preliminary DSH limit. Its structure is based on data that is generally available through the hospital cost reporting process, paid claims data and other hospital financial records. Costs are derived based on charges and overall hospital inpatient and outpatient cost to charge ratios. However, if a hospital has a more accurate method of determining costs using Medicare cost reporting principles, the hospital should use its own amount. This guidance is provided solely for the purpose of technical assistance. Reliance on this document does not preclude future recovery from CMS or the State.

Template specific notes:

In the DSH Template, data should be entered into all the **Yellow** cells. Select your Hospital from the dropdown menu provided and its respective Medicare ID will populate. As a Value cell is updated with whole numbers, the cell will turn **Green**. If a value is to remain $0.00 (no value), that cell will remain **Yellow**. The **Orange** cells are calculated fields.

In the Identify Data Field Source cells, provide the data source of the updated Values. If they are sourced from internal financial documents, please note this. If they are sourced from a recent Medicare Cost Report, include details for: Submission Year, Worksheet, Part, Line and Column (example: 2019, Worksheet E, Part A, Line 71, Col 1).

In the Comments cells, provide any additional information regarding the Values updated, especially for Lines 16 (Cost inflation factor), Line 19 (Estimated Medicaid Cost Increase between base year to target year) and Line 33 (Estimated Medicaid Payment Increase between base year to target year).

No additional worksheets or tabs can be added to this Template file, but additional back-up data or information should be submitted as separate files, and identified.

The SFY23 DSH Limit Template should be submitted using the following naming convention:
DSHFORM_Medicare ID_County Name_ Submission Date (YYYYMMDD)
(example: DSHFORM_111111_Mercer_20211015).

The DSH limit is the difference between Medicaid costs plus costs for treating the uninsured minus Medicaid payments and any payments received on behalf of the uninsured. Payments received on behalf of the uninsured exclude payments made to a hospital for services provided to indigent patients made by a State or a unit of local government, including Charity Care. In additional to the new County Option payments, any Quality Improvement Program - New Jersey (QIP-NJ) payments will also impact a hospitals DSH Limit.

The calculation includes both inpatient and outpatient costs and payments for both fee-for-service and managed care programs and **only for individuals for whom Medicaid is the primary payer.** Both in state and out-of-state Medicaid and uninsured costs and payments are included in this calculation. Costs and payments for dually-eligible individuals where Medicaid is not the primary payer should be excluded, unless the hospital believes it qualifies for the exception at Section 203 of the Consolidated Appropriations Act of 2021. The result of the calculation provides the estimated maximum amount of DSH payments a hospital may receive for which federal matching funds would be available. Since the calculation is for a future fiscal period (SFY23), the hospital is best positioned to calculate the most accurate DSH limit for its own facility based on its own projections of services, cost trends and revenue trends. **It is recommended that CMS Market Basket be utilized for cost trending purposes.***

CMS requires the DSH limits to be audited once the actual data for the fiscal year is available. This is required regardless of whether the hospital does projections. The audit is typically two to three years after the year for which the projected DSH limit was calculated. If CMS finds through these audits that a hospital received DSH payments in excess of the audited DSH limit, CMS will require the state to refund the federal share of the overpayment. The state will also recoup the nonfederal share of a DSH overpayment from the hospital. For this reason, it is important for the preliminary hospital specific (DSH) limit to be as accurate as possible to minimize the hospital's risk. If the preliminary limit is higher than the final audited limit and the hospital received DSH payments above the audited DSH limit, the hospital will need to return the overpayment. If the preliminary limit is lower than the final audited limit and the preliminary limit was used to limit DSH payments, the hospital could potentially lose out on DSH payments it otherwise was scheduled to receive. **The projected DSH limit is unlikely to perfectly match the audited DSH calculation, but should be as close as possible to avoid potential overpayments or underpayments, as the hospitals will bear the risk, not the State.**

* Market Basket history and forecasts | Developed by IHS Global Insight https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

NJ FAMILYCARE
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SFY23 Preliminary Disproportionate Share Hospital (DSH) Limit Calculation Template

Hospital Name	Hospital
Medicare ID#	Medicare ID

Select Your Hospital From The Dropdown List

	= Enter Value
	= Valid Value Entered
	= Calculated Value

Item*	Field Notes*	Line	Source	Entry/Calculation	Value	Identify Data Field Source	Comments
INPATIENT CHARGES CONVERTED TO COSTS							
Medicaid (MA) Fee For Service (FFS) Inpatient Charges	Enter (MA) inpatient (FFS) charges for the referenced fiscal year (SFY23).	1	Data	A	$0.00		
MA Managed Care (MCO) Inpatient Charges	Enter MA inpatient (MCO) charges for the referenced fiscal year.	2	Data	B	$0.00		
Uninsured Inpatient Charges	Enter inpatient charges for uninsured individuals for the referenced fiscal year.	3	Data	C	$0.00		
Total Medicaid/Uninsured Inpatient Charges	**Sum of inpatient charges, Lines 1-3.**	**4**	**Calculated**	**D = A + B + C**	**$0.00**		
MEDICARE COST TO CHARGE RATIO							
Total Hospital Costs	Enter the hospital's Total Hospitals Costs from Worksheet C Part I Column 1 Line 202 (from Medicare cost Report (2552-10) for the referenced fiscal year).	5	Data	E	$0.00		
Total Hospital Charges	Enter the hospital's Total Hospital Charges from Worksheet C Part I Column 8 Line 202 (from Medicare cost Report (2552-10) for the referenced fiscal year).	6	Date	F	$0.00		
Medicare Cost to Charge Ratio	**Medicare Cost to Charge is calculated by dividing Total Hospitals Costs Line 5, by Total Hospital Charges Line 6.**	**7**	**Calculated**	**G = E ÷ F**	**0**		
Estimated Medicaid/Uninsured Inpatient Costs	**Multiply the hospital cost to charge ratio from Line 7 with the total inpatient charges from Line 4 to determine estimated inpatient costs.**	**8**	**Calculated**	**H = D x G**	**$0.00**		
OUTPATIENT CHARGES CONVERTED TO COSTS							
MA FFS Outpatient Charges	Enter MA outpatient FFS charges for the referenced fiscal year.	9	Data	I	$0.00		
MA MCO Outpatient Charges	Enter MA outpatient MCO charges for the referenced fiscal year.	10	Data	J	$0.00		
Uninsured Outpatient Charges	Enter outpatient charges for uninsured individuals for the referenced fiscal year.	11	Data	K	$0.00		
Total Medicaid/Uninsured Outpatient Charges	**Sum of outpatient charges, Lines 9-11.**	**12**	**Calculated**	**L = I + J + K**	**$0.00**		
Medicare Cost to Charge Ratio	**Hospital's Medicare Cost to Charge ratio from Line 7.**	**13**	**Calculated**	**M**	**0**		
Estimated Medicaid/Uninsured Outpatient Costs	**Multiply the hospital cost to charge ratio from Line 13 with the total outpatient charges from Line 12 to determine estimated outpatient costs.**	**14**	**Calculated**	**N = L x M**	**$0.00**		
TOTAL COSTS TRENDED TO TARGET YEAR							
Subtotal Hospital Inpatient and Outpatient Costs for DSH Limit calculation	**Add estimated inpatient costs from Line 8 and estimated outpatient costs from Line 14.**	**15**	**Calculated**	**O = H + N**	**$0.00**		
Cost inflation factor (See Field Notes). Enter a percentage (ex. 2.3% entered as 2.3, 5% entered as 5)	Enter a cost trend factor to trend costs forward from the data year to the target year using either the hospitals own cost inflation factor or the CMS inpatient hospital market basket. The market basket link is CMS: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData	16	Data	P	0.0%		
Subtotal MA Inpatient and Outpatient Costs for DSH Limit calculation	**Multiply the total hospital costs from Line 15 by the cost trend factor from Line 16 to determine total costs for DSH limit calculation purposes.**	**17**	**Calculated**	**Q = O x (1 + P)**	**$0.00**		
Cost determined by the Medicaid & Uninsured percentage formula used, multiplied by the actual annual Assessment amount.	**County Option Assessment Related Cost:** This Cost should be based on Medicaid & Uninsured days ÷ Total days; Medicaid & Uninsured discharges ÷ Total discharges or Medicaid & Uninsured Net Patient Revenue (NPR) ÷ Total NPR. The appropriate formula percentage should reflect the respective County level Assessment methodology/basis of your County Option Hospital tax.	18	Data	R	$0.00		
Estimated Dollar Amount of Medicaid Cost Increase between base year to target year (if any).	Enter the estimated dollar amount of any Medicaid cost increases that occurred between the data year and the target year - not included in any of the above fields. **Include a brief description in the Comments section.**	19	Data	S	$0.00		
Total MA Inpatient and Outpatient Costs for DSH Limit calculation	**Total Calculated Costs, Sum Lines 17-19.**	**20**	**Calculated**	**T = Q + R + S**	**$0.00**		
MEDICAID SERVICE PAYMENTS							
MA FFS Inpatient Payments	Enter MA FFS inpatient payments.	21	Data	U1	$0.00		
MA FFS Outpatient Payments	Enter MA FFS outpatient payments.	22	Data	U2	$0.00		
MA MCO Inpatient Payments	Enter MA MCO inpatient payments.	23	Data	U3	$0.00		
MA MCO Outpatient Payments	Enter MA MCO outpatient payments	24	Data	U4	$0.00		
Total MA Service Payments	**Total MA service payments. Sum Lines 21-24.**	**25**	**Calculated**	**UT=U1+U2+U3+U4**	**$0.00**		
SUPPLEMENTAL AND OTHER PAYMENTS							
Medicaid Graduate Medical Education (GME) Payments not included in Line 16	Enter hospital's Medicaid GME payments, for the current year, if they are not included in line 21.	26	Data	V1	$0.00		
Directed County Option Payment from MCOs - Annual Amount	Enter hospital's Expected Annual Medicaid County Option Directed Payment.	27	Data	V2	$0.00		
Supplemental MA Inpatient or Outpatient Payments	Enter MA supplemental FFS and/or MCO inpatient and outpatient payment. This does NOT include Charity Care Payments.	28	Data	V3	$0.00		
Indigent Self-Pay Revenue	Enter payments received for services to the uninsured.	29	Data	V4	$0.00		
Section 1011 Payments	Enter any Section 1011 payments.	30	Data	V5	$0.00		
Total MA Supplemental and Other Payments	**Total MA Supplemental and Other Payments. Sum Lines 26-30.**	**31**	**Calculated**	**VT = V1 + V2 + V3 + V4 + V5**	**$0.00**		
TOTAL SERVICE AND SUPPLEMENTAL PAYMENTS							
Total Service and Supplemental Payments	**Total Service and Supplemental payments for data year, Sum Lines 25 and 31.**	**32**	**Calculated**	**W = UT + VT**	**$0.00**		
Estimated Dollar Amount of Medicaid Payment Increase between base year to target year (if any)	Enter the estimated dollar amount of any Medicaid payment increases that occurred between the data year and the target year. This would also include any known SFY23 QIP Perfomance Payments and/or any Perinatal Payments. **Include a brief description in the Comments section.**	33	Data	X	$0.00		
TOTAL PAYMENTS							
Total Estimated Payments for target year	**Total Payments, Sum Lines 32 and 33.**	**34**	**Calculated**	**Y = W + X**	**$0.00**		
DSH LIMIT							
DSH Upper Limit	**DSH upper limit. Subtract total payments from Line 34 from Total Costs from Line 20.**	**35**	**Calculated**	**Z = Y - T**	**$0.00**		
MA Disproportionate Share Payment	Enter hospital's Charity Care (DSH) payments for the current year.	36	Data	AA	$0.00		
DSH Limit Room	**DSH Room. Subtract DSH payments from Line 36 from DSH Upper Limit from Line 35 to determine estimated remaining DSH room for hospital.**	**37**	**Calculated**	**AB = Z - AA**	**$0.00**		

* **For Medicaid Specific Costs and Payments: Only Include Where Medicaid is the Primary Payer.**

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. If you speak any other language, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a.	0.00%	0.00%	0.00%	0.00%	0.00%
b.	0.00%	0.00%	0.00%	0.00%	0.00%
c.	0.00%	0.00%	0.00%	0.00%	0.00%
d.	0.00%	0.00%	0.00%	0.00%	0.00%
e.	0.00%	0.00%	0.00%	0.00%	0.00%
f.	0.00%	0.00%	0.00%	0.00%	0.00%
g.	0.00%	0.00%	0.00%	0.00%	0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

Appendix G

Please use this form to populate the Hospital Name, Hospital System, Medicare ID, NPI number, and Facility Type for all hospitals participating in the program including Acute Care, Behavioral Health Facilities, and LTACHs. Nursing facilities or federal VA hospitals are not necessary to include.

Please note that this NPI number will be used by the State to pull out the hospital specific encounter data for program modeling

County	Hospital Name	Hospital System	Medicare ID	NPI Number	Facility Type

ATLANTIC COUNTY ORDINANCE NO. 1 -2021

AN ORDINANCE OF THE COUNTY OF ATLANTIC AUTHORIZING AND ADOPTING AN ASSESSMENT ON CERTAIN SERVICES FURNISHED BY HOSPITALS LOCATED WITHIN THE COUNTY'S BORDERS FOR THE PURPOSE OF INCREASING FUNDING TO SUPPORT THE PROVISION OF NECESSARY SERVICES BY SUCH HOSPITALS TO LOW-INCOME CITIZENS AND PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF ATLANTIC.

WHEREAS, hospitals in Atlantic County (the "County") provide essential services and serve a critical role in promoting the health of the County's citizens and expanding access to care throughout the community; and

WHEREAS, each year, hospitals in the County provide millions of dollars of uncompensated health care to Medicaid and uninsured patients; and

WHEREAS, on November 1, 2018, the State of New Jersey (the "State") Legislature enacted the County Option Hospital Fee Pilot Program (the "County Option Program") to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients through increased reimbursement rates. (P.L.2018, c. 136); and

WHEREAS, pursuant to P.L.2018, c. 136, the County is eligible to participate in the County Option Program and is thereby authorized to impose an Assessment on hospitals located within the County's borders; and

WHEREAS, the funding from the County Assessment will be transferred to the Division of Medical Assistance and Health Services ("DMAHS") to enable the State to draw down federal matching funds to support an estimated $60,252,447 in new Medicaid payments to hospitals in the County for certain services furnished to Medicaid/NJ FamilyCare beneficiaries; and

WHEREAS, the County's contracted attorneys have developed a model to participate in the County Option program, based on a comprehensive process of consulting and gathering feedback from all Assessed Hospitals; and

WHEREAS, the consultation process consisted of educating all Assessed Hospitals on the intent and goals of the program and associated requirements, supporting hospital submission of required data forms, presenting available options to all Assessed Hospitals and hosting multiple

hospital-wide discussions and follow-up discussions as requested, and soliciting written feedback from all Assessed Hospitals to inform the County's Assessment selection; and

WHEREAS, on December 10, 2020, the County submitted the required Fee & Expenditure Report to DMAHS describing its proposed model and on January 29, 2021, DMAHS approved the proposal; and

WHEREAS, the County has an interest in supporting access to health care to its low-income residents, as well as the broader community through support of necessary care provided by local hospitals; and

WHEREAS, imposing an assessment to help fund the provision of necessary care by local hospitals to low-income patients in the County is a valid public purpose that benefits the health, safety and welfare of its citizens; and

WHEREAS, ensuring the financial stability and viability of local hospitals providing such necessary health care supports important contributors to the County's economy; and

WHEREAS, the County desires to participate in the County Option program through the model described in the approved Fee and Expenditure Report including by levying and collecting an Assessment on certain services furnished by hospitals located within the County's borders more specifically described herein.

NOW, THEREFORE, BE IT ORDAINED, by the Board of Commissioners of the County of Atlantic, that:

Section 1. Recitals. The Recitals set forth above are hereby incorporated by reference.

Section 2. Definitions. As used in this Ordinance, the following capitalized terms, not otherwise defined herein, shall have the following meanings, unless the context hereof otherwise requires.

"Assessment" means the assessment imposed and levied upon the Assessed Hospitals as defined herein.

"Assessment Notice" means the notice distributed to each Assessed Hospital at the beginning of each Program Year specifying the annual Assessment owed and the quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

"Assessed Discharges" means, with respect to each Assessed Hospital, the total number of annual discharges, other than Medicare discharges, reported on the most recent "Data Form

for County Option Hospital Fee Pilot Program" prepared by the Assessed Hospital and submitted to the State prior to the effective date of this Ordinance. Such non-Medicare discharges are determined by adding together the Medicaid and Other inpatient discharges reported in columns A and C, respectively, of lines 11 and 12 of such data form.

"Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services.

"Directed Payments" means the Medicaid managed care rate increase payments distributed by DMAHS through the Managed Care Organizations to hospitals as authorized under the County Option Program.

"Implementation Date" means July 1, 2021 provided that the County Option Program has received all necessary federal approvals, but in no case shall the Assessment be implemented if the County has not entered into an Intergovernmental Agreement consistent with Section 11.

"Intergovernmental Agreement" means the agreement between the County and DMAHS governing the transfer of the Assessment funds collected from the Assessed Hospitals.

"Managed Care Organizations" means the health plans under contract with DMAHS to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program and that will be directed to distribute Medicaid managed care rate increase payments to hospitals under the County Option Program.

"Program Year" means each 12-month period of the County Option Program, beginning with July 1, 2021 through June 30, 2022.

"Quarterly Assessment Invoice" means the notice distributed to each Assessed Hospital prior to each quarterly Assessment due date specifying the quarterly Assessment amount due, any interest incurred, and any additional elements specified herein.

Section 3. Authority. This Ordinance is adopted pursuant to P.L.2018, c. 136.

Section 4. Assessment Scope, Basis and Use.

(A) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Section 5, to take effect on the Implementation Date.

(B) The County shall use the amounts collected from the Assessment only as follows:

(1) The County shall transfer 91% of total collected funds to DMAHS to be used as outlined in the Intergovernmental Agreement, described in Section 11.
(2) The County shall retain 9% of total collected funds to be allocated at the discretion of County Administration

(C) In the event that DMAHS returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital within 15 days of receipt the pro rata portion of such funds.

(D) In the event that an individual Assessed Hospital is determined to have overpaid their Assessment or otherwise paid in error, the County shall refund the overpayment or the amount paid in error to the Assessed Hospital within 15 days of the later of:
(1) Discovering the overpayment or error, if the funds have not been transferred to DMAHS, or
(2) Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to DMAHS.

(E) Assessed Hospitals shall not pass on the cost of the fee to any patient, insurer, self-insured employer program, or other responsible party, nor list it separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

Section 5. Computation of Assessment.

(A) The annual Assessment for each Assessed Hospital shall equal $1,264.05 multiplied by the number of Assessed Discharges.

(B) The annual Assessment amounts for each Assessed Hospital, calculated pursuant to (A), equal the following:
(1) AtlantiCare Regional Medical Center, $21,747,953
(2) Shore Medical Center, $4,640,322
(3) Bacharach Institute for Rehabilitation, $329, 917
(4) Acuity Specialty Hospital of New Jersey, $60,674

(C) The annual Assessment shall be payable in four quarterly installments, each to equal 25% of the annual Assessment amount.

Section 6. Assessment Notice.

(A) At least 30 days prior to the due date of the first Assessment of each Program Year, the County shall provide an Assessment Notice by first class mail to the owner of each Assessed Hospital.

(B) The Assessment Notice shall include (1) a brief explanation of the Assessment, (2) a description of the methodology used to determine the Assessment amount, (3) the annual Assessment amount owed by the Assessed Hospital for the upcoming Program Year, (4) the quarterly Assessment amounts owed by the Assessed Hospital for the Program Year; (5) the acceptable methods of payment, (6) the dates on which each quarterly Assessment is due, (7) the interest rate that will be charged for late payments; and (8) a statement of the Assessed Hospital's appeal right and the timing and requirements of such appeal.

Section 7. Assessment Invoice.

(A) At least 20 days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by first class mail to the owner of each Assessed Hospital.

(B) The Assessment Invoice shall include (1) the Assessment amount due for the relevant quarter, including any accrued interest from prior quarters, (2) the acceptable methods of payment, and (3) the due date of such payment.

Section 8. Interest. Should an Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may require the Assessed Hospital to pay interest in the amount of 1.5% of the outstanding payment amount per month, to be added to the following quarter's Assessment Invoice.

Section 9. Appeal Process.

(A) Upon receipt of the County's Assessment Notice at the beginning of each Program Year, Assessed Hospitals shall have 15 days to file an appeal of the Assessment amount stated in the Assessment Notice with the County's Appeal Tribunal.

(B) All appeals shall be in writing and shall indicate the specific basis for the appeal and shall include all documentation in support thereof. The appeals shall be made to the County's Appeal Tribunal which shall consist of the County Administrator, County Treasurer, and a designee from the County's Division of Public Health. The Appeal Tribunal shall review the appeal submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The Appeal Tribunal shall render a written decision within 15 days in any case where an oral presentation is made or within 15 days of receipt of the written appeal materials where no oral presentation is requested. The decision of the Appeal Tribunal shall be final, binding, and no further appeal may be taken.

Section 10. Requirement to Submit Necessary Documentation. Assessed Hospitals shall submit any data forms related to the County Option Program requested by the County by the due date specified by the County.

Section 11. Intergovernmental Agreement. The County is authorized to enter into an Intergovernmental Agreement with DMAHS governing the transfer of Assessment funds from the County to the State. The agreement shall include the following:

(A) Timing requirements for the transfer of Assessment funds from the County to DMAHS, from DMAHS to the Managed Care Organizations, and from the Managed Care Organizations to the hospitals.

(B) A requirement that DMAHS use 90% of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that DMAHS may permit the Managed Care Organizations that make the Directed Payments to retain up to 5% of the total amount paid to them exclusively to cover their incremental cost of any state insurance premium tax.

(C) Assurances that the County will not be liable for any unpaid Assessment amounts and will only be responsible for transferring Assessed funds to the extent received by the Assessed Hospitals.

(D) A requirement that DMAHS return to the County the non-federal share of any Directed Payment funds recouped by DMAHS from Assessed Hospitals.

(E) A statement that any resulting Medicaid/NJ Family Care payments distributed under the County Option Program shall not supplant or otherwise offset payments made to hospitals from other state or federal funding mechanisms or pools, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(F) Assurances that funds generated by the Assessment shall not supplant or offset any current or future State funds allocated to the County.

Section 12. Termination. The Assessment shall terminate upon expiration of the County Option Program under state law, unless any of the following conditions occur earlier:

(A) DMAHS notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation.

(B) The Assessment is otherwise finally determined to be unlawful under County, State, or Federal law by an agency or court competent to make such a final determination; or

(C) The County Option Program is terminated or fails to obtain required approval or reapproval by the federal Centers for Medicare and Medicaid Services; or

(D) The Intergovernmental Agreement described in Section 11 is terminated or no longer meets the conditions described in such section.

Section 13. Impact of Termination. In the event that the Assessment terminates early pursuant to Section 12 (A)-(D), the County shall refund to each Assessed Hospital within 15 days of the effective date of such termination the pro rata portion of:

(A) Any funds that have not been transferred to DMAHS or that DMAHS returns to the County; and

(B) Any of the portion allocated for the County's use pursuant to Section 4(B)(2) that has not already been spent or irrevocably allocated for its designated purposes.

Section 14. Public Hearing. A public hearing for the purpose of hearing persons interested in or affected by this proposed ordinance authorizing the Assessment shall be held on March 2, 2021 at the Commissioners' Meeting Room, Stillwater Building, 201 Shore Road, Northfield, New Jersey at 4:00 P.M., or by Webex video conference should the limitations prohibit in-person meetings due to the COVID-19 pandemic remain in effect.

Section 15. Construction and Severability.

(A) This Ordinance is to be liberally construed to effectuate its purposes.

(B) If any section, subsection, paragraph, sentence, clause, phrase, or word contained in this Ordinance shall be declared invalid for any reason whatsoever, such decision shall not affect the remaining portions of this Ordinance which shall remain in full force and effect.

(C) All other terms, provisions and requirements of Atlantic County Code Chapter 97 not specifically amended by or inconsistent with the terms of this Ordinance shall remain in full force and effect.

Section 16. Repealer. Any Ordinance or portion thereof enacted by the County that contains any subject matter governed by this Ordinance, which is inconsistent with or which stands as an obstacle to the effective implementation of this Ordinance shall be superseded by this Ordinance and is hereby repealed and set aside.

Section 17. Effective Date. This ordinance shall take effect following passage and publication in accordance with the law.

SONYA G. HARRIS, Clerk
Board of Commissioners
Date: 3-2, 2021

Dennis Levinson
County Executive
Date: 3/4, 2021

MAUREEN KERN, Chairwoman
Board of Commissioners
Date: 3-2, 2021

Approved as to form:
James F. Ferguson
County Counsel
Date: 2/5, 2021

Ord Hospital Fee-2021.doc

NOTICE IS HEREBY GIVEN that the foregoing Ordinance was introduced and passed on first reading at a meeting of the Board of County Commissioners of the County of Atlantic held on **Tuesday, February 16, 2021** and said Ordinance will be further considered for passage and adoption at the public meeting of the Board of County Commissioners to be held at the **Stillwater Building, 201 Shore Road, Northfield, New Jersey** and **via live stream at https://www.atlantic-county.org/commissioners/ on Tuesday, March 2, 2021, at 4 p.m.**

CAMDEN COUNTY BOARD OF COMMISSIONERS

Commissioners Meeting Agenda

Commissioner Meeting Venue:

Date: Mar 18, 2021 - 12:00 PM

Location: Camden County Courthouse
520 Market Street
16th Floor Conference Room
Camden, NJ 08102

Agenda: PUBLIC HEARING- Ordinance of the County of Camden authorizing and adopting an assessment on certain services furnished by hospitals located within the County's borders for the purpose of increasing funding to support the provision of necessary services by such hospitals to low-income citizens and provide new fiscal resources to the County of Camden.

Official Resolution#	**2021-00165**						
Meeting Date	03/18/2021						
Introduced Date	03/18/2021						
Adopted Date	03/18/2021						
Agenda Item	i						
Result	Adopted						
COUNTY COMMISSIONER	**PRES.**	**ABS.**	**MOVE**	**SEC**	**AYE**	**NAY**	**ABST.**
Dyer		✓					
Kane	✓			✓	✓		
Nash		✓					
Rodriguez	✓				✓		
Young	✓		✓		✓		
McDonnell	✓				✓		
Cappelli, Jr.	✓				✓		

CERTIFICATION

I HEREBY CERTIFY THE ATTACHED TO BE A TRUE COPY OF A RESOLUTION ADOPTED BY THE BOARD OF COMMISSIONERS OF THE COUNTY OF CAMDEN AT ITS MEETING HELD ON MARCH 18, 2021

KARYN GILMORE
CLERK OF THE BOARD

RESOLUTION

AN ORDINANCE OF THE COUNTY OF CAMDEN AUTHORIZING AND ADOPTING AN ASSESSMENT ON CERTAIN SERVICES FURNISHED BY HOSPITALS LOCATED WITHIN THE COUNTY'S BORDERS FOR THE PURPOSE OF INCREASING FUNDING TO SUPPORT THE PROVISION OF NECESSARY SERVICES BY SUCH HOSPITALS TO LOW-INCOME CITIZENS AND PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF CAMDEN.

WHEREAS, hospitals in Camden County (the "County") provide essential services and serve a critical role in promoting the health of the County's citizens and expanding access to care throughout the community; and

WHEREAS, each year, hospitals in the County provide millions of dollars of uncompensated health care to Medicaid and uninsured patients; and

WHEREAS, on November 1, 2018, the State of New Jersey (the "State") Legislature enacted the County Option Hospital Fee Pilot Program (the "County Option Program") to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients (P.L.2018, c. 136); and

WHEREAS, pursuant to P.L.2018, c. 136, the County is eligible to participate in the County Option Program and is thereby authorized to impose an Assessment on hospitals located within the County's borders; and

WHEREAS, the funding from the County Assessment will be transferred to the Division of Medical Assistance and Health Services ("DMAHS") to enable the State to draw down federal matching funds to support a rate increase in payments to hospitals in the County for certain services furnished to Medicaid/NJ FamilyCare beneficiaries; and

WHEREAS, the County, through its contracted attorneys, has developed a model to participate in the County Option Program, based on a comprehensive process of consulting and gathering feedback from all Assessed Hospitals; and

WHEREAS, the consultation process consisted of educating all Assessed Hospitals on the intent and goals of the Program and associated requirements, supporting hospital submission of required data forms, presenting available options to all Assessed Hospitals and hosting multiple hospital-wide discussions and follow-up discussions as requested, and soliciting written feedback from all Assessed Hospitals to inform the County's Assessment selection; and

WHEREAS, on December 16, 2020, the County submitted the required Fee & Expenditure Report to DMAHS describing its proposed model and on January 29, 2021, DMAHS approved the proposal; and

WHEREAS, the County has an interest in supporting access to health care to its low-income residents, as well as the broader community through support of necessary care provided by local hospitals; and

WHEREAS, imposing an assessment to help fund the provision of necessary care by local hospitals to low-income patients in the County is a valid public purpose that benefits the health, safety and welfare of its citizens; and

WHEREAS, ensuring the financial stability and viability of local hospitals providing such necessary health care supports important contributors to the County's economy; and

WHEREAS, the County desires to participate in the County Option Program through the model described in the approved Fee and Expenditure Report including by levying and collecting an Assessment on certain services furnished by hospitals located within the County's borders more specifically described herein.

NOW, THEREFORE, BE IT ORDAINED, by the Board of Commissioners of the County of Camden, that:

Section 1. Recitals. The Recitals set forth above are hereby incorporated by reference.

Section 2. Definitions. As used in this Ordinance, the following capitalized terms, not otherwise defined herein, shall have the following meanings, unless the context hereof otherwise requires.

"Assessment" means the assessment imposed and levied upon the Assessed Hospitals as defined herein.

"Assessment Notice" means the notice distributed to each Assessed Hospital at the beginning of each Program Year specifying the annual Assessment owed and the quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

"Assessed Revenues" means, with respect to each Assessed Hospital, the total amount of net inpatient hospital service revenues reported on the most recent "Data Form for County Option Hospital Fee Pilot Program" prepared by the Assessed Hospital and submitted to the State prior to the effective date of this Ordinance. Such net inpatient hospital service revenues are determined by subtracting Lines 2, 3, and 5 of Column A from the total net inpatient revenues reported in Line 1 of Column A of such data form.

"Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services.

"Directed Payments" means the Medicaid managed care rate increase payments distributed by DMAHS through the Managed Care Organizations to hospitals as authorized under the County Option Program.

"Implementation Date" means July 1, 2021 provided that the County Option Program has received all necessary federal approvals, but in no case shall the Assessment be implemented if the County has not entered into an Intergovernmental Agreement consistent with Section 11.

"Intergovernmental Agreement" means the agreement between the County and DMAHS governing the transfer of the Assessment funds collected from the Assessed Hospitals.

"Managed Care Organizations" means the health plans under contract with DMAHS to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program and that will be directed to distribute Medicaid managed care rate increase payments to hospitals under the County Option Program.

"Program Year" means each 12-month period of the County Option Program, beginning with July 1, 2021 through June 30, 2022.

"Quarterly Assessment Invoice" means the notice distributed to each Assessed Hospital prior to each quarterly Assessment due date specifying the quarterly Assessment amount due, any interest incurred, and any additional elements specified herein.

Section 3. Authority. This Ordinance is adopted pursuant to P.L.2018, c. 136.

Section 4. Assessment Scope, Basis and Use.

(A) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Section 5, to take effect on the Implementation Date.

(B) The County shall use the amounts collected from the Assessment only as follows:
  (1) The County shall transfer 91% of total collected funds to DMAHS to be used as outlined in the Intergovernmental Agreement, described in Section 11.
  (2) The County shall retain 9% of total collected funds to be allocated as directed by the Board of County Commissioners.

(C) In the event that DMAHS returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital within 15 days of receipt the pro rata portion of such funds.

(D) In the event that an individual Assessed Hospital is determined to have overpaid their Assessment or otherwise paid in error, the County shall refund the overpayment or the amount paid in error to the Assessed Hospital within 15 days of the later of:

(1) Discovering the overpayment or error, if the funds have not been transferred to DMAHS, or
(2) Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to DMAHS.

(E) Assessed Hospitals shall not pass on the cost of the fee to any patient, insurer, self-insured employer program, or other responsible party, nor list it separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

Section 5. Computation of Assessment.

(A) The annual Assessment for each Assessed Hospital shall equal 4.16% of Assessed Revenues.

(B) The annual Assessment amounts for each Assessed Hospital, calculated pursuant to (A), equal the following:
(1) Cooper Hospital University Medical Center, $20,923,233
(2) Virtua West Jersey - Voorhees, $12,451,662
(3) Virtua – Our Lady of Lourdes, $8,575,853
(4) Jefferson University Hospitals, $9,041,383
(5) Northbrook Behavioral Health Hospital, $1,626,130

(C) The annual Assessment shall be payable in four quarterly installments, each to equal 25% of the annual Assessment amount.

Section 6. Assessment Notice.

(A) At least 30 days prior to the due date of the first Assessment of each Program Year, the County shall provide an Assessment Notice by first class mail and/or electronic mail to the owner of each Assessed Hospital.

(B) The Assessment Notice shall include (1) a brief explanation of the Assessment, (2) a description of the methodology used to determine the Assessment amount, (3) the annual Assessment amount owed by the Assessed Hospital for the upcoming Program Year, (4) the quarterly Assessment amounts owed by the Assessed Hospital for the Program Year; (5) the acceptable methods of payment, (6) the dates on which each quarterly Assessment is due, (7) the interest rate that will be charged for late payments; and (8) a statement of the Assessed Hospital's appeal right and the timing and requirements of such appeal.

Section 7. Assessment Invoice.

(A) At least 20 days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by first class mail and/or electronic mail to the owner of each Assessed Hospital.

(B) The Assessment Invoice shall include (1) the Assessment amount due for the relevant quarter, including any accrued interest from prior quarters, (2) the acceptable methods of payment, and (3) the due date of such payment.

Section 8. Interest. Should an Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may require the Assessed Hospital to pay interest in the amount of 1.5% of the outstanding payment amount per month, to be added to the following quarter's Assessment Invoice.

Section 9. Appeals.

(A) Upon receipt of the County's Assessment Notice at the beginning of each Program Year, Assessed Hospitals shall have 15 days to file an appeal of the Assessment amount stated in the Assessment Notice with the County's Appeal Tribunal.

(B) All appeals shall be in writing and shall indicate the specific basis for the appeal and shall include all documentation in support thereof. The appeals shall be made to the County's Appeal Tribunal which shall consist of the County Administrator, County Treasurer, and County Counsel. The Appeal Tribunal shall review the appeal submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The Appeal Tribunal shall render a written decision within 15 days in any case where an oral presentation is made or within 15 days of receipt of the written appeal materials where no oral presentation is requested. The decision of the Appeal Tribunal shall be final, binding, and no further appeal may be taken.

Section 10. Requirement to Submit Necessary Documentation. Assessed Hospitals shall submit any data forms related to the County Option Program requested by the County by the due date specified by the County.

Section 11. Intergovernmental Agreement. The County is authorized to enter into an Intergovernmental Agreement with DMAHS governing the transfer of Assessment funds from the County to the State. The agreement shall include the following:

(A) Timing requirements for the transfer of Assessment funds from the County to DMAHS, from DMAHS to the Managed Care Organizations, and from the Managed Care Organizations to the hospitals.

(B) A requirement that DMAHS use 90% of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that DMAHS may permit the Managed Care Organizations that make the Directed Payments to retain up to 5% of the total amount paid to them exclusively to cover their incremental cost of any state insurance premium tax.

(C) Assurances that the County will not be liable for any unpaid Assessment amounts and will only be responsible for transferring Assessed funds to the extent received by the Assessed Hospitals.

(D) A requirement that DMAHS return to the County the non-federal share of any Directed Payment funds recouped by DMAHS from Assessed Hospitals.

(E) A statement that any resulting Medicaid/NJ Family Care payments distributed under the County Option Program shall not supplant or otherwise offset payments made to hospitals from other State or federal funding mechanisms or pools, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(F) Assurances that funds generated by the Assessment shall not supplant or offset any current or future State funds allocated to the County.

Section 12. Termination. The Assessment shall terminate upon expiration of the County Option Program under state law, unless any of the following conditions occur earlier:

(A) DMAHS notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation.

(B) The Assessment is otherwise finally determined to be unlawful under County, State, or Federal law by an agency or court competent to make such a final determination; or

(C) The County Option Program is terminated or fails to obtain required approval or reapproval by the federal Centers for Medicare and Medicaid Services; or

(D) The Intergovernmental Agreement described in Section 11 is terminated or no longer meets the conditions described in such section.

Section 13. Impact of Termination. In the event that the Assessment terminates early pursuant to Section 12 (A)-(D), the County shall refund to each Assessed Hospital within 15 days of the effective date of such termination the pro rata portion of:

(A) Any funds that have not been transferred to DMAHS or that DMAHS returns to the County; and

(B) Any of the portion allocated for the County's use pursuant to Section 4(B)(2) that has not already been spent or irrevocably allocated for its designated purposes.

Section 14. Public Hearing. A public hearing for the purpose of hearing persons interested in or affected by this proposed Ordinance authorizing the Assessment shall be held on March 18, 2021 at 12 noon at the Camden County Courthouse, 520 Market Street, Camden, New Jersey. Due to

the current State of Emergency and Public Health Emergency declared by Governor Phil Murphy pursuant to Executive Order and in an effort to prevent the further spread of COVID-19, the general public will be excluded from attending the Public Hearing in person. The meeting will be streamed live via https://www.camdencounty.com/live where members of the public can view and participate via the live feed.

Section 15. Severability. If any section, paragraph, subdivision, clause or provision of this Ordinance shall be judged invalid such adjudication shall apply only to the section, paragraph, subdivision, clause or provision so judged, and the remainder of the Ordinance shall be deemed valid and effective.

Section 16. Effective Date. This Ordinance shall take effect 20 days following final adoption and publication in accordance with applicable law; provided, however, that in no event shall this Ordinance become effective until such date as the Local Finance Board shall render findings in connection with the matters set forth herein, in satisfaction of the provisions of N.J.S.A. 40A:5A-7.

BOARD OF COMMISSIONERS
COUNTY OF HUDSON

ORDINANCE

No. 205-4-2021

On Motion of Commissioner Vainieri
Seconded by Commissioner Walker

AN ORDINANCE OF THE COUNTY OF HUDSON AUTHORIZING AND ADOPTING AN ASSESSMENT ON CERTAIN SERVICES FURNISHED BY HOSPITALS LOCATED WITHIN THE COUNTY'S BORDERS FOR THE PURPOSE OF INCREASING FUNDING TO SUPPORT THE PROVISION OF NECESSARY SERVICES BY SUCH HOSPITALS TO LOW-INCOME CITIZENS AND PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF HUDSON.

WHEREAS, hospitals in Hudson County (the "County") provide essential services and serve a critical role in promoting the health of the County's citizens and expanding access to care throughout the community; and

WHEREAS, each year, hospitals in the County provide millions of dollars of uncompensated health care to Medicaid and uninsured patients; and

WHEREAS, on November 1, 2018, the State of New Jersey (the "State") Legislature enacted the County Option Hospital Fee Pilot Program (the "County Option Program") to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients (P.L.2018, c. 136); and

WHEREAS, pursuant to P.L.2018, c. 136, the County is eligible to participate in the County Option Program and is thereby authorized to impose an Assessment on hospitals located within the County's borders; and

WHEREAS, the funding from the County Assessment will be transferred to the Division of Medical Assistance and Health Services ("DMAHS") to enable the State to draw down federal matching funds to support a rate increase in payments to hospitals in the County for certain services furnished to Medicaid/NJ FamilyCare beneficiaries; and

WHEREAS, the County, through its contracted attorneys, has developed a model to participate in the County Option program, based on a comprehensive process of consulting and gathering feedback from all Assessed Hospitals; and

WHEREAS, the consultation process consisted of educating all Assessed Hospitals on the intent and goals of the program and associated requirements, supporting hospital submission of required data forms, presenting available options to all Assessed Hospitals and hosting multiple hospital-wide discussions and follow-up discussions as requested, and soliciting written feedback from all Assessed Hospitals to inform the County's Assessment selection; and

WHEREAS, on December 10, 2020, the County submitted the required Fee & Expenditure Report to DMAHS describing its proposed model and on January 29, 2021, DMAHS approved the proposal; and

WHEREAS, the County has an interest in supporting access to health care to its low-income residents, as well as the broader community through support of necessary care provided by local hospitals; and

WHEREAS, imposing an assessment to help fund the provision of necessary care by local hospitals to low-income patients in the County is a valid public purpose that benefits the health, safety and welfare of its citizens; and

WHEREAS, ensuring the financial stability and viability of local hospitals providing such necessary health care supports important contributors to the County's economy; and

WHEREAS, the County desires to participate in the County Option program through the model described in the approved Fee and Expenditure Report including by levying and collecting an Assessment on certain services furnished by hospitals located within the County's borders more specifically described herein.

NOW, THEREFORE, BE IT ORDAINED, by the Board of Commissioners of the County of Hudson, that:

Section 1. Recitals. The Recitals set forth above are hereby incorporated by reference.

Section 2. Definitions. As used in this Ordinance, the following capitalized terms, not otherwise defined herein, shall have the following meanings, unless the context hereof otherwise requires.

"Assessment" means the assessment imposed and levied upon the Assessed Hospitals as defined herein.

"Assessment Notice" means the notice distributed to each Assessed Hospital at the beginning of each Program Year specifying the annual Assessment owed and the quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

"Assessed Days" means, with respect to each Assessed Hospital, the total number of annual days reported on the most recent 2019 Medicare Cost Report prepared by the Assessed Hospital and submitted to the State prior to the effective date of this Ordinance. Such total patient days are determined by adding together Lines 14, 16, 17, 30, and 31 of Column 8 in Worksheet S-3 Part I of the 2019 Medicare Cost Report.

"Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services.

"Directed Payments" means the Medicaid managed care rate increase payments distributed by DMAHS through the Managed Care Organizations to hospitals as authorized under the County Option Program.

"Implementation Date" means July 1, 2021 provided that the County Option Program has received all necessary federal approvals, but in no case shall the Assessment be implemented if the County has not entered into an Intergovernmental Agreement consistent with Section 11.

"Intergovernmental Agreement" means the agreement between the County and DMAHS governing the transfer of the Assessment funds collected from the Assessed Hospitals.

"Managed Care Organizations" means the health plans under contract with DMAHS to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program and that will be directed to distribute Medicaid managed care rate increase payments to hospitals under the County Option Program.

"Program Year" means each 12-month period of the County Option Program, beginning with July 1, 2021 through June 30, 2022.

"Quarterly Assessment Invoice" means the notice distributed to each Assessed Hospital prior to each quarterly Assessment due date specifying the quarterly Assessment amount due, any interest incurred, and any additional elements specified herein.

Section 3. Authority. This Ordinance is adopted pursuant to P.L.2018, c. 136.

Section 4. Assessment Scope, Basis and Use.

(A) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Section 5, to take effect on the Implementation Date.

(B) The County shall use the amounts collected from the Assessment only as follows:

(1) The County shall transfer 91% of total collected funds to DMAHS to be used as outlined in the Intergovernmental Agreement, described in Section 11.

(2) The County shall retain 9% of total collected funds to be appropriated in accordance with the New Jersey budgetary statute.

(C) In the event that DMAHS returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital within 15 days of receipt the pro rata portion of such funds.

(D) In the event that an individual Assessed Hospital is determined to have overpaid their Assessment or otherwise paid in error, the County shall refund the overpayment or the amount paid in error to the Assessed Hospital within 15 days of the later of:

(1) Discovering the overpayment or error, if the funds have not been transferred to DMAHS, or

(2) Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to DMAHS.

(E) Assessed Hospitals shall not pass on the cost of the fee to any patient, insurer, self-insured employer program, or other responsible party, nor list it separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

Section 5. Computation of Assessment.

(A) The annual Assessment for each Assessed Hospital shall equal $133.33 multiplied by the number of Assessed Days.

(B) The annual Assessment amounts for each Assessed Hospital, calculated pursuant to (A), equal the following:

(1) Palisades Medical Center, $4,554,306

(2) CarePoint Health – Christ Hospital, $5,825,880

(3) CarePoint Health – Bayonne Medical Center, $3,431,262

(4) CarePoint Health – Hoboken Medical Center, $4,473,908

(5) Jersey City Medical Center, $10,451,651

(6) Hudson Regional Hospital, $1,341,972

(C) The annual Assessment shall be payable in four quarterly installments, each to equal 25% of the annual Assessment amount.

Section 6. Assessment Notice.

(A) At least 30 days prior to the due date of the first Assessment of each Program Year, the County shall provide an Assessment Notice by first class mail and/or electronic mail to the owner of each Assessed Hospital.

(B) The Assessment Notice shall include (1) a brief explanation of the Assessment, (2) a description of the methodology used to determine the Assessment amount, (3) the annual Assessment amount owed by the Assessed Hospital for the upcoming Program Year, (4)

the quarterly Assessment amounts owed by the Assessed Hospital for the Program Year; (5) the acceptable methods of payment, (6) the dates on which each quarterly Assessment is due, (7) the interest rate that will be charged for late payments; and (8) a statement of the Assessed Hospital's appeal right and the timing and requirements of such appeal.

Section 7. Assessment Invoice.

(A) At least 20 days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by first class mail and/or electronic mail to the owner of each Assessed Hospital.

(B) The Assessment Invoice shall include (1) the Assessment amount due for the relevant quarter, including any accrued interest from prior quarters, (2) the acceptable methods of payment, and (3) the due date of such payment.

Section 8. Interest. Should an Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may require the Assessed Hospital to pay interest in the amount of 1.5% of the outstanding payment amount per month, to be added to the following quarter's Assessment Invoice.

Section 9. Appeals.

(A) Upon receipt of the County's Assessment Notice at the beginning of each Program Year, Assessed Hospitals shall have 15 days to file an appeal of the Assessment amount stated in the Assessment Notice with the County's Appeal Tribunal.

(B) All appeals shall be in writing and shall indicate the specific basis for the appeal and shall include all documentation in support thereof. The appeals shall be made to the County's Appeal Tribunal which shall consist of the County Administrator, County Treasurer, and the Director of the County's Department of Health and Human Services. The Appeal Tribunal shall review the appeal submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The Appeal Tribunal shall render a written decision within 15 days in any case where an oral presentation is made or within 15 days of receipt of the written appeal materials where no oral presentation is requested. The decision of the Appeal Tribunal shall be final, binding, and no further appeal may be taken.

Section 10. Requirement to Submit Necessary Documentation. Assessed Hospitals shall submit an annual report detailing the community benefits provided by the Assessed Hospital to Hudson County residents, as well as any data forms related to the County Option Program requested by the County, by the due date specified by the County. Tax-exempt hospitals that report community benefit annually to the IRS under Form 990 Schedule H may provide a copy of its most recent IRS Form 990 Schedule H form to comply with this section.

Reports shall be due on April 1 of each year or within ninety (90) days of the end of the fiscal year for those Assessed Hospitals not operating on a calendar year budget. Assessed Hospitals may request a ninety (90) day extension of the time in which to file this report with the County for good cause shown, which extension shall not be unreasonably withheld.

Section 11. Intergovernmental Agreement. The County is authorized to enter into an Intergovernmental Agreement with DMAHS governing the transfer of Assessment funds from the County to the State. The agreement shall include the following:

(A) Timing requirements for the transfer of Assessment funds from the County to DMAHS, from DMAHS to the Managed Care Organizations, and from the Managed Care Organizations to the hospitals.

(B) A requirement that DMAHS use 90% of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that DMAHS may permit the Managed Care Organizations that make the Directed Payments to retain up to 5% of the total amount paid to them exclusively to cover their incremental cost of any state insurance premium tax.

(C) Assurances that the County will not be liable for any unpaid Assessment amounts and will only be responsible for transferring Assessed funds to the extent received by the Assessed Hospitals.

(D) A requirement that DMAHS return to the County the non-federal share of any Directed Payment funds recouped by DMAHS from Assessed Hospitals.

(E) A statement that any resulting Medicaid/NJ Family Care payments distributed under the County Option Program shall not supplant or otherwise offset payments made to hospitals from other state or federal funding mechanisms or pools, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(F) Assurances that funds generated by the Assessment shall not supplant or offset any current or future State funds allocated to the County.

Section 12. Termination. The Assessment shall terminate upon expiration of the County Option Program under state law, unless any of the following conditions occur earlier:

(A) DMAHS notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation.

(B) The Assessment is otherwise finally determined to be unlawful under County, State, or Federal law by an agency or court competent to make such a final determination; or

(C) The County Option Program is terminated or fails to obtain required approval or reapproval by the federal Centers for Medicare and Medicaid Services; or

(D) The Intergovernmental Agreement described in Section 11 is terminated or no longer meets the conditions described in such section.

Section 13. Impact of Termination. In the event that the Assessment terminates early pursuant to Section 12 (A)-(D), the County shall refund to each Assessed Hospital within 15 days of the effective date of such termination the pro rata portion of:

(A) Any funds that have not been transferred to DMAHS or that DMAHS returns to the County; and

(B) Any of the portion allocated for the County's use pursuant to Section 4(B)(2) that has not already been spent or irrevocably allocated for its designated purposes.

Section 14. Public Hearing. A public hearing for the purpose of hearing persons interested in or affected by this proposed ordinance authorizing the Assessment shall be held on April 15, 2021, at 567 Pavonia Avenue, Board of Commissioners Chambers, 1st Floor, Jersey City N.J. 07306 at 4:00PM, or by web or video conference should the limitations prohibit in-person meetings due to the COVID-19 pandemic remain in effect.

Section 15. Publication of the Ordinance shall be performed as set forth in N.J.S.A. 40:49-2.

Section 16. Severability. If any section, paragraph, subdivision, clause or provision of this Ordinance shall be judged invalid such adjudication shall apply only to the section, paragraph, subdivision, clause or provision so judged, and the remainder of the Ordinance shall be deemed valid and effective.

Section 17. Effective Date. This Ordinance shall take effect after passage by the Board of Commissioners and approval by the County Executive.

Commissioner	Aye	Nay	Abst.	N.P.	Commissioner	Aye	Nay	Abst.	N.P.
Walker	✓				Cedeño				✓
Cifelli	✓				Rodriguez	✓			
Kopacz	✓				Romano	✓			
Aponte-Lipski	✓				Chairperson Vainieri	✓			
O'Dea	✓								

It is hereby certified that at a regular meeting of the Board of County Commissioners of the County of Hudson held on the 15th day of April A.D. 2021, the foregoing ordinance was finally adopted with 8 members voting in the affirmative and 0 in the negative.

_____, Clerk

The foregoing ordinance having been duly presented to me, I hereby _____ the same

Dated: A.D. 2021

_____
County Executive

Source: Law
DJD/ek

COUNTY OF MERCER, NEW JERSEY

ORDINANCE NO. 2021- 1

1st Reading...April 8, 2021.....

2nd Reading...April 22, 2021.....

Public Hearing..April 22, 2021

Date Adopted:

.....April 22, 2021.....

.....

.....May 12, 2021.....

Effective Date

Date to County Executive.....

Date Returned.....

Date Resubmitted to Board.....

Approved as to Form ~~and Legality~~

.....

County Counsel

AN ORDINANCE OF THE COUNTY OF MERCER AMENDING THE ADMINISTRATIVE CODE OF MERCER COUNTY, NEW JERSEY, AND AUTHORIZING AN ASSESSMENT ON CERTAIN SERVICES FURNISHED BY HOSPITALS LOCATED WITHIN THE COUNTY'S BORDERS FOR THE PURPOSE OF INCREASING FUNDING TO SUPPORT THE PROVISION OF NECESSARY SERVICES BY SUCH HOSPITALS TO LOW-INCOME CITIZENS, AND TO PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF MERCER. N.J.S.A. 30:4D-7r, et seq. (AMENDMENT NO. 22)

RECORD OF VOTE

First Reading							Second Reading						
FREEHOLDER	Aye	Nay	N.V.	Abs.	Res.	Sec.	FREEHOLDER	Aye	Nay	N.V.	Abs.	Res.	Sec.
Cannon	X						Cannon	X					
Cimino				X			Cimino	X					
Colavita				X			Colavita				X		
Koontz	X					✓	Koontz	X					✓
Melker	X						Melker	X					
Walter	X				✓		Walter	X				✓	
Frisby	X						Frisby	X					

X—Indicates Vote Abs.—Absent N.V.—Not Voting
Res.—Resolution Moved Sec.—Resolution Seconded

Rejected [ ]
Approved [X]
Reconsidered
By Board.....

By.....
County Executive

Override Vote [ ] Aye [ ] Nay

.....Samuel Frisby.....
Chair of the Board

.....Jerlene N. Worthy.....
Clerk to the Board

ORDINANCE NO. 2021-1

WHEREAS, hospitals in Mercer County (the "County") provide essential services and serve a critical role in promoting the health of the County's citizens and expanding access to care throughout the community; and,

WHEREAS, each year, hospitals in the County provide millions of dollars of uncompensated health care to Medicaid and uninsured patients; and,

WHEREAS, on November 1, 2018, the State of New Jersey (the "State") enacted the County Option Hospital Fee Pilot Program (the "County Option Program") a 5-year pilot program designed to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients (P.L.2018, c. 136), N.J.S.A. 30:4D-7r, et seq; and,

WHEREAS, under the County Option Program, the County is authorized to impose an Assessment on certain services furnished by local hospitals; and,

WHEREAS, the funding collected from the County Assessment will be transferred to the State's Division of Medical Assistance and Health Services ("DMAHS") to enable the State to draw down federal matching funds to support a rate increase in payments to hospitals in the County for certain services furnished to Medicaid/NJ FamilyCare beneficiaries; and,

WHEREAS, the County, through contracted counsel, has developed a model to participate in the County Option Program, based on a comprehensive process of consulting and gathering feedback from all Assessed Hospitals; and,

WHEREAS, the consultation process consisted of educating all Assessed Hospitals on the intent and goals of the program and associated requirements, supporting hospital submission of required data forms, presenting available options to all Assessed Hospitals and hosting multiple hospital-wide discussions and follow-up discussions as requested, and soliciting written feedback from all Assessed Hospitals to inform the County's Assessment selection; and,

WHEREAS, on November 13, 2020, the County submitted the required Fee & Expenditure Report to DMAHS describing its proposed model, and on February 8, 2021, DMAHS approved the proposal; and,

WHEREAS, imposing an assessment to help fund the provision of necessary care by local hospitals to low-income patients in the County is a valid public purpose that benefits the health, safety and welfare of its citizens; and,

WHEREAS, the County desires to participate in the County Option program through the approved model described in the approved Fee and Expenditure Report by levying and collecting an Assessment on certain services furnished by hospitals located within the County's borders, as more specifically described herein; now, therefore,

BE IT ORDAINED, by the Mercer County Board of Commissioners that the Mercer County Administrative Code shall be amended to provide as follows:

ORDINANCE NO. 2021-1

1. Chapter 4.08, County Hospital Fee Program

Section 4.08.01. Recitals. The Recitals set forth above are hereby incorporated by reference.

Section 4.08.02. Definitions. As used in this Ordinance, the following capitalized terms, not otherwise defined herein, shall have the following meanings, unless the context hereof otherwise requires.

"Assessment" means the assessment imposed and levied upon the Assessed Hospitals as defined herein.

"Assessment Notice" means the notice distributed to each Assessed Hospital at the beginning of each Program Year specifying the annual Assessment owed and the quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

"Assessed Revenues" means, with respect to each Assessed Hospital, the total amount of net inpatient hospital service revenues, other than Medicare revenues, reported on the most recent "Data Form for County Option Hospital Fee Pilot Program" prepared by the Assessed Hospital and submitted to the State prior to the effective date of this Ordinance. Such non-Medicare net inpatient hospital service revenues are determined by subtracting Lines 2, 3, 5 and 7 of Column A from the total net inpatient revenues reported in Line 1 of Column A of such data form. A blank data form is included herein for informational purposes.

"Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services, including: Capital Health Regional Medical Center; Capital Health Medical Center – Hopewell; St. Francis Medical Center; Robert Wood Johnson University Hospital – Hamilton; St. Lawrence Rehabilitation Center; and Princeton House Behavioral Health.

"Directed Payments" means the Medicaid managed care rate increase payments distributed by DMAHS through the Managed Care Organizations to hospitals as authorized under the County Option Program.

"Implementation Date" means July 1, 2021 provided that the County Option Program has received all necessary federal approvals, but in no case shall the Assessment be implemented if the County has not entered into an Intergovernmental Agreement consistent with Section 4.08.11.

"Intergovernmental Agreement" means the agreement between the County and DMAHS governing the transfer of the Assessment funds collected from the Assessed Hospitals.

"Managed Care Organizations" means the health plans under contract with DMAHS to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program and that will be directed to distribute Medicaid managed care rate increase payments to hospitals under the County Option Program.

"Program Year" means each 12-month period of the County Option Program, beginning with July 1, 2021 through June 30, 2022.

"Quarterly Assessment Invoice" means the notice distributed to each Assessed Hospital prior to each quarterly Assessment due date specifying the quarterly Assessment amount due, any interest incurred, and any additional elements specified herein.

Section 4.08.03. Authority. This Ordinance is adopted pursuant to P.L.2018, c. 136, and N.J.S.A. 30:4D-7r, et seq., as same may be amended and supplemented from time to time.

Section 4.08.04. Assessment Scope, Basis and Use.

(A) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Section 4.08.05, to take effect on the Implementation Date.

(B) The County shall use the amounts collected from the Assessment only as follows:
  (1) The County shall transfer 91% of total collected funds to DMAHS to be used as outlined in the Intergovernmental Agreement, described in Section 4.08.11.
  (2) The County shall retain 9% of total collected funds to be allocated at the County's discretion.

(C) In the event that DMAHS returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital the pro rata portion of such funds.

(D) In the event that an individual Assessed Hospital is determined to have overpaid their Assessment or otherwise paid in error, the County shall refund the overpayment or the amount paid in error to the Assessed Hospital within 15 days of the later of:
  (1) Discovering the overpayment or error, if the funds have not been transferred to DMAHS, or
  (2) Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to DMAHS.

(E) Assessed Hospitals shall not pass on the cost of the fee to any patient, insurer, self-insured employer program, or other responsible party, nor list it separately on any

invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

Section 4.08.05. Computation of Assessment.

(A) The annual Assessment for each Assessed Hospital shall equal 6.76% of Assessed Revenues.

(B) The annual Assessment amounts for each Assessed Hospital, calculated pursuant to (A), above, shall equal the following:

(1) Capital Health Regional Medical Center: $8,661,359
(2) Capital Health Medical Center – Hopewell: $10,691,108
(3) St. Francis Medical Center: $1,911,437
(4) Robert Wood Johnson University Hospital – Hamilton: $2,942,842
(5) St. Lawrence Rehabilitation Center: $214,149
(6) Princeton House Behavioral Health: $1,816,610

(C) The annual Assessment shall be payable in four quarterly installments, each to equal 25% of the annual Assessment amount.

Section 4.08.06. Assessment Notice.

(A) At least 30 days prior to the due date of the first Assessment of each Program Year, the County shall provide an Assessment Notice by certified mail/RRR and first class mail to the each Assessed Hospital.

(B) The Assessment Notice shall include (1) a brief explanation of the Assessment, (2) a description of the methodology used to determine the Assessment amount, (3) the annual Assessment amount owed by the Assessed Hospital for the upcoming Program Year, (4) the quarterly Assessment amounts owed by the Assessed Hospital for the Program Year; (5) the acceptable methods of payment, (6) the dates on which each quarterly Assessment is due, (7) the interest rate that will be charged for late payments; and (8) a statement of the Assessed Hospital's appeal right and the timing and requirements of such appeal.

Section 4.08.07. Assessment Invoice.

(A) At least 20 days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by certified mail/RRR and first class mail to each Assessed Hospital.

(B) The Assessment Invoice shall include (1) the Assessment amount due for the relevant quarter, including any accrued interest from prior quarters, (2) the acceptable methods of payment, and (3) the due date of such payment.

Section 4.08.08. Interest. Should an Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may require the Assessed Hospital to pay interest in the amount of 1.5% of the outstanding payment amount per month, to be added to the following quarter's Assessment Invoice.

Section 4.08.09. Appeals/appeal panel.

(A) Upon receipt of the County's Assessment Notice at the beginning of each Program Year, Assessed Hospitals shall have 15 days to file an appeal of the Assessment amount stated in the Assessment Notice.

(B) Any appeal shall be in writing and shall indicate the specific basis for the appeal, and shall include all documentation in support thereof. The appeal shall be made to the County's appeal panel which shall consist of the County Administrator, County Treasurer, and a designee from the County's Department of Health & Human Services. The appeal panel shall review the submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The appeal panel shall render a written decision within fifteen (15) days of receipt of the appeal materials where no oral presentation is requested; a written decision shall be provided within fifteen (15) days of the conclusion of any oral presentation. The decision of the appeal panel shall be final and binding upon the parties.

Section 4.08.10. Requirement to Submit Necessary Documentation. Assessed Hospitals shall submit any data forms reasonably related to the County Option Program requested by the County by the due date specified by the County.

Section 4.08.11. Intergovernmental Agreement. The County is authorized to enter into an Intergovernmental Agreement with DMAHS governing the transfer of Assessment funds from the County to the State, including the following general terms:

(A) Timing requirements for the transfer of Assessment funds from the County to DMAHS, from DMAHS to the Managed Care Organizations, and from the Managed Care Organizations to the hospitals.

(B) A requirement that DMAHS use 90% of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that DMAHS may permit the Managed Care Organizations that make the Directed Payments

to retain up to 5% of the total amount paid to them exclusively to cover their incremental cost of any state insurance premium tax.

(C) Assurances that the County will not be liable for any unpaid Assessment amounts and will only be responsible for transferring Assessed funds to the extent received by the Assessed Hospitals.

(D) A requirement that DMAHS return to the County the non-federal share of any Medicaid Directed Payment funds received by the assessed hospitals but subsequently recouped by DMAHS.

(E) A statement that any resulting Medicaid/NJ Family Care payments distributed under the County Option Program shall not supplant or otherwise offset payments made to hospitals from other State or federal funding mechanisms or pools, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(F) A statement describing DMAHS's use of the Assessment funds as the non—federal share of payments to draw down federal matching funds.

Section 4.08.12. Termination. The Assessment shall terminate upon expiration of the County Option Program under State law, unless any of the following conditions occur earlier:

(A) DMAHS notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation;

(B) The Assessment is otherwise finally determined to be unlawful under County, State, or Federal law by an agency or Court competent to make such a final determination;

(C) The County Option Program is terminated by the State, or fails to obtain required approval or reapproval by the federal Centers for Medicare and Medicaid Services; or

(D) The Intergovernmental Agreement described in Section 4.08.11 is terminated by its terms or no longer meets the conditions described in such section.

Section 4.08.13. Impact of Termination. In the event that the Assessment terminates early pursuant to Section 4.08.12 (A)-(D), the County shall refund to each Assessed Hospital within 15 days of the effective date of such termination the pro rata portion of:

(A) Any funds that have not been transferred to DMAHS or that DMAHS returns to the County; and

(B) Any of the portion allocated for the County's use pursuant to Section 4.08.04(B)(2) that has not already been spent or irrevocably allocated for its designated purposes.

2. The Clerk to the Board is hereby directed to comply with the publication of the Ordinance with the provisions of law.

3. This Ordinance shall take effect immediately upon passage and publication, subject to all necessary State and federal approvals.

4. Upon adoption, the Clerk shall forward a certified copy of this Ordinance to the County's Chief Financial Officer, County Counsel and the County Administrator.

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File Number: 21-318-R

Resolution Authorizing And Adopting An Assessment On Certain Services Furnished By Hospitals Located Within The County's Borders For The Purpose Of Increasing Funding To Support The Provision Of Necessary Services By Such Hospitals To Low-Income Citizens And Provide New Fiscal Resources To The County Of Middlesex

WHEREAS, hospitals in Middlesex County (the "County") provide essential services and serve a critical role in promoting the health of the County's citizens and expanding access to care throughout the community; and

WHEREAS, each year, hospitals in the County provide millions of dollars of uncompensated health care to Medicaid and uninsured patients; and

WHEREAS, on November 1, 2018, the State of New Jersey (the "State") Legislature enacted The County Option Hospital Fee Pilot Program (the "County Option Program") to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients (P.L.2018, c. 136); and

WHEREAS, pursuant to P.L.2018, c. 136, the County is eligible to participate in the County Option Program and is thereby authorized to impose an Assessment (as defined herein) on hospitals located within the County's borders; and

WHEREAS, the funding from the Assessment will be transferred to the Division of Medical Assistance and Health Services in the State Department of Human Services (the "DMAHS") to enable the State to draw down federal matching funds to support a rate increase in payments to hospitals in the County for certain services furnished to Medicaid/NJ FamilyCare beneficiaries; and

WHEREAS, the County, through its contracted attorneys, has developed a model to participate in the County Option Program, based on a comprehensive process of consulting and gathering feedback from all Assessed Hospitals (as defined herein); and

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WHEREAS, the consultation process consisted of educating all Assessed Hospitals on the intent and goals of the County Option Program and associated requirements, supporting hospital submission of required data forms, presenting available options to all Assessed Hospitals and hosting multiple hospital-wide discussions and follow-up discussions as requested, and soliciting written feedback from all Assessed Hospitals to inform the County's development of the Assessment; and

WHEREAS, the County submitted the required Fee & Expenditure Report dated December 10, 2020 to DMAHS describing the County's plan for the imposition and disposition of the Assessment, and, after DMAHS made such Fee & Expenditure Report available for review and comment by the Assessed Hospitals and other interested parties for 21 days, DMAHS approved such Fee & Expenditure Report on February 8, 2021; and

WHEREAS, the County has an interest in supporting access to health care to its low-income residents, as well as the broader community through support of necessary care provided by local hospitals; and

WHEREAS, imposing an assessment to help fund the provision of necessary care by local hospitals to low-income patients in the County is a valid public purpose that benefits the health, safety and welfare of its citizens; and

WHEREAS, ensuring the financial stability and viability of local hospitals providing such necessary health care supports important contributors to the County's economy; and

WHEREAS, the County desires to participate in the County Option Program through the model described in the approved Fee and Expenditure Report including by levying and collecting an Assessment on certain services furnished by hospitals located within the County's borders more specifically described herein.

NOW, THEREFORE, BE IT RESOLVED, by the Board of Commissioners of the County of Middlesex, that:

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Section 1. Recitals. The Recitals set forth above are hereby incorporated by reference.

Section 2. Definitions. As used in this Resolution, the following capitalized terms, not otherwise defined herein, shall have the following meanings, unless the context hereof otherwise requires.

"Assessment" means the assessment imposed and levied upon the Assessed Hospitals as defined herein.

"Assessment Notice" means the notice distributed to each Assessed Hospital at the beginning of each Program Year specifying the annual Assessment owed and the quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

"Assessed Discharges" means, with respect to each Assessed Hospital, the total number of annual

discharges, other than Medicare discharges, reported on the most recent "Data Form for County

Option Hospital Fee Pilot Program" prepared by the Assessed Hospital and submitted to the State

prior to the effective date of this Ordinance. Such non-Medicare discharges are determined by

adding together the Medicaid and Other inpatient discharges reported in columns A and C,

respectively, of lines 11 and 12 of such data form.

"Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services.

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"Directed Payments" means the Medicaid managed care rate increase payments distributed by DMAHS through the Managed Care Organizations to hospitals as authorized under the County Option Program.

"Implementation Date" means July 1, 2021 provided that the County Option Program has received all necessary federal approvals, but in no case shall the Assessment be implemented if the County has not entered into an Intergovernmental Agreement consistent with Section 11.

"Intergovernmental Agreement" means the agreement between the County and DMAHS governing the transfer of the Assessment funds collected from the Assessed Hospitals, as described further in Section 11.

"Managed Care Organizations" means the health plans under contract with DMAHS to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program and that will be directed to distribute Medicaid managed care rate increase payments to hospitals under the County Option Program.

"Program Year" means each 12-month period of the County Option Program, beginning with July 1, 2021 through June 30, 2022.

"Quarterly Assessment Invoice" means the notice distributed to each Assessed Hospital prior to each quarterly Assessment due date specifying the quarterly Assessment amount due, any interest incurred, and any additional elements specified herein.

Section 3. <u>Authority</u>. This Resolution is adopted pursuant to P.L.2018, c. 136.

Section 4. <u>Assessment Scope, Basis and Use</u>.

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(A) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Section 5, to take effect on the Implementation Date.

(B) The County shall use the amounts collected from the Assessment only as follows:

(1) The County shall transfer 91% of total collected funds to DMAHS to be used as outlined in the Intergovernmental Agreement, inclusive of any State administrative costs.

(2) The County shall retain 9% of total collected funds to be allocated at the County's discretion, including towards any administrative costs.

(C) In the event that DMAHS returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital within 15 days of receipt the pro rata portion of such funds.

(D) In the event that an individual Assessed Hospital is determined to have overpaid their Assessment or otherwise paid in error, the County shall refund the overpayment, or the amount paid in error to the Assessed Hospital within 15 days of the later of:

(1) Discovering the overpayment or error, if the funds have not been transferred to DMAHS, or

(2) Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to DMAHS.

(E) Assessed Hospitals shall not pass on the cost of the fee to any patient, insurer, self-insured employer program, or other responsible party, nor list it separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

Section 5. <u>Computation of Assessment</u>.

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(A) The annual Assessment for each Assessed Hospital shall equal $1,156.36 multiplied by the number of Assessed Discharges.

(B) The annual Assessment amounts for each Assessed Hospital, calculated pursuant to (A), equal the following:

(1) Penn Medicine Princeton Health, $9,147,938

(2) Robert Wood Johnson University Hospital, $21,134,731

(3) Raritan Bay Medical Center, $7,988,112

(4) Saint Peter's University Hospital, $15,410,765

(5) JFK Medical Center/Johnson Rehabilitation Institute, $13,949,131

(6) LTACH CareOne, $6,938

(7) Children's Specialized Hospital, $661,436

(C) The annual Assessment shall be payable in four quarterly installments, each to equal 25% of the annual Assessment amount.

Section 6. <u>Assessment Notice</u>.

(A) At least 30 days prior to the due date of the first Assessment of each Program Year, the County shall provide an Assessment Notice by first class mail and/or by electronic e-mail to the owner of each Assessed Hospital.

(B) The Assessment Notice shall include (1) a brief explanation of the Assessment, (2) a description of the methodology used to determine the Assessment amount, (3) the annual Assessment amount owed by the Assessed Hospital for the upcoming Program Year, (4) the quarterly Assessment amounts owed by the Assessed Hospital for the Program Year; (5) the acceptable methods of payment, (6) the dates on which each quarterly Assessment is due, (7) the interest rate that will be charged for late payments;

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and (8) a statement of the Assessed Hospital's appeal right and the timing and requirements of such appeal.

Section 7. Assessment Invoice.

(A) At least 20 days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by first class mail and/or electronic e-mails to the owner of each Assessed Hospital.

(B) The Assessment Invoice shall include (1) the Assessment amount due for the relevant quarter, including any accrued interest from prior quarters, (2) the acceptable methods of payment, and (3) the due date of such payment.

Section 8. Interest. Should an Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may require the Assessed Hospital to pay interest in the amount of 1.5% of the outstanding payment amount per month, to be added to the following quarter's Assessment Invoice.

Section 9. Appeals.

(A) Upon receipt of the Assessment Notice at the beginning of each Program Year, Assessed Hospitals shall have 15 days to file an appeal of the Assessment amount stated in the Assessment Notice with the County's Appeal Tribunal.

(B) All appeals shall be in writing and shall indicate the specific basis for the appeal and shall include all documentation in support thereof. The appeals shall be made to the County's Appeal Tribunal which shall consist of the County Administrator, County Treasurer, and a designee from the County's Division of Public Health. The Appeal Tribunal shall review the appeal submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The Appeal Tribunal shall render a written decision within 15 days in any case where an oral presentation is made or within 15 days of receipt of the written appeal materials where no oral presentation is

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requested. The decision of the Appeal Tribunal shall be final, binding, and no further appeal may be taken.

Section 10. Requirement to Submit Necessary Documentation. Assessed Hospitals shall submit any data forms related to the County Option Program requested by the County by the due date specified by the County.

Section 11. Intergovernmental Agreement. The County is authorized to enter into an Intergovernmental Agreement with DMAHS governing the transfer of Assessment funds from the County to the State. The Intergovernmental Agreement shall include the following:

(A) Timing requirements for the transfer of Assessment funds from the County to DMAHS, from DMAHS to the Managed Care Organizations, and from the Managed Care Organizations to the hospitals.

(B) A requirement that DMAHS use 90% of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that DMAHS may permit the Managed Care Organizations that make the Directed Payments to retain up to 5% of the total amount paid to them exclusively to cover their incremental cost of any state insurance premium tax.

(C) Assurances that the County will not be liable for any unpaid Assessment amounts and will only be responsible for transferring Assessment funds to the extent received by the Assessed Hospitals.

(D) A requirement that DMAHS return to the County the non-federal share of any Directed Payment funds recouped by DMAHS from Assessed Hospitals.

(E) A statement that any resulting Medicaid/NJ Family Care payments distributed under the County Option Program shall not supplant or otherwise offset payments made to hospitals from other State or federal funding mechanisms or pools, except that

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payments may be otherwise limited to the hospital's hospital-specific disproportionate share limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(F) Assurances that funds generated by the Assessment shall not supplant or offset any current or future State funds allocated to the County.

Section 12. Termination. The Assessment shall terminate upon expiration of the County Option Program under State law, unless any of the following conditions occur earlier:

(A) DMAHS notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation.

(B) The Assessment is otherwise finally determined to be unlawful under County, State, or federal law by an agency or court competent to make such a final determination; or

(C) The County Option Program is terminated or fails to obtain required approval or reapproval by the federal Centers for Medicare and Medicaid Services; or

(D) The Intergovernmental Agreement described in Section 11 is terminated or no longer meets the conditions described in such section.

Section 13. Impact of Termination. In the event that the Assessment terminates early pursuant to Section 12 (A)-(D), the County shall refund to each Assessed Hospital within 15 days of the effective date of such termination the pro rata portion of:

(A) Any funds that have not been transferred to DMAHS or that DMAHS returns to the County; and

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08901

(B) Any of the portion allocated for the County's use pursuant to Section 4(B)(2) that has not already been spent or irrevocably allocated for its designated purposes.

Section 14. Public Hearing. A public hearing for the purpose of hearing persons interested in or affected by this proposed resolution authorizing the Assessment shall be held on Thursday, March 4, 2021 at 7:00 PM. Information regarding remote access to the meeting may be found on the County's website at http://www.middlesexcountynj.gov/.

Section 15. Notice of Resolution. The Clerk or Deputy Clerk of the Board of County Commissioners is hereby authorized and directed to arrange for the publication of such resolution in full or in summary after introduction upon first reading in the Home News Tribune and after final adoption in full or in summary as required by law in the Home News Tribune.

Section 16. Severability. If any section, paragraph, subdivision, clause or provision of this Resolution shall be judged invalid such adjudication shall apply only to the section, paragraph, subdivision, clause or provision so judged, and the remainder of the Resolution shall be deemed valid and effective.

Section 17. Effective Date. This Resolution shall take effect after passage by the Board of Commissioners and approval by the County Executive.

Approved as to form and legality

Alessandra Baldini, Deputy County Counsel 2/22/2021

Leslie Koppel, County Commissioner 3/4/2021

Middlesex County

Adopted

Resolution: 21-318-R

Administration Building
75 Bayard Street
New Brunswick, NJ
08901

I, Amy R. Petrocelli, Clerk of the Board of County Commissioners of the County of Middlesex and State of New Jersey, do hereby certify that the above is a true copy of a resolution adopted at a meeting of the Board held on March 4, 2021

Amy R. Petrocelli, Clerk of the Board 3/4/2021

March 4, 2021

County of Passaic
Board of County Commissioners

OFFICE OF COUNTY COMMISSIONERS

Director Pasquale "Pat" Lepore
Deputy Director Bruce James
Assad R. Akhter
John W. Bartlett
Theodore O. Best, Jr.
Terry Duffy
Cassandra "Sandi" Lazzara

401 Grand Street
Paterson, New Jersey 07505
Tel: 973-881-4402
Fax: 973-742-3746

Anthony J. De Nova III
Administrator
Matthew P. Jordan, Esq.
County Counsel
Louis E. Imhof, III, RMC
Clerk Of The Board

Public Meeting (Board Meeting)

Date: Feb 23, 2021 - 5:30 PM

Location: County Administration Building
220- Webex
401 Grand Street
Paterson, NJ 07505

Agenda: RESOLUTION AUTHORIZING AND ADOPTING AN ASSESSMENT ON CERTAIN SERVICES FURNISHED BY HOSPITALS LOCATED WITHIN THE COUNTY'S BORDERS FOR THE PURPOSE OF INCREASING FUNDING TO SUPPORT THE PROVISION OF NECESSARY SERVICES BY SUCH HOSPITALS TO LOW-INCOME CITIZENS AND PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF PASSAIC, PURSUANT TO P.L. 2018, c 136. AND N.J.A.C. 10:52B-2.2, ALL AS NOTED IN THE RESOLUTION.

THIS RESOLUTION WAS REQUESTED BY:

REVIEWED BY:

Anthony J. De Nova III
COUNTY ADMINISTRATOR

APPROVED AS TO FORM AND LEGALITY:

Matthew P. Jordan, Esq.
COUNTY COUNSEL

Administration and Finance
COMMITTEE NAME

Official Resolution#	**R20210155**							
Meeting Date	02/23/2021							
Introduced Date	02/23/2021							
Adopted Date	02/23/2021							
Agenda Item	I-9							
CAF #								
Purchase Req. #								
Result	Adopted							
COMMISSIONER	**PRES.**	**ABS.**	**MOVE**	**SEC**	**AYE**	**NAY**	**ABST.**	**RECU.**
Lepore	✓				✓			
James	✓		✓		✓			
Akhter	✓				✓			
Bartlett	✓			✓	✓			
Best Jr.	✓				✓			
Duffy	✓				✓			
Lazzara	✓				✓			

PRES.= present ABS.= absent
MOVE= moved SEC= seconded
AYE= yes NAY= no ABST.= abstain
RECU.= recuse

Dated: February 24, 2021

RESOLUTION AUTHORIZING AND ADOPTING AN ASSESSMENT ON CERTAIN SERVICES FURNISHED BY HOSPITALS LOCATED WITHIN THE COUNTY'S BORDERS FOR THE PURPOSE OF INCREASING FUNDING TO SUPPORT THE PROVISION OF NECESSARY SERVICES BY SUCH HOSPITALS TO LOW-INCOME CITIZENS AND PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF PASSAIC, PURSUANT TO P.L. 2018, c 136. AND N.J.A.C. 10:52B-2.2

WHEREAS, the County of Passaic (hereafter "County") is a body politic and corporate pursuant to N.J.S.A. 40:18-1 and vested with all rights contained therein; and

WHEREAS, pursuant to N.J.S.A. 40:20-1 the Board of County Commissioners of the County of Passaic (hereafter "Board") is vested with managing the property, finances, and affairs of the County; and

WHEREAS, hospitals in Passaic County provide millions of dollars of uncompensated health care to Medicaid and uninsured patients; and

WHEREAS, on November 1, 2018, the New Jersey Legislature enacted the County Option Hospital Fee Pilot Program (hereafter "County Option Program") to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients (P.L.2018, c. 136); and

WHEREAS, pursuant to P.L.2018, c. 136, the County is eligible to participate in the County Option Program and is thereby authorized to impose an Assessment on hospitals located within the County's borders; and

WHEREAS, pursuant to N.J.A.C. 10:52B-2.2, for the County to participate in the County Option Program, the Board may enact a county ordinance or resolution, as appropriate, including the terms and condition set forth in N.J.A.C. 10:52B-2.2(a), et seq.; and

WHEREAS, the funding from the County Assessment will be transferred to the New Jersey Division of Medical Assistance and Health Services ("DMAHS") to enable the State of New Jersey (hereafter "State") to draw down federal matching funds to support a rate increase in payments to hospitals in the County for certain services furnished to Medicaid/NJ FamilyCare beneficiaries; and

WHEREAS, the County, in partnership with St. Joseph's University Medical Center, St. Mary's General Hospital, and Kindred Hospital, developed a model to participate in the County Option program, based on a comprehensive process of consulting and gathering feedback from the Assessed Hospitals; and

WHEREAS, the consultation process consisted of educating all Assessed Hospitals on the intent and goals of the program and associated requirements, supporting hospital submission of required data forms, presenting available options to all Assessed Hospitals and hosting multiple hospital-wide discussions and follow-up discussions as requested, and soliciting written feedback from all Assessed Hospitals to inform the County's Assessment selection; and

WHEREAS, on December 10, 2020, the County submitted the required Fee & Expenditure Report to DMAHS describing its proposed model and on January 29, 2021, DMAHS approved the proposal; and

WHEREAS, the County has an interest in supporting access to health care to its low-income residents, as well as the broader community through support of necessary care provided by local hospitals; and

WHEREAS, imposing an assessment to help fund the provision of necessary care by local hospitals to low-income patients in the County is a valid public purpose that benefits the health, safety and welfare of its citizens; and

WHEREAS, ensuring the financial stability and viability of local hospitals providing such necessary health care supports important contributors to the County's economy; and

WHEREAS, the County desires to participate in the County Option program through the model described in the approved Fee and Expenditure Report including by levying and collecting an Assessment on certain services furnished by hospitals located within the County's borders more specifically described herein; and

WHEREAS, this matter was discussed at the February 10, 2021 meeting of the Administration and Finance Committee and is being recommended to the Board for approval; and

NOW, THEREFORE, LET IT BE RESOLVED, by the Board of County Commissioners of the County of Passaic, pursuant to P.L. 2018, c. 136, as follows:

Section 1. Recitals.

The Recitals set forth above are hereby incorporated by reference.

Section 2. Definition.

As used in this Resolution, the following capitalized terms, not otherwise defined herein, shall have the following meanings, unless the context hereof otherwise requires.

(a) "Assessment" means the assessment imposed and levied upon the Assessed Hospitals as defined herein.

(b) "Assessment Notice" means the notice distributed to each Assessed Hospital at the beginning of each Program Year specifying the annual Assessment owed and the quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

(c) "Assessed Discharges" means, with respect to each Assessed Hospital, the total number of annual discharges reported on the most recent "Data Form for County Option Hospital Fee Pilot Program" prepared by the Assessed Hospital and submitted to the State prior to the effective date of this Resolution. Such total discharges are determined by adding together the Medicaid, Medicare, and Other inpatient discharges reported in Columns A, B, and C, respectively, of Lines 11 and 12 of such data form.

(d) "Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services.

(e) "Board" means the Board of County Commissioners of the County of Passaic.

(f) "County" means the County of Passaic.

(g) "Directed Payments" means the Medicaid managed care rate increase payments distributed by DMAHS through the Managed Care Organizations to hospitals as authorized under the County Option Program.

(h) "Director" means the Director of the Board of County Commissioners of the County of Passaic.

(i) "Implementation Date" means July 1, 2021 provided that the County Option Program has received all necessary federal approvals, but in no case shall the Assessment be implemented if the County has not entered into an Intergovernmental Agreement consistent with Section 11.

(j) "Intergovernmental Agreement" means the agreement between the County and DMAHS governing the transfer of the Assessment funds collected from the Assessed Hospitals.

(k) "Managed Care Organizations" means the health plans under contract with DMAHS to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program and that will be directed to distribute Medicaid managed care rate increase payments to hospitals under the County Option Program.

(l) "Program Year" means each 12-month period of the County Option Program, beginning with July 1, 2021 through June 30, 2022.

(m) "Quarterly Assessment Invoice" means the notice distributed to each Assessed Hospital prior to each quarterly Assessment due date specifying the quarterly Assessment amount due, any interest incurred, and any additional elements specified herein.

Section 3. Authority.

This Resolution is adopted pursuant to P.L.2018, c. 136.

Section 4. Assessment Scope; Basis; and Use.

(a) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Section 5, to take effect on the Implementation Date.

(b) The County shall use the amounts collected from the Assessment only as follows:

i. The County shall transfer ninety-one percent (91%) of total collected funds to DMAHS to be used as outlined in the Intergovernmental Agreement, described in Section 11.

ii. The County shall retain nine percent (9%) of total collected funds to be allocated and appropriated at the discretion of the Board.

(c) If DMAHS returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital within fifteen (15) days of receipt the pro rata portion of such funds.

(d) If an individual Assessed Hospital is determined to have overpaid their Assessment or otherwise paid in error, the County shall refund the overpayment, or the amount paid in error to the Assessed Hospital within 15 days of the later of:

i. Discovering the overpayment or error if the funds have not been transferred to DMAHS; or

ii. Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to DMAHS.

(e) Assessed Hospitals shall not pass on the cost of the fee to any patient, insurer, self-insured employer program, or other responsible party, nor list it separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

Section 5. Computation of Assessment.

(a) The annual Assessment for each Assessed Hospital shall equal five hundred twenty-six dollar and sixty-seven cents ($526.67) multiplied by the number of Assessed Discharges.

(b) The annual Assessment for each Assessed Hospital, calculated pursuant to Section 5, Computation of Assessment, Part (a), shall equal the following:

i. St. Joseph's University Medical Center - $17,582,325
ii. St. Mary's General Hospital - $3,183,189
iii. Kindred Healthcare - $150,627

(c) The annual Assessment shall be payable in four (4) quarterly installments, each equal to twenty five percent (25%) of the annual Assessment amount.

Section 6. Assessment Notice.

(a) At least thirty (30) days prior to the due date of the first Assessment of each Program Year, the County shall provide an Assessment Notice by first class mail and electronic to the designated representative of each Assessed Hospital.

(b) The Assessment Notice shall include:

i. A brief explanation of the Assessment;

ii. A description of the methodology used to determine the Assessment amount;

iii. The annual Assessment amount owed by the Assessed Hospital for the upcoming Program Year;

iv. The quarterly Assessment amounts owed by the Assessed Hospital for the Program Year;

v. The acceptable methods of payment;

vi. The dates on which each quarterly Assessment is due;

vii. The interest rate that will be charged for late payments; and

viii. A statement of the Assessed Hospital's appeal right and the timing and requirements of such appeal.

Section 7. Assessment Invoice.

(a) At least twenty (20) days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by first class mail and electronic mail to the designated representative of each Assessed Hospital.

(b) The Assessment Invoice shall include:

i. The Assessment amount due for the relevant quarter, including any accrued interest from prior quarters;

ii. The acceptable methods of payment; and

iii. The due date of such payment.

Section 8. Interest.

Should an Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may require the Assessed Hospital to pay interest in the amount of one and a half percent (1.5%) of the outstanding payment amount per month, to be added to the following quarter's Assessment Invoice.

Section 9. Appeals.

(a) Upon receipt of the Assessment Notice at the beginning of each Program Year, Assessed Hospitals shall have 15 days to file an appeal of the Assessment amount stated in the Assessment Notice with the County's Appeal Tribunal.

(b) All appeals shall be in writing and shall indicate the specific basis for the appeal and shall include all documentation in support thereof. The appeals shall be made to the County's Appeal Tribunal which shall consist of the County Administrator, Chief Financial Officer, and County Treasurer. The Appeal Tribunal shall review the appeal submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The Appeal Tribunal shall render a written decision within 15 days in any case where an oral presentation is made or within 15 days of receipt of the written appeal materials where no oral presentation is requested. The decision of the Appeal Tribunal shall be final, binding, and no further appeal may be taken.

Section 10. Requirements to Submit Necessary Documentation.

Assessed Hospitals shall submit any data forms related to the County Option Program requested by the County by the due date specified by the County.

Section 11. Intergovernmental Agreement.

The County is authorized to enter into an Intergovernmental Agreement with DMAHS governing the transfer of Assessment funds from the County to the State. The agreement shall include the following:

(a) Timing requirements for the transfer of Assessment funds from the County to DMAHS, from DMAHS to the Managed Care Organizations, and from the Managed Care Organizations to the hospitals.

(b) A requirement that DMAHS use ninety percent (90%) of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that DMAHS may permit the Managed Care Organizations that make the Directed Payments to retain up to five percent (5%) of the total amount paid to them exclusively to cover their incremental cost of any state insurance premium tax.

(c) Assurances that the County will not be liable for any unpaid Assessment amounts and will only be responsible for transferring Assessed funds to the extent received by the Assessed Hospitals.

(d) A requirement that DMAHS return to the County the non-federal share of any Directed Payment funds recouped by DMAHS from Assessed Hospitals.

(e) A statement that any resulting Medicaid/NJ Family Care payments distributed under the County Option Program shall not supplant or otherwise offset payments made to hospitals from other State or federal funding mechanisms or pools, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(f) Assurances that funds generated by the Assessment shall not supplant or offset any current or future State funds allocated to the County.

(g) Any other terms and conditions as necessary to carry out the purpose of this Resolution and the County Option Program.

Section 12. Termination.

The Assessment shall terminate upon expiration of the County Option Program under State law, unless any of the following conditions occur earlier:

(a) DMAHS notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation; or

(b) The County Option Program is terminated or fails to obtain required approval or reapproval by the federal Centers for Medicare and Medicaid Services; or

(c) The Intergovernmental Agreement described in Section 11 is terminated or no longer meets the conditions described in such section.

Section 13. Impact of Termination.

If the Assessment terminates pursuant to Section 12, Termination, Parts (a) – (d), the County shall refund to each Assessed Hospital within thirty (30) days of the effective date of such termination the pro rata portion of:

(a) Any funds that have not been transferred to DMAHS or that DMAHS returns to the County; and

(b) Any of the portion allocated for the County's use pursuant to Section 4, Assessment Scope; Basis; and Use, Part (b)(ii) that has not already been spent or irrevocably allocated for its designated purposes.

Section 14. Notice of Resolution; Filed with Clerk of the Board.

The Resolution shall be published by the Clerk of the Board, posted on the County website, and kept on file for public inspection in the Office of the Clerk of the Board.

Section 15. Severability.

If any section, paragraph, subdivision, clause or provision of this Resolution shall be judged invalid such adjudication shall apply only to the section, paragraph, subdivision, clause or provision so judged, and the remainder of the Resolution shall be deemed valid and effective.

Section 16. Effective Date.

The Resolution shall take effect immediately after passage by the Board.

LET IT BE FURTHER RESOLVED that the Clerk of the Board, County Administrator, County Counsel, Chief Financial Officer, and Director of the Board are authorized to take any and all action necessary to carry out the purpose of this Resolution.

EYMAN/MPJ February 23, 2021

O-1

ORDINANCE OF THE BOARD OF COUNTY COMMISSIONERS
COUNTY OF ESSEX

ORDINANCE NO. O-2022 - 00009 **AUTHORITY FOR ORDINANCE:** **N.J.S.A. 40:41A-38(n)**

PROPOSED BY: COUNTY EXECUTIVE **AUTHORITY FOR ACTION:** **N.J.S.A. 40:41A-36(i)**

SUBJECT: ORDINANCE FOR CONTINUATION OF THE NEW JERSEY COUNTY OPTION HOSPITAL FEE PILOT PROGRAM FOR THE COUNTY OF ESSEX

WHEREAS, the New Jersey State Legislature has enacted The County Option Hospital Fee Pilot Program Act, P.L. 2018, Chapter 136, permitting seven authorized counties to pilot a health care-related hospital fee program for hospital services; and

WHEREAS, to increase financial resources through the Medicaid program to support local hospitals and to ensure that they continue to provide necessary services to low-income citizens and to provide participating counties with new fiscal resources, the County of Essex seeks to implement a health care-related fee program for the County; and

WHEREAS, the health care-related fee, hereafter referred to as the Essex County Hospital Fee, shall be imposed on licensed hospitals located within the borders of Essex County; and

WHEREAS, hospitals subject to the Essex County Hospital Fee are New Jersey hospitals licensed under N.J.A.C. Title 8, Chapter 43G, Hospital Licensing Standards, including general and special hospitals and Chapter 43H, Rehabilitation Hospital Licensing Standards, including rehabilitation hospitals; and

WHEREAS, Essex County exempts the Essex county-owned and operated Essex County Hospital Center from the Essex County Hospital Fee; and

WHEREAS, Essex County submitted a proposed Fee and Expenditure Report to the Commissioner of the New Jersey Department of Human Services to ensure that the proposed fee and expenditure plan satisfies the requirements of The County Option Hospital Fee Pilot Program Act and the requirements of the New Jersey Department of Human Services' implementing regulations at N.J.A.C. 10:52B; and

WHEREAS, Essex County communicated with affected hospitals within its jurisdiction and collected feedback and comments throughout the development process of the Fee and Expenditure Report through conference calls, e-mails, fee model issuances, hospital data form collection, responses to hospital questions, and consideration of hospital feedback; and

WHEREAS, the New Jersey Department of Human Services commissioner approved the Essex County Fee and Expenditure Report on January 29, 2021; and

WHEREAS, Essex County will obtain approval from the New Jersey Department of Human Services commissioner for required amendments to the Essex County Fee and Expenditure Report; and

WHEREAS, the Essex County Hospital Fee shall be imposed on each hospital's annualized non-Medicare discharges, which is the difference between annualized total inpatient discharges and annualized Medicare inpatient discharges derived from the hospital's Medicare cost report, form CMS-2552-10 or successor; and

WHEREAS, a hospital fee shall be charged to each eligible hospital in an amount that shall not exceed the amount necessary to fund The County Option Hospital Fee Pilot Program for the County of Essex; and

WHEREAS, interest at a rate not to exceed one and one-half percent (1.5%) per month of the outstanding payment amount will be imposed by the County upon a hospital when payment of the fee is more than ten (10) days past the established due date, and

WHEREAS, the Essex County Hospital Fee will be collected only to the extent, and for the period, that the Commissioner determines that the revenues to be generated qualify as the non-federal share of Medicaid program expenditures eligible for federal financial participation pursuant to 42 C.F.R. §433.68; and

WHEREAS, the Essex County Hospital Fee will be determined annually and collected in equal quarterly installments; and

WHEREAS, the County will issue a fee notification letter to each hospital for each annual fee period corresponding to the state fiscal year, that will contain an explanation of the calculation of the fee, the amount of the fee to be assessed to the hospital, the due date of the quarterly installment payments, instructions for making the quarterly installment payments, the calculation of interest for late payments, penalties for non-payment, and the process for filing an appeal; and

WHEREAS, the County will send notice of the quarterly fee and delinquent amounts to each hospital and hospital fee payments shall be made to the County Treasurer on or before the due date during the last month of each quarter; and

WHEREAS, the fee plus any interest or other income earned on the monies deposited in the county trust fund shall be used exclusively for the purposes authorized by P.L. 2018, Chapter 136; and

WHEREAS, an accounting shall be made on or before the fifteenth day following the end of the quarter that shall clearly set forth all sums charged or which shall have accrued or become payable during the preceding quarter. Such statements shall be made under oath and filed in the office of the county treasurer as public records pursuant to N.J.S.A. 22A:4-17(a); and

WHEREAS, the delinquent fees and interest for late payment shall be recovered in the name of the Board of County Commissioners of the county in a civil action in the Superior Court and said officers may also be proceeded against; and

WHEREAS, hospitals may appeal errors in the computation of the fee and cost report data reported by the hospital, and if not affirmed by the County, may request a formal administrative hearing; and

WHEREAS, hospitals may appeal the decision to impose penalties and/or the amount of the penalties assessed, and if not affirmed by the County, may request a formal administrative hearing; and

WHEREAS, hospitals must identify and file appeals of the fee and cost report data within fifteen (15) days after the receipt of the fee notice and must file appeals on the decision to impose penalties and/or the amount of the penalties assessed within fifteen (15) days after the receipt of the notice of interest penalties; and

WHEREAS, appeals must be submitted to the County Administrator in writing and must describe the specific issues being appealed, and the county will notify the hospital of its decision within thirty (30) days; and

WHEREAS, hospitals dissatisfied with the county's response may request a formal administrative hearing within fifteen (15) days after the receipt of the county's response to the initial appeal, and the hearing officer will make a written summary of findings and recommendation to the County Administrator, who will issue a final administrative decision; and

WHEREAS, the County and the Commissioner have entered into an intergovernmental transfer agreement necessary to transfer funds to satisfy the Act; and

WHEREAS, the County will establish the Essex County Hospital Fee Trust Fund for collection of the fees; and

WHEREAS, not later than fifteen (15) days after the close of each quarter of the State fiscal year, ninety-one percent (91%) of the fee proceeds will be transferred to the Commissioner to cover State administrative costs and to be used as non-Federal share of Medicaid/NJ FamilyCare payments to hospitals in Essex County; and

WHEREAS, the County's treasurer will retain nine percent (9%) of the fee proceeds; and

WHEREAS, not later than fifteen (15) days after the close of each quarter, the county portion of hospital fees plus any interest or other income earned on the monies deposited shall be paid over to the county treasurer and such offices shall be personally liable to the county for such fees and moneys pursuant to N.J.S.A. 22A:4-17(a); and

WHEREAS, there will be no impact on patients or payers; and

WHEREAS, payments made under the program will not supplant or otherwise offset payments made to hospitals from other sources, except that payments may be otherwise limited to the hospitals' hospital-specific disproportionate share (DSH) limit as provided in section 1923(g) of the Social Security Act; now, therefore, be it

ORDAINED, by the Essex County Board of County Commissioners of the County of Essex that the Essex County Hospital Fee authorized by the County Option Hospital Fee Pilot Program Act is hereby established.

1. The Clerk of the Board is hereby directed to publish and distribute this Ordinance in accordance with law.

2. A public hearing on this Ordinance shall be held on July 6, 2022, at 5 p.m. at Hall of Records, 465 Dr. Martin Luther King, Jr., Blvd., Newark, New Jersey, Room 506

3. Upon adoption, the Clerk of the Board shall forward certified copies of this Ordinance to Frank DelGaudio, Director Essex County Hospital Center.

Approved as to form and legality _____
Assistant ESSEX COUNTY COUNSEL

RECORD OF VOTE: X=Vote N.V.=Abstention ABS=Absent

FIRST READING
Moved by Commissioner Cooper
Seconded by Commissioner Mercado

Commissioner	Yes	No	N.V.	ABS
COOPER	X			
GILL	X			
GRAHAM				X
JOHNSON	X			
LUCIANO	X			
MERCADO	X			
POMARES, V.P.				X
RICHARDSON, President	X			
SEBOLD	X			

Date Mailed to Municipal Clerks 6/10/22
Date Public Hearing 7/6/22
Date Published 6/14/22

It is hereby certified that the foregoing Ordinance was

(✓) adopted ( ) defeated ( ) tabled by roll call vote at Regular meeting of the Board of County Commissioners of the County of Essex, New Jersey, held on June 8, 2022

Wayne L. Richardson, President

SECOND READING
Moved by Commissioner Graham
Seconded by Commissioner Mercado

Commissioner	Yes	No	N.V.	ABS
COOPER				✓
GILL	✓			
GRAHAM	✓			
JOHNSON				✓
LUCIANO				✓
MERCADO	✓			
POMARES, V.P.				✓
RICHARDSON, President	✓			
SEBOLD	✓			

Date Mailed to Municipal Clerks 7-15-22
Date Published 7-20-22

It is hereby certified that the foregoing Ordinance

was (✓) adopted ( ) defeated ( ) tabled by roll call vote at Regular meeting of the Board of County Commissioners of the County of Essex, New Jersey, held on July 6, 2022

Wayne L. Richardson, President

The foregoing Ordinance has been duly presented to me on July 7, 2022
I hereby (✓) approve ( ) disapprove the same on July 11, 2022
Returned and filed July 11, 2022

Deborah Davis Ford, Clerk

Joseph N. DiVincenzo Jr., County Executive

Ordinance – Continuation of Hospital Fee Program

5/26/2022

INTERGOVERNMENTAL AGREEMENT
BETWEEN
STATE OF NEW JERSEY, DEPARTMENT OF HUMAN SERVICES
AND
COUNTY OF ATLANTIC

This Intergovernmental Agreement ("Agreement"), by and between the State of New Jersey, Department of Human Services (the "STATE") and the County of Atlantic, New Jersey (the "COUNTY"), a public body corporate and politic of the State of New Jersey, provides for intergovernmental transfers of funds to the STATE in order implement the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136. This Agreement and the intergovernmental transfer of funds it authorizes are made pursuant to N.J.S.A 30:4D-7r et seq., N.J.A.C. 10:52-1.1 et seq., N.J.S.A. 30:4D-19.4 et seq., 42 U.S.C. 1396b(w)(6) and 42 C.F.R. 433.51.

RECITALS

WHEREAS, the Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income; and

WHEREAS, the Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain up to 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining proceeds to the STATE by way of this Agreement; and

WHEREAS, the Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents; and

WHEREAS, the Transferred Fee Amount will be combined with matching Federal Medicaid dollars as specified in the Fee & Expenditure report and distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement; and

WHEREAS, N.J.S.A 30:4D-7v(d) restricts funds generated by the Fee from supplanting or offsetting any current or future State funds allocated to the COUNTY; and

WHEREAS, N.J.S.A 30:4D-7v(e) et seq. restricts Hospital Payments from supplanting or offsetting any current or future funds paid to hospitals through other State or federal funding mechanisms or pools; and

WHEREAS, the COUNTY and the STATE wish to enter into this Agreement in order to facilitate the transfer of the Fee to serve as the non-federal share of the MCO Payments authorized under the Program;

NOW, THEREFORE, the COUNTY and the STATE, (collectively referred to as "the parties") agree as follows:

1. Definitions: When used in this Agreement, the following terms have the meanings assigned to them in this section:

"Fee" means the local health care-related fee imposed by the COUNTY on hospitals located within its borders as authorized under N.J.S.A. 30:4D-7r et seq. and described in the Fee & Expenditure Report.

"CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

"Federal Financial Participation" or "FFP" means the federal matching funds received by the STATE for expenditures for medical assistance, including expenditures under the Program.

"Fee & Expenditure Report" means the proposal submitted by the COUNTY, including any modifications necessary to secure STATE and CMS approval of the Program, detailing the COUNTY's Fee on the Hospitals, the use of such funds, and how the proposal satisfies the purpose and requirements of the Program.

"Hospital Payments" means the payments that the STATE will direct the MCOs to pay to the hospitals pursuant to 42 C.F.R. 438.6(c), consistent with this Agreement, which in the aggregate equal the MCO Payments less the MCO Fee.

"Hospitals" means the hospital facilities located within the COUNTY's borders that are subject to the COUNTY's Assessment as defined herein.

"Intergovernmental Transfer" or "IGT" means the transfer, authorized under the Social Security Act and CMS regulations (see 42 CFR 433.51 - Public Funds as the State share of financial participation and 42 CFR 433.68), of the Transferred Fee Amount from the COUNTY to the STATE.

"Managed Care Organizations" or "MCOs" means the health plans under contract with the STATE to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program that will be directed to distribute the Hospital Payments.

"MCO Payments" means the increased payments made by the STATE to MCOs to enable the MCOs to make the Hospital Payments as specified in the Fee & Expenditure Report and modified as suggested by CMS through the annual approval process.

"MCO Fee" means the portion of the MCO Payments retained by the MCOs, not to exceed the amount specified in P.L. 2020, c. 96 or any similar or successor

law, to cover their incremental costs of such fees resulting from the MCO Payments.

"Program" means the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136.

"Program Year" means each 12-month period that corresponds with the contract year of the STATE's contracts with the MCOs, for which the implementation of the Program is approved, generally from July 1 through June 30 of each year.

"Transferred Fee Amount" means the funds transferred by the COUNTY to the STATE as specified in the Fee & Expenditure Report, equal to not less than 91 percent of the proceeds of the Fee.

2. CMS Approval Required: The Hospital Payments set forth in this Agreement are contingent upon CMS approval. To obtain CMS approval, the STATE will submit a preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c). The COUNTY will make the IGTs provided for hereunder only after the STATE receives approval from CMS for the Hospital Payments.

3. Voluntariness: The COUNTY attests that it entered voluntarily into this Agreement to make the IGTs described hereunder. The COUNTY further attests that it and its representatives have independently analyzed the validity of the IGTs and Hospital Payments, and in making the final determination to enter into this Agreement, relied upon the advice of their advisors and legal counsel.

4. Permissible Sources: The COUNTY will provide IGT funds to the STATE that satisfy the requirements of 42 CFR 433.51 and 42 CFR 433.68, and that are not derived from an impermissible source, including federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations. At the time the COUNTY makes an IGT to the STATE, the COUNTY will certify to the STATE that the IGT funds are derived from the Fee as authorized under N.J.S.A. 30:4D-7r et seq. and specified in the COUNTY's Fee & Expenditure Report.

5. Transfer and Use of Funds: The parties will transfer and use the proceeds of the Fee as specified below:

    a. The COUNTY will retain 9 percent of the proceeds of the Fee for its discretionary use.

    b. The COUNTY will make four quarterly IGTs per year, each equal to $6,092,192 (25 percent of the annual Transferred Fee Amount of $24,368,768) unless the COUNTY receives less than the full Fee from Hospitals, in which case the IGTs will be reduced by 91% of the total

shortfall amount. The COUNTY will make the IGT no later than 15 business days prior to the close of each quarter of the State fiscal year.

c. In the event federal approval of the Program is obtained less than 45 calendar days prior to a regularly scheduled IGT due date, the COUNTY will make its first quarterly IGT (and any subsequent IGTs not yet transferred) no later than 45 calendar days after being notified of the approval from the STATE. If, pursuant to that 45-day schedule, the revised IGT due date lands within 15 days prior to a regularly scheduled IGT due date, the COUNTY will make a consolidated IGT on the regularly scheduled due date.

d. The COUNTY's failure to make the IGT within this timeframe will result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding IGT amount per month and/or removal from the Program.

e. The COUNTY will transfer the Transferred Fee Amount to the STATE via the Automated Clearing House, or via wire transfer, to an account designated by the STATE.

f. The STATE will use the Transferred Fee Amount (less amounts allocated to the STATE for Program administration) as specified in the Fee & Expenditure Report for the sole purpose of funding the non-federal share of the MCO Payments for each fiscal year that the program is in effect, as authorized by the aforementioned CMS approval.

g. From the Transferred Fee Amount, the STATE will receive at least one percent of the Fee proceeds for the cost of administering the Program. Should the STATE's direct administrative costs for the program exceed the total value of funding transferred by the participating counties for the cost of administering the program, the STATE will provide to the COUNTY documentation of the STATE's direct administrative costs and the remaining costs will be subtracted from amounts otherwise available to fund the non-federal share of Medicaid payments, consistent with N.J.A.C. 10:52B-3.3(a)3.

h. The STATE will make the MCO Payments through its then-existing payment process and ensure that the Hospitals receive the Hospital Payments within 30 calendar days of the receipt of the IGT, barring exceptional circumstances.

i. Should the total of all quarterly IGTs made by the COUNTY to the STATE differ from the Transferred Fee Amount (specified in Section 6.b) due to hospital non-payment, or any other reason, the value of this difference will be subtracted from the amounts otherwise available to fund the non-federal share of enhanced payments in the subsequent Program Year. If the value of this difference is collected in a subsequent Program Year, that value will

be added to the amounts otherwise available to fund the non-federal share of MCO Payments in the following Program Year.

6. Deferrals and Disallowances:

   a. The STATE will notify the COUNTY within 5 business days if CMS defers or disallows FFP in any of the payments under the Program. The STATE will consult with the COUNTY and consider the COUNTY's feedback in preparing any STATE response to the CMS deferral or disallowance. The STATE will provide the COUNTY a copy of any STATE response to the CMS deferral or disallowance.

   b. If the STATE determines that meritorious grounds exist to appeal the disallowance of FFP, the STATE will file an appeal with the United States Department of Health & Human Services Departmental Appeals Board contesting the CMS' disallowance. In the event the STATE files such an appeal, the STATE may, upon request by the COUNTY, allow the COUNTY to intervene in and to appear with STATE as a party to the appeal subject to Appeals Board approval.

   c. If, after any appeals are exhausted, a CMS disallowance of FFP in the Hospital Payments is finalized,

      i. The STATE will recoup the amount of Hospital Payments disallowed, and related interest and penalties, if any, from the recipient hospitals, offsetting the recouped amount from payments otherwise due to the hospitals; and

      ii. The STATE will return to the COUNTY the non-federal share of the recouped payments, refunding the federal share to CMS; and

      iii. The COUNTY will refund such returned non-federal share to Hospitals in proportion to their share of the Fee.

7. If, after the COUNTY has made an IGT but before the STATE makes the related MCO Payments, CMS, for any reason, does not permit or revokes approval of the Program described herein, the STATE will return the IGT funds to the COUNTY within 15 business days of STATE receiving such notification.

8. Record Maintenance: The parties will maintain necessary records and supporting documentation applicable to the Fee, the IGTs, the MCO Payments and the Hospital Payments to assure that claims for total funds and federal funds are in accordance with applicable State and federal requirements.

9. Records Access and Cooperation:
   a. The COUNTY will provide the STATE or its designee access to the COUNTY's records and the supporting documentation relating to the IGTs and will

cooperate and assist the STATE, as requested, in any Federal or STATE review or audit of the IGTs or payments funded with those IGTs.

b. If the STATE's costs for administering the Program exceed 1% of the Transfer Amount (as specified in Section 5.g), the STATE will provide the COUNTY or its designee cooperation and access to the State's records and the supporting documentation relating to the STATE's costs for administering the Program.

10. Notice: Any written notice required by the Agreement will be sent to:

For the Department	For Atlantic County
Name: Brian Francz, CFO	Name: Gerald DelRosso, Administrator
E-mail address: Brian.Francz@dhs.nj.gov	E-mail address: delrosso_jerry@aclink.org
Mailing address:	Mailing address:
222 S Warren St, Trenton, NJ 08608	1333 Atlantic Ave. Atlantic City, NJ 08401

11. Term/Termination: This Agreement will become effective on the earliest date it is fully executed by both parties and the Program is approved by CMS. In the event CMS withdraws or fails to extend its approval of the Program or the Program is otherwise determined to be unlawful in a final determination under County, State, or Federal law, this agreement will terminate immediately, except that applicable procedures in Sections 7 through 12 will survive such termination. Notwithstanding the foregoing, either party may terminate this Agreement for an upcoming Program Year by providing written notice received by the other party prior to April 1 preceding that Program Year.

12. Rights and Responsibilities: This Agreement is only intended to establish the IGT set forth above, and nothing in this Agreement will be construed to limit, restrict or modify the respective rights and responsibilities of either party under federal or state law and policies, including the right of the STATE to recover overpayments made to Hospitals within the COUNTY other than the Hospital Payments set forth in above.

The parties, by their authorized representatives, have duly executed this agreement and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

STATE

Printed Name: BRIAN FRANCZ

Title: DHS – CFO

By: [signature]

Date: June 22, 2021

Atlantic County

Printed Name: Dennis Levinson

Title: County Executive

By: [signature]

Date: May 20, 2021

INTERGOVERNMENTAL AGREEMENT
BETWEEN
STATE OF NEW JERSEY, DEPARTMENT OF HUMAN SERVICES
AND
COUNTY OF CAMDEN

This Intergovernmental Agreement ("Agreement"), by and between the State of New Jersey, Department of Human Services (the "STATE") and the County of Camden, New Jersey (the "COUNTY"), a public body corporate and politic of the State of New Jersey, provides for intergovernmental transfers of funds to the STATE in order implement the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136. This Agreement and the intergovernmental transfer of funds it authorizes are made pursuant to N.J.S.A 30:4D-7r et seq., N.J.A.C. 10:52-1.1 et seq., N.J.S.A. 30:4D-19.4 et seq., 42 U.S.C. 1396b(w)(6) and 42 C.F.R. 433.51.

RECITALS

WHEREAS, the Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income; and

WHEREAS, the Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain up to 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining proceeds to the STATE by way of this Agreement; and

WHEREAS, the Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents; and

WHEREAS, the Transferred Fee Amount will be combined with matching Federal Medicaid dollars as specified in the Fee & Expenditure report and distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement; and

WHEREAS, N.J.S.A 30:4D-7v(d) restricts funds generated by the Fee from supplanting or offsetting any current or future State funds allocated to the COUNTY; and

WHEREAS, N.J.S.A 30:4D-7v(e) et seq. restricts Hospital Payments from supplanting or offsetting any current or future funds paid to hospitals through other State or federal funding mechanisms or pools; and

WHEREAS, the COUNTY and the STATE wish to enter into this Agreement in order to facilitate the transfer of the Fee to serve as the non-federal share of the MCO Payments authorized under the Program;

NOW, THEREFORE, the COUNTY and the STATE, (collectively referred to as "the parties") agree as follows:

1. Definitions: When used in this Agreement, the following terms have the meanings assigned to them in this section:

"Fee" means the local health care-related fee imposed by the COUNTY on hospitals located within its borders as authorized under N.J.S.A. 30:4D-7r et seq. and described in the Fee & Expenditure Report.

"CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

"Federal Financial Participation" or "FFP" means the federal matching funds received by the STATE for expenditures for medical assistance, including expenditures under the Program.

"Fee & Expenditure Report" means the proposal submitted by the COUNTY, including any modifications necessary to secure STATE and CMS approval of the Program, detailing the COUNTY's Fee on the Hospitals, the use of such funds, and how the proposal satisfies the purpose and requirements of the Program.

"Hospital Payments" means the payments that the STATE will direct the MCOs to pay to the hospitals pursuant to 42 C.F.R. 438.6(c), consistent with this Agreement, which in the aggregate equal the MCO Payments less the MCO Fee.

"Hospitals" means the hospital facilities located within the COUNTY's borders that are subject to the COUNTY's Assessment as defined herein.

"Intergovernmental Transfer" or "IGT" means the transfer, authorized under the Social Security Act and CMS regulations (see 42 CFR 433.51 - Public Funds as the State share of financial participation and 42 CFR 433.68), of the Transferred Fee Amount from the COUNTY to the STATE.

"Managed Care Organizations" or "MCOs" means the health plans under contract with the STATE to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program that will be directed to distribute the Hospital Payments.

"MCO Payments" means the increased payments made by the STATE to MCOs to enable the MCOs to make the Hospital Payments as specified in the Fee & Expenditure Report and modified as suggested by CMS through the annual approval process.

"MCO Fee" means the portion of the MCO Payments retained by the MCOs, not to exceed the amount specified in P.L. 2020, c. 96 or any similar or successor

law, to cover their incremental costs of such fees resulting from the MCO Payments.

"Program" means the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136.

"Program Year" means each 12-month period that corresponds with the contract year of the STATE's contracts with the MCOs, for which the implementation of the Program is approved, generally from July 1 through June 30 of each year.

"Transferred Fee Amount" means the funds transferred by the COUNTY to the STATE as specified in the Fee & Expenditure Report, equal to not less than 91 percent of the proceeds of the Fee.

2. CMS Approval Required: The Hospital Payments set forth in this Agreement are contingent upon CMS approval. To obtain CMS approval, the STATE will submit a preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c). The COUNTY will make the IGTs provided for hereunder only after the STATE receives approval from CMS for the Hospital Payments.

3. Voluntariness: The COUNTY attests that it entered voluntarily into this Agreement to make the IGTs described hereunder. The COUNTY further attests that it and its representatives have independently analyzed the validity of the IGTs and Hospital Payments, and in making the final determination to enter into this Agreement, relied upon the advice of their advisors and legal counsel.

4. Permissible Sources: The COUNTY will provide IGT funds to the STATE that satisfy the requirements of 42 CFR 433.51 and 42 CFR 433.68, and that are not derived from an impermissible source, including federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations. At the time the COUNTY makes an IGT to the STATE, the COUNTY will certify to the STATE that the IGT funds are derived from the Fee as authorized under N.J.S.A. 30:4D-7r et seq. and specified in the COUNTY's Fee & Expenditure Report.

5. Transfer and Use of Funds: The parties will transfer and use the proceeds of the Fee as specified below:

    a. The COUNTY will retain 9 percent of the proceeds of the Fee for its discretionary use.

    b. The COUNTY will make four quarterly IGTs per year, each equal to $11,970,654.50 (25 percent of the annual Transferred Fee Amount of $47,882,618) unless the COUNTY receives less than the full Fee from Hospitals, in which case the IGTs will be reduced by 91% of the total

shortfall amount. The COUNTY will make the IGT no later than 15 business days prior to the close of each quarter of the State fiscal year.

c. In the event federal approval of the Program is obtained less than 45 calendar days prior to a regularly scheduled IGT due date, the COUNTY will make its first quarterly IGT (and any subsequent IGTs not yet transferred) no later than 45 calendar days after being notified of the approval from the STATE. If, pursuant to that 45-day schedule, the revised IGT due date lands within 15 days prior to a regularly scheduled IGT due date, the COUNTY will make a consolidated IGT on the regularly scheduled due date.

d. The COUNTY's failure to make the IGT within this timeframe will result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding IGT amount per month and/or removal from the Program.

e. The COUNTY will transfer the Transferred Fee Amount to the STATE via the Automated Clearing House, or via wire transfer, to an account designated by the STATE.

f. The STATE will use the Transferred Fee Amount (less amounts allocated to the STATE for Program administration) as specified in the Fee & Expenditure Report for the sole purpose of funding the non-federal share of the MCO Payments for each fiscal year that the program is in effect, as authorized by the aforementioned CMS approval.

g. From the Transferred Fee Amount, the STATE will receive at least one percent of the Fee proceeds for the cost of administering the Program. Should the STATE's direct administrative costs for the program exceed the total value of funding transferred by the participating counties for the cost of administering the program, the STATE will provide to the COUNTY documentation of the STATE's direct administrative costs and the remaining costs will be subtracted from amounts otherwise available to fund the non-federal share of Medicaid payments, consistent with N.J.A.C. 10:52B-3.3(a)3.

h. The STATE will make the MCO Payments through its then-existing payment process and ensure that the Hospitals receive the Hospital Payments within 30 calendar days of the receipt of the IGT, barring exceptional circumstances.

i. Should the total of all quarterly IGTs made by the COUNTY to the STATE differ from the Transferred Fee Amount (specified in Section 6.b) due to hospital non-payment, or any other reason, the value of this difference will be subtracted from the amounts otherwise available to fund the non-federal share of enhanced payments in the subsequent Program Year. If the value of this difference is collected in a subsequent Program Year, that value will

be added to the amounts otherwise available to fund the non-federal share of MCO Payments in the following Program Year.

6. Deferrals and Disallowances:

   a. The STATE will notify the COUNTY within 5 business days if CMS defers or disallows FFP in any of the payments under the Program. The STATE will consult with the COUNTY and consider the COUNTY's feedback in preparing any STATE response to the CMS deferral or disallowance. The STATE will provide the COUNTY a copy of any STATE response to the CMS deferral or disallowance.

   b. If the STATE determines that meritorious grounds exist to appeal the disallowance of FFP, the STATE will file an appeal with the United States Department of Health & Human Services Departmental Appeals Board contesting the CMS' disallowance. In the event the STATE files such an appeal, the STATE may, upon request by the COUNTY, allow the COUNTY to intervene in and to appear with STATE as a party to the appeal subject to Appeals Board approval.

   c. If, after any appeals are exhausted, a CMS disallowance of FFP in the Hospital Payments is finalized,

      i. The STATE will recoup the amount of Hospital Payments disallowed, and related interest and penalties, if any, from the recipient hospitals, offsetting the recouped amount from payments otherwise due to the hospitals; and

      ii. The STATE will return to the COUNTY the non-federal share of the recouped payments, refunding the federal share to CMS; and

      iii. The COUNTY will refund such returned non-federal share to Hospitals in proportion to their share of the Fee.

7. If, after the COUNTY has made an IGT but before the STATE makes the related MCO Payments, CMS, for any reason, does not permit or revokes approval of the Program described herein, the STATE will return the IGT funds to the COUNTY within 15 business days of STATE receiving such notification.

8. Record Maintenance: The parties will maintain necessary records and supporting documentation applicable to the Fee, the IGTs, the MCO Payments and the Hospital Payments to assure that claims for total funds and federal funds are in accordance with applicable State and federal requirements.

9. Records Access and Cooperation:
   a. The COUNTY will provide the STATE or its designee access to the COUNTY's records and the supporting documentation relating to the IGTs and will

cooperate and assist the STATE, as requested, in any Federal or STATE review or audit of the IGTs or payments funded with those IGTs.

b. If the STATE's costs for administering the Program exceed 1% of the Transfer Amount (as specified in Section 5.g), the STATE will provide the COUNTY or its designee cooperation and access to the State's records and the supporting documentation relating to the STATE's costs for administering the Program.

10. Notice: Any written notice required by the Agreement will be sent to:

For the Department	For CAMDEN COUNTY
Name: Brian Francz, CFO	Name: Ross Angilella
E-mail address: Brian.Francz@dhs.nj.gov	E-mail address: rossa@camdencounty.com
Mailing address:	Mailing address:
222 S Warren St, Trenton, NJ 08608	520 Market Street, 16th Floor Camden, NJ 08102

11. Term/Termination: This Agreement will become effective on the earliest date it is fully executed by both parties and the Program is approved by CMS. In the event CMS withdraws or fails to extend its approval of the Program or the Program is otherwise determined to be unlawful in a final determination under County, State, or Federal law, this agreement will terminate immediately, except that applicable procedures in Sections 7 through 12 will survive such termination. Notwithstanding the foregoing, either party may terminate this Agreement for an upcoming Program Year by providing written notice received by the other party prior to April 1 preceding that Program Year.

12. Rights and Responsibilities: This Agreement is only intended to establish the IGT set forth above, and nothing in this Agreement will be construed to limit, restrict or modify the respective rights and responsibilities of either party under federal or state law and policies, including the right of the STATE to recover overpayments made to Hospitals within the COUNTY other than the Hospital Payments set forth in above.

The parties, by their authorized representatives, have duly executed this agreement and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

STATE

Printed Name: BRIAN FRANCZ

Title: DHS - CFO

By:

Date: 6/22/2021

CAMDEN COUNTY

Printed Name: Ross Angilella

Title: County Administrator

By:

Date: 6-9-2021

INTERGOVERNMENTAL AGREEMENT
BETWEEN
STATE OF NEW JERSEY, DEPARTMENT OF HUMAN SERVICES
AND
COUNTY OF HUDSON

This Intergovernmental Agreement ("Agreement"), by and between the State of New Jersey, Department of Human Services (the "STATE") and the County of Hudson, New Jersey (the "COUNTY"), a public body corporate and politic of the State of New Jersey, provides for intergovernmental transfers of funds to the STATE in order implement the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136. This Agreement and the intergovernmental transfer of funds it authorizes are made pursuant to N.J.S.A 30:4D-7r et seq., N.J.A.C. 10:52-1.1 et seq., N.J.S.A. 30:4D-19.4 et seq., 42 U.S.C. 1396b(w)(6) and 42 C.F.R. 433.51.

RECITALS

WHEREAS, the Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income; and

WHEREAS, the Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain up to 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining proceeds to the STATE by way of this Agreement; and

WHEREAS, the Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents; and

WHEREAS, the Transferred Fee Amount will be combined with matching Federal Medicaid dollars as specified in the Fee & Expenditure report and distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement; and

WHEREAS, N.J.S.A 30:4D-7v(d) restricts funds generated by the Fee from supplanting or offsetting any current or future State funds allocated to the COUNTY; and

WHEREAS, N.J.S.A 30:4D-7v(e) et seq. restricts Hospital Payments from supplanting or offsetting any current or future funds paid to hospitals through other State or federal funding mechanisms or pools; and

WHEREAS, the COUNTY and the STATE wish to enter into this Agreement in order to facilitate the transfer of the Fee to serve as the non-federal share of the MCO Payments authorized under the Program;

NOW, THEREFORE, the COUNTY and the STATE, (collectively referred to as "the parties") agree as follows:

1. Definitions: When used in this Agreement, the following terms have the meanings assigned to them in this section:

"Fee" means the local health care-related fee imposed by the COUNTY on hospitals located within its borders as authorized under N.J.S.A. 30:4D-7r et seq. and described in the Fee & Expenditure Report.

"CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

"Federal Financial Participation" or "FFP" means the federal matching funds received by the STATE for expenditures for medical assistance, including expenditures under the Program.

"Fee & Expenditure Report" means the proposal submitted by the COUNTY, including any modifications necessary to secure STATE and CMS approval of the Program, detailing the COUNTY's Fee on the Hospitals, the use of such funds, and how the proposal satisfies the purpose and requirements of the Program.

"Hospital Payments" means the payments that the STATE will direct the MCOs to pay to the hospitals pursuant to 42 C.F.R. 438.6(c), consistent with this Agreement, which in the aggregate equal the MCO Payments less the MCO Fee.

"Hospitals" means the hospital facilities located within the COUNTY's borders that are subject to the COUNTY's Assessment as defined herein.

"Intergovernmental Transfer" or "IGT" means the transfer, authorized under the Social Security Act and CMS regulations (see 42 CFR 433.51 - Public Funds as the State share of financial participation and 42 CFR 433.68), of the Transferred Fee Amount from the COUNTY to the STATE.

"Managed Care Organizations" or "MCOs" means the health plans under contract with the STATE to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program that will be directed to distribute the Hospital Payments.

"MCO Payments" means the increased payments made by the STATE to MCOs to enable the MCOs to make the Hospital Payments as specified in the Fee & Expenditure Report and modified as suggested by CMS through the annual approval process.

"MCO Fee" means the portion of the MCO Payments retained by the MCOs, not to exceed the amount specified in P.L. 2020, c. 96 or any similar or successor

law, to cover their incremental costs of such fees resulting from the MCO Payments.

"Program" means the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136.

"Program Year" means each 12-month period that corresponds with the contract year of the STATE's contracts with the MCOs, for which the implementation of the Program is approved, generally from July 1 through June 30 of each year.

"Transferred Fee Amount" means the funds transferred by the COUNTY to the STATE as specified in the Fee & Expenditure Report, equal to not less than 91 percent of the proceeds of the Fee.

2. CMS Approval Required: The Hospital Payments set forth in this Agreement are contingent upon CMS approval. To obtain CMS approval, the STATE will submit a preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c). The COUNTY will make the IGTs provided for hereunder only after the STATE receives approval from CMS for the Hospital Payments.

3. Voluntariness: The COUNTY attests that it entered voluntarily into this Agreement to make the IGTs described hereunder. The COUNTY further attests that it and its representatives have independently analyzed the validity of the IGTs and Hospital Payments, and in making the final determination to enter into this Agreement, relied upon the advice of their advisors and legal counsel.

4. Permissible Sources: The COUNTY will provide IGT funds to the STATE that satisfy the requirements of 42 CFR 433.51 and 42 CFR 433.68, and that are not derived from an impermissible source, including federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations. At the time the COUNTY makes an IGT to the STATE, the COUNTY will certify to the STATE that the IGT funds are derived from the Fee as authorized under N.J.S.A. 30:4D-7r et seq. and specified in the COUNTY's Fee & Expenditure Report.

5. Transfer and Use of Funds: The parties will transfer and use the proceeds of the Fee as specified below:

    a. The COUNTY will retain 9 percent of the proceeds of the Fee for its discretionary use.

    b. The COUNTY will make four quarterly IGTs per year, each equal to $6,842,968 (25 percent of the annual Transferred Fee Amount of $27,371,871) unless the COUNTY receives less than the full Fee from Hospitals, in which case the IGTs will be reduced by 91% of the total

shortfall amount. The COUNTY will make the IGT no later than 15 business days prior to the close of each quarter of the State fiscal year.

c. In the event federal approval of the Program is obtained less than 45 calendar days prior to a regularly scheduled IGT due date, the COUNTY will make its first quarterly IGT (and any subsequent IGTs not yet transferred) no later than 45 calendar days after being notified of the approval from the STATE. If, pursuant to that 45-day schedule, the revised IGT due date lands within 15 days prior to a regularly scheduled IGT due date, the COUNTY will make a consolidated IGT on the regularly scheduled due date.

d. The COUNTY's failure to make the IGT within this timeframe will result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding IGT amount per month and/or removal from the Program.

e. The COUNTY will transfer the Transferred Fee Amount to the STATE via the Automated Clearing House, or via wire transfer, to an account designated by the STATE.

f. The STATE will use the Transferred Fee Amount (less amounts allocated to the STATE for Program administration) as specified in the Fee & Expenditure Report for the sole purpose of funding the non-federal share of the MCO Payments for each fiscal year that the program is in effect, as authorized by the aforementioned CMS approval.

g. From the Transferred Fee Amount, the STATE will receive at least one percent of the Fee proceeds for the cost of administering the Program. Should the STATE's direct administrative costs for the program exceed the total value of funding transferred by the participating counties for the cost of administering the program, the STATE will provide to the COUNTY documentation of the STATE's direct administrative costs and the remaining costs will be subtracted from amounts otherwise available to fund the non-federal share of Medicaid payments, consistent with N.J.A.C. 10:52B-3.3(a)3.

h. The STATE will make the MCO Payments through its then-existing payment process and ensure that the Hospitals receive the Hospital Payments within 30 calendar days of the receipt of the IGT, barring exceptional circumstances.

i. Should the total of all quarterly IGTs made by the COUNTY to the STATE differ from the Transferred Fee Amount (specified in Section 6.b) due to hospital non-payment, or any other reason, the value of this difference will be subtracted from the amounts otherwise available to fund the non-federal share of enhanced payments in the subsequent Program Year. If the value of this difference is collected in a subsequent Program Year, that value will

be added to the amounts otherwise available to fund the non-federal share of MCO Payments in the following Program Year.

6. Deferrals and Disallowances:

   a. The STATE will notify the COUNTY within 5 business days if CMS defers or disallows FFP in any of the payments under the Program. The STATE will consult with the COUNTY and consider the COUNTY's feedback in preparing any STATE response to the CMS deferral or disallowance. The STATE will provide the COUNTY a copy of any STATE response to the CMS deferral or disallowance.

   b. If the STATE determines that meritorious grounds exist to appeal the disallowance of FFP, the STATE will file an appeal with the United States Department of Health & Human Services Departmental Appeals Board contesting the CMS' disallowance. In the event the STATE files such an appeal, the STATE may, upon request by the COUNTY, allow the COUNTY to intervene in and to appear with STATE as a party to the appeal subject to Appeals Board approval.

   c. If, after any appeals are exhausted, a CMS disallowance of FFP in the Hospital Payments is finalized,

      i. The STATE will recoup the amount of Hospital Payments disallowed, and related interest and penalties, if any, from the recipient hospitals, offsetting the recouped amount from payments otherwise due to the hospitals; and

      ii. The STATE will return to the COUNTY the non-federal share of the recouped payments, refunding the federal share to CMS; and

      iii. The COUNTY will refund such returned non-federal share to Hospitals in proportion to their share of the Fee.

7. If, after the COUNTY has made an IGT but before the STATE makes the related MCO Payments, CMS, for any reason, does not permit or revokes approval of the Program described herein, the STATE will return the IGT funds to the COUNTY within 15 business days of STATE receiving such notification.

8. Record Maintenance: The parties will maintain necessary records and supporting documentation applicable to the Fee, the IGTs, the MCO Payments and the Hospital Payments to assure that claims for total funds and federal funds are in accordance with applicable State and federal requirements.

9. Records Access and Cooperation:
   a. The COUNTY will provide the STATE or its designee access to the COUNTY's records and the supporting documentation relating to the IGTs and will

cooperate and assist the STATE, as requested, in any Federal or STATE review or audit of the IGTs or payments funded with those IGTs.

b. If the STATE's costs for administering the Program exceed 1% of the Transfer Amount (as specified in Section 5.g), the STATE will provide the COUNTY or its designee cooperation and access to the State's records and the supporting documentation relating to the STATE's costs for administering the Program.

10. Notice: Any written notice required by the Agreement will be sent to:

For the Department	For Hudson County
Name: Brian Francz, CFO	Name: Abraham Antun
E-mail address: Brian.Francz@dhs.nj.gov	E-mail address: aantun@hcnj.us
Mailing address:	Mailing address:
222 S Warren St, Trenton, NJ 08608	570 Pavonia Ave. Jersey City, NJ 07306

11. Term/Termination: This Agreement will become effective on the earliest date it is fully executed by both parties and the Program is approved by CMS. In the event CMS withdraws or fails to extend its approval of the Program or the Program is otherwise determined to be unlawful in a final determination under County, State, or Federal law, this agreement will terminate immediately, except that applicable procedures in Sections 7 through 12 will survive such termination. Notwithstanding the foregoing, either party may terminate this Agreement for an upcoming Program Year by providing written notice received by the other party prior to April 1 preceding that Program Year.

12. Rights and Responsibilities: This Agreement is only intended to establish the IGT set forth above, and nothing in this Agreement will be construed to limit, restrict or modify the respective rights and responsibilities of either party under federal or state law and policies, including the right of the STATE to recover overpayments made to Hospitals within the COUNTY other than the Hospital Payments set forth in above.

The parties, by their authorized representatives, have duly executed this agreement and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

STATE

Printed Name: BRIAN FRANCZ

Title: DHS - CFO

By: [signature]

Date: 6/22/2021

HUDSON COUNTY

Printed Name: Abraham Antun

Title: County Administrator

By: [signature]

Date: 5/19/2021

INTERGOVERNMENTAL AGREEMENT
BETWEEN
STATE OF NEW JERSEY, DEPARTMENT OF HUMAN SERVICES
AND
COUNTY OF MERCER

This Intergovernmental Agreement ("Agreement"), by and between the State of New Jersey, Department of Human Services (the "STATE") and the County of Mercer, New Jersey (the "COUNTY"), a public body corporate and politic of the State of New Jersey, provides for intergovernmental transfers of funds to the STATE in order implement the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136. This Agreement and the intergovernmental transfer of funds it authorizes are made pursuant to N.J.S.A 30:4D-7r et seq., N.J.A.C. 10:52-1.1 et seq., N.J.S.A. 30:4D-19.4 et seq., 42 U.S.C. 1396b(w)(6) and 42 C.F.R. 433.51.

RECITALS

WHEREAS, the Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income; and

WHEREAS, the Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain up to 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining proceeds to the STATE by way of this Agreement; and

WHEREAS, the Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents; and

WHEREAS, the Transferred Fee Amount will be combined with matching Federal Medicaid dollars as specified in the Fee & Expenditure report and distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement; and

WHEREAS, N.J.S.A 30:4D-7v(d) restricts funds generated by the Fee from supplanting or offsetting any current or future State funds allocated to the COUNTY; and

WHEREAS, N.J.S.A 30:4D-7v(e) et seq. restricts Hospital Payments from supplanting or offsetting any current or future funds paid to hospitals through other State or federal funding mechanisms or pools; and

WHEREAS, the COUNTY and the STATE wish to enter into this Agreement in order to facilitate the transfer of the Fee to serve as the non-federal share of the MCO Payments authorized under the Program;

NOW, THEREFORE, the COUNTY and the STATE, (collectively referred to as "the parties") agree as follows:

1. Definitions: When used in this Agreement, the following terms have the meanings assigned to them in this section:

"Fee" means the local health care-related fee imposed by the COUNTY on hospitals located within its borders as authorized under N.J.S.A. 30:4D-7r et seq. and described in the Fee & Expenditure Report.

"CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

"Federal Financial Participation" or "FFP" means the federal matching funds received by the STATE for expenditures for medical assistance, including expenditures under the Program.

"Fee & Expenditure Report" means the proposal submitted by the COUNTY, including any modifications necessary to secure STATE and CMS approval of the Program, detailing the COUNTY's Fee on the Hospitals, the use of such funds, and how the proposal satisfies the purpose and requirements of the Program.

"Hospital Payments" means the payments that the STATE will direct the MCOs to pay to the hospitals pursuant to 42 C.F.R. 438.6(c), consistent with this Agreement, which in the aggregate equal the MCO Payments less the MCO Fee.

"Hospitals" means the hospital facilities located within the COUNTY's borders that are subject to the COUNTY's Assessment as defined herein.

"Intergovernmental Transfer" or "IGT" means the transfer, authorized under the Social Security Act and CMS regulations (see 42 CFR 433.51 - Public Funds as the State share of financial participation and 42 CFR 433.68), of the Transferred Fee Amount from the COUNTY to the STATE.

"Managed Care Organizations" or "MCOs" means the health plans under contract with the STATE to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program that will be directed to distribute the Hospital Payments.

"MCO Payments" means the increased payments made by the STATE to MCOs to enable the MCOs to make the Hospital Payments as specified in the Fee & Expenditure Report and modified as suggested by CMS through the annual approval process.

"MCO Fee" means the portion of the MCO Payments retained by the MCOs, not to exceed the amount specified in P.L. 2020, c. 96 or any similar or successor

law, to cover their incremental costs of such fees resulting from the MCO Payments.

"Program" means the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136.

"Program Year" means each 12-month period that corresponds with the contract year of the STATE's contracts with the MCOs, for which the implementation of the Program is approved, generally from July 1 through June 30 of each year.

"Transferred Fee Amount" means the funds transferred by the COUNTY to the STATE as specified in the Fee & Expenditure Report, equal to not less than 91 percent of the proceeds of the Fee.

2. CMS Approval Required: The Hospital Payments set forth in this Agreement are contingent upon CMS approval. To obtain CMS approval, the STATE will submit a preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c). The COUNTY will make the IGTs provided for hereunder only after the STATE receives approval from CMS for the Hospital Payments.

3. Voluntariness: The COUNTY attests that it entered voluntarily into this Agreement to make the IGTs described hereunder. The COUNTY further attests that it and its representatives have independently analyzed the validity of the IGTs and Hospital Payments, and in making the final determination to enter into this Agreement, relied upon the advice of their advisors and legal counsel.

4. Permissible Sources: The COUNTY will provide IGT funds to the STATE that satisfy the requirements of 42 CFR 433.51 and 42 CFR 433.68, and that are not derived from an impermissible source, including federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations. At the time the COUNTY makes an IGT to the STATE, the COUNTY will certify to the STATE that the IGT funds are derived from the Fee as authorized under N.J.S.A. 30:4D-7r et seq. and specified in the COUNTY's Fee & Expenditure Report.

5. Transfer and Use of Funds: The parties will transfer and use the proceeds of the Fee as specified below:

    a. The COUNTY will retain 9 percent of the proceeds of the Fee for its discretionary use.

    b. The COUNTY will make four quarterly IGTs per year, each equal to $5,969,032 (25 percent of the annual Transferred Fee Amount of $23,876,129) unless the COUNTY receives less than the full Fee from Hospitals, in which case the IGTs will be reduced by 91% of the total

shortfall amount. The COUNTY will make the IGT no later than 15 business days prior to the close of each quarter of the State fiscal year.

c. In the event federal approval of the Program is obtained less than 45 calendar days prior to a regularly scheduled IGT due date, the COUNTY will make its first quarterly IGT (and any subsequent IGTs not yet transferred) no later than 45 calendar days after being notified of the approval from the STATE. If, pursuant to that 45-day schedule, the revised IGT due date lands within 15 days prior to a regularly scheduled IGT due date, the COUNTY will make a consolidated IGT on the regularly scheduled due date.

d. The COUNTY's failure to make the IGT within this timeframe will result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding IGT amount per month and/or removal from the Program.

e. The COUNTY will transfer the Transferred Fee Amount to the STATE via the Automated Clearing House, or via wire transfer, to an account designated by the STATE.

f. The STATE will use the Transferred Fee Amount (less amounts allocated to the STATE for Program administration) as specified in the Fee & Expenditure Report for the sole purpose of funding the non-federal share of the MCO Payments for each fiscal year that the program is in effect, as authorized by the aforementioned CMS approval.

g. From the Transferred Fee Amount, the STATE will receive at least one percent of the Fee proceeds for the cost of administering the Program. Should the STATE's direct administrative costs for the program exceed the total value of funding transferred by the participating counties for the cost of administering the program, the STATE will provide to the COUNTY documentation of the STATE's direct administrative costs and the remaining costs will be subtracted from amounts otherwise available to fund the non-federal share of Medicaid payments, consistent with N.J.A.C. 10:52B-3.3(a)3.

h. The STATE will make the MCO Payments through its then-existing payment process and ensure that the Hospitals receive the Hospital Payments within 30 calendar days of the receipt of the IGT, barring exceptional circumstances.

i. Should the total of all quarterly IGTs made by the COUNTY to the STATE differ from the Transferred Fee Amount (specified in Section 6.b) due to hospital non-payment, or any other reason, the value of this difference will be subtracted from the amounts otherwise available to fund the non-federal share of enhanced payments in the subsequent Program Year. If the value of this difference is collected in a subsequent Program Year, that value will

be added to the amounts otherwise available to fund the non-federal share of MCO Payments in the following Program Year.

6. Deferrals and Disallowances:

   a. The STATE will notify the COUNTY within 5 business days if CMS defers or disallows FFP in any of the payments under the Program. The STATE will consult with the COUNTY and consider the COUNTY's feedback in preparing any STATE response to the CMS deferral or disallowance. The STATE will provide the COUNTY a copy of any STATE response to the CMS deferral or disallowance.

   b. If the STATE determines that meritorious grounds exist to appeal the disallowance of FFP, the STATE will file an appeal with the United States Department of Health & Human Services Departmental Appeals Board contesting the CMS' disallowance. In the event the STATE files such an appeal, the STATE may, upon request by the COUNTY, allow the COUNTY to intervene in and to appear with STATE as a party to the appeal subject to Appeals Board approval.

   c. If, after any appeals are exhausted, a CMS disallowance of FFP in the Hospital Payments is finalized,

      i. The STATE will recoup the amount of Hospital Payments disallowed, and related interest and penalties, if any, from the recipient hospitals, offsetting the recouped amount from payments otherwise due to the hospitals; and

      ii. The STATE will return to the COUNTY the non-federal share of the recouped payments, refunding the federal share to CMS; and

      iii. The COUNTY will refund such returned non-federal share to Hospitals in proportion to their share of the Fee.

7. If, after the COUNTY has made an IGT but before the STATE makes the related MCO Payments, CMS, for any reason, does not permit or revokes approval of the Program described herein, the STATE will return the IGT funds to the COUNTY within 15 business days of STATE receiving such notification.

8. Record Maintenance: The parties will maintain necessary records and supporting documentation applicable to the Fee, the IGTs, the MCO Payments and the Hospital Payments to assure that claims for total funds and federal funds are in accordance with applicable State and federal requirements.

9. Records Access and Cooperation:
   a. The COUNTY will provide the STATE or its designee access to the COUNTY's records and the supporting documentation relating to the IGTs and will

cooperate and assist the STATE, as requested, in any Federal or STATE review or audit of the IGTs or payments funded with those IGTs.

b. If the STATE's costs for administering the Program exceed 1% of the Transfer Amount (as specified in Section 5.g), the STATE will provide the COUNTY or its designee cooperation and access to the State's records and the supporting documentation relating to the STATE's costs for administering the Program.

10. Notice: Any written notice required by the Agreement will be sent to:

For the Department	For Mercer County
Name: Brian Francz, CFO	Name: Lillian L. Nazzaro, Administrator
E-mail address: Brian.Francz@dhs.nj.gov	E-mail address: lnazzaro@mercercounty.org
Mailing address:	Mailing address:
222 S Warren St, Trenton, NJ 08608	640 S. Broad Street Trenton, NJ 08650

11. Term/Termination: This Agreement will become effective on the earliest date it is fully executed by both parties and the Program is approved by CMS. In the event CMS withdraws or fails to extend its approval of the Program or the Program is otherwise determined to be unlawful in a final determination under County, State, or Federal law, this agreement will terminate immediately, except that applicable procedures in Sections 7 through 12 will survive such termination. Notwithstanding the foregoing, either party may terminate this Agreement for an upcoming Program Year by providing written notice received by the other party prior to April 1 preceding that Program Year.

12. Rights and Responsibilities: This Agreement is only intended to establish the IGT set forth above, and nothing in this Agreement will be construed to limit, restrict or modify the respective rights and responsibilities of either party under federal or state law and policies, including the right of the STATE to recover overpayments made to Hospitals within the COUNTY other than the Hospital Payments set forth in above.

The parties, by their authorized representatives, have duly executed this agreement and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

STATE

Printed Name: BRIAN FRANCE

Title: DHS -CFO

By:

Date: 6/22/2021

MERCER COUNTY

Printed Name: Brian M. Hughes

Title: County Executive

By:

Date: 6/1/21

Attest.

Jerlene H. Worthy, Clerk
Mercer County Board of County Commissioners

INTERGOVERNMENTAL AGREEMENT
BETWEEN
STATE OF NEW JERSEY, DEPARTMENT OF HUMAN SERVICES
AND
COUNTY OF MIDDLESEX

This Intergovernmental Agreement ("Agreement"), by and between the State of New Jersey, Department of Human Services (the "STATE") and the County of Middlesex, New Jersey (the "COUNTY"), a public body corporate and politic of the State of New Jersey, provides for intergovernmental transfers of funds to the STATE in order implement the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136. This Agreement and the intergovernmental transfer of funds it authorizes are made pursuant to N.J.S.A 30:4D-7r et seq., N.J.A.C. 10:52-1.1 et seq., N.J.S.A. 30:4D-19.4 et seq., 42 U.S.C. 1396b(w)(6) and 42 C.F.R. 433.51.

RECITALS

WHEREAS, the Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income; and

WHEREAS, the Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain up to 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining proceeds to the STATE by way of this Agreement; and

WHEREAS, the Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents; and

WHEREAS, the Transferred Fee Amount will be combined with matching Federal Medicaid dollars as specified in the Fee & Expenditure report and distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement; and

WHEREAS, N.J.S.A 30:4D-7v(d) restricts funds generated by the Fee from supplanting or offsetting any current or future State funds allocated to the COUNTY; and

WHEREAS, N.J.S.A 30:4D-7v(e) et seq. restricts Hospital Payments from supplanting or offsetting any current or future funds paid to hospitals through other State or federal funding mechanisms or pools; and

WHEREAS, the COUNTY and the STATE wish to enter into this Agreement in order to facilitate the transfer of the Fee to serve as the non-federal share of the MCO Payments authorized under the Program;

NOW, THEREFORE, the COUNTY and the STATE, (collectively referred to as "the parties") agree as follows:

1. Definitions: When used in this Agreement, the following terms have the meanings assigned to them in this section:

   "Fee" means the local health care-related fee imposed by the COUNTY on hospitals located within its borders as authorized under N.J.S.A. 30:4D-7r et seq. and described in the Fee & Expenditure Report.

   "CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

   "Federal Financial Participation" or "FFP" means the federal matching funds received by the STATE for expenditures for medical assistance, including expenditures under the Program.

   "Fee & Expenditure Report" means the proposal submitted by the COUNTY, including any modifications necessary to secure STATE and CMS approval of the Program, detailing the COUNTY's Fee on the Hospitals, the use of such funds, and how the proposal satisfies the purpose and requirements of the Program.

   "Hospital Payments" means the payments that the STATE will direct the MCOs to pay to the hospitals pursuant to 42 C.F.R. 438.6(c), consistent with this Agreement, which in the aggregate equal the MCO Payments less the MCO Fee.

   "Hospitals" means the hospital facilities located within the COUNTY's borders that are subject to the COUNTY's Assessment as defined herein.

   "Intergovernmental Transfer" or "IGT" means the transfer, authorized under the Social Security Act and CMS regulations (see 42 CFR 433.51 - Public Funds as the State share of financial participation and 42 CFR 433.68), of the Transferred Fee Amount from the COUNTY to the STATE.

   "Managed Care Organizations" or "MCOs" means the health plans under contract with the STATE to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program that will be directed to distribute the Hospital Payments.

   "MCO Payments" means the increased payments made by the STATE to MCOs to enable the MCOs to make the Hospital Payments as specified in the Fee & Expenditure Report and modified as suggested by CMS through the annual approval process.

   "MCO Fee" means the portion of the MCO Payments retained by the MCOs, not to exceed the amount specified in P.L. 2020, c. 96 or any similar or successor

law, to cover their incremental costs of such fees resulting from the MCO Payments.

"Program" means the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136.

"Program Year" means each 12-month period that corresponds with the contract year of the STATE's contracts with the MCOs, for which the implementation of the Program is approved, generally from July 1 through June 30 of each year.

"Transferred Fee Amount" means the funds transferred by the COUNTY to the STATE as specified in the Fee & Expenditure Report, equal to not less than 91 percent of the proceeds of the Fee.

2. CMS Approval Required: The Hospital Payments set forth in this Agreement are contingent upon CMS approval. To obtain CMS approval, the STATE will submit a preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c). The COUNTY will make the IGTs provided for hereunder only after the STATE receives approval from CMS for the Hospital Payments.

3. Voluntariness: The COUNTY attests that it entered voluntarily into this Agreement to make the IGTs described hereunder. The COUNTY further attests that it and its representatives have independently analyzed the validity of the IGTs and Hospital Payments, and in making the final determination to enter into this Agreement, relied upon the advice of their advisors and legal counsel.

4. Permissible Sources: The COUNTY will provide IGT funds to the STATE that satisfy the requirements of 42 CFR 433.51 and 42 CFR 433.68, and that are not derived from an impermissible source, including federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations. At the time the COUNTY makes an IGT to the STATE, the COUNTY will certify to the STATE that the IGT funds are derived from the Fee as authorized under N.J.S.A. 30:4D-7r et seq. and specified in the COUNTY's Fee & Expenditure Report.

5. Transfer and Use of Funds: The parties will transfer and use the proceeds of the Fee as specified below:

    a. The COUNTY will retain 9 percent of the proceeds of the Fee for its discretionary use.

    b. The COUNTY will make four quarterly IGTs per year, each equal to $15,538,034 (25 percent of the annual Transferred Fee Amount of $62,152,136) unless the COUNTY receives less than the full Fee from Hospitals, in which case the IGTs will be reduced by 91% of the total

shortfall amount. The COUNTY will make the IGT no later than 15 business days prior to the close of each quarter of the State fiscal year.

c. In the event federal approval of the Program is obtained less than 45 calendar days prior to a regularly scheduled IGT due date, the COUNTY will make its first quarterly IGT (and any subsequent IGTs not yet transferred) no later than 45 calendar days after being notified of the approval from the STATE. If, pursuant to that 45-day schedule, the revised IGT due date lands within 15 days prior to a regularly scheduled IGT due date, the COUNTY will make a consolidated IGT on the regularly scheduled due date.

d. The COUNTY's failure to make the IGT within this timeframe will result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding IGT amount per month and/or removal from the Program.

e. The COUNTY will transfer the Transferred Fee Amount to the STATE via the Automated Clearing House, or via wire transfer, to an account designated by the STATE.

f. The STATE will use the Transferred Fee Amount (less amounts allocated to the STATE for Program administration) as specified in the Fee & Expenditure Report for the sole purpose of funding the non-federal share of the MCO Payments for each fiscal year that the program is in effect, as authorized by the aforementioned CMS approval.

g. From the Transferred Fee Amount, the STATE will receive at least one percent of the Fee proceeds for the cost of administering the Program. Should the STATE's direct administrative costs for the program exceed the total value of funding transferred by the participating counties for the cost of administering the program, the STATE will provide to the COUNTY documentation of the STATE's direct administrative costs and the remaining costs will be subtracted from amounts otherwise available to fund the non-federal share of Medicaid payments, consistent with N.J.A.C. 10:52B-3.3(a)3.

h. The STATE will make the MCO Payments through its then-existing payment process and ensure that the Hospitals receive the Hospital Payments within 30 calendar days of the receipt of the IGT, barring exceptional circumstances.

i. Should the total of all quarterly IGTs made by the COUNTY to the STATE differ from the Transferred Fee Amount (specified in Section 6.b) due to hospital non-payment, or any other reason, the value of this difference will be subtracted from the amounts otherwise available to fund the non-federal share of enhanced payments in the subsequent Program Year. If the value of this difference is collected in a subsequent Program Year, that value will

be added to the amounts otherwise available to fund the non-federal share of MCO Payments in the following Program Year.

6. Deferrals and Disallowances:

    a. The STATE will notify the COUNTY within 5 business days if CMS defers or disallows FFP in any of the payments under the Program. The STATE will consult with the COUNTY and consider the COUNTY's feedback in preparing any STATE response to the CMS deferral or disallowance. The STATE will provide the COUNTY a copy of any STATE response to the CMS deferral or disallowance.

    b. If the STATE determines that meritorious grounds exist to appeal the disallowance of FFP, the STATE will file an appeal with the United States Department of Health & Human Services Departmental Appeals Board contesting the CMS' disallowance. In the event the STATE files such an appeal, the STATE may, upon request by the COUNTY, allow the COUNTY to intervene in and to appear with STATE as a party to the appeal subject to Appeals Board approval.

    c. If, after any appeals are exhausted, a CMS disallowance of FFP in the Hospital Payments is finalized,

        i. The STATE will recoup the amount of Hospital Payments disallowed, and related interest and penalties, if any, from the recipient hospitals, offsetting the recouped amount from payments otherwise due to the hospitals; and

        ii. The STATE will return to the COUNTY the non-federal share of the recouped payments, refunding the federal share to CMS; and

        iii. The COUNTY will refund such returned non-federal share to Hospitals in proportion to their share of the Fee.

7. If, after the COUNTY has made an IGT but before the STATE makes the related MCO Payments, CMS, for any reason, does not permit or revokes approval of the Program described herein, the STATE will return the IGT funds to the COUNTY within 15 business days of STATE receiving such notification.

8. Record Maintenance: The parties will maintain necessary records and supporting documentation applicable to the Fee, the IGTs, the MCO Payments and the Hospital Payments to assure that claims for total funds and federal funds are in accordance with applicable State and federal requirements.

9. Records Access and Cooperation:
    a. The COUNTY will provide the STATE or its designee access to the COUNTY's records and the supporting documentation relating to the IGTs and will

cooperate and assist the STATE, as requested, in any Federal or STATE review or audit of the IGTs or payments funded with those IGTs.

b. If the STATE's costs for administering the Program exceed 1% of the Transfer Amount (as specified in Section 5.g), the STATE will provide the COUNTY or its designee cooperation and access to the State's records and the supporting documentation relating to the STATE's costs for administering the Program.

10. Notice: Any written notice required by the Agreement will be sent to:

For the Department	For Middlesex County
Name: Brian Francz, CFO	Name: John Pulomena, Administrator
E-mail address: Brian.Francz@dhs.nj.gov	E-mail address: john.pulomena@co.middlesex.nj.us
Mailing address:	Mailing address:
222 S Warren St, Trenton, NJ 08608	75 Bayard Street New Brunswick, NJ 08901

11. Term/Termination: This Agreement will become effective on the earliest date it is fully executed by both parties and the Program is approved by CMS. In the event CMS withdraws or fails to extend its approval of the Program or the Program is otherwise determined to be unlawful in a final determination under County, State, or Federal law, this agreement will terminate immediately, except that applicable procedures in Sections 7 through 12 will survive such termination. Notwithstanding the foregoing, either party may terminate this Agreement for an upcoming Program Year by providing written notice received by the other party prior to April 1 preceding that Program Year.

12. Rights and Responsibilities: This Agreement is only intended to establish the IGT set forth above, and nothing in this Agreement will be construed to limit, restrict or modify the respective rights and responsibilities of either party under federal or state law and policies, including the right of the STATE to recover overpayments made to Hospitals within the COUNTY other than the Hospital Payments set forth in above.

The parties, by their authorized representatives, have duly executed this agreement and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

STATE

Printed Name: BRIAN FRANCZ

Title: DHS - CFO

By: [signature]

Date: 6/22/2021

Middlesex County

Printed Name: John Pulomena

Title: County Administrator

By: [signature]

Date: 5/26/2021

INTERGOVERNMENTAL AGREEMENT
BETWEEN
STATE OF NEW JERSEY, DEPARTMENT OF HUMAN SERVICES
AND
COUNTY OF ESSEX

This Intergovernmental Agreement ("Agreement"), by and between the State of New Jersey, Department of Human Services (the "STATE") and the County of Essex, New Jersey (the "COUNTY"), a public body corporate and politic of the State of New Jersey, provides for intergovernmental transfers of funds to the STATE in order implement the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136. This Agreement and the intergovernmental transfer of funds it authorizes are made pursuant to N.J.S.A 30:4D-7r et seq., N.J.A.C. 10:52-1.1 et seq., N.J.S.A. 30:4D-19.4 et seq., 42 U.S.C. 1396b(w)(6), 42 C.F.R. 433.51, and 42 C.F.R 433.68(c).

RECITALS

WHEREAS, the Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income; and

WHEREAS, the Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain up to 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining proceeds to the STATE by way of this Agreement; and

WHEREAS, the Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents; and

WHEREAS, the Transferred Fee Amount will be combined with matching Federal Medicaid dollars as specified in the preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c) and approved by CMS then distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement; and

WHEREAS, N.J.S.A 30:4D-7v(d) restricts funds generated by the Fee from supplanting or offsetting any current or future State funds allocated to the COUNTY; and

WHEREAS, N.J.S.A 30:4D-7v(e) et seq. restricts Hospital Payments from supplanting or offsetting any current or future funds paid to hospitals through other State or federal funding mechanisms or pools; and

WHEREAS, the COUNTY and the STATE wish to enter into this Agreement in order to facilitate the transfer of the Fee to serve as the non-federal share of the MCO Payments authorized under the Program;

The COUNTY and the STATE, (collectively referred to as "the parties") agree as follows:

1. Definitions: When used in this Agreement, the following terms have the meanings assigned to them in this section:

"Fee" means the local health care-related fee imposed by the COUNTY on hospitals located within its borders as authorized under N.J.S.A. 30:4D-7r et seq.

"CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

"Federal Financial Participation" or "FFP" means the federal matching funds received by the STATE for expenditures for medical assistance, including expenditures under the Program.

"Hospital Payments" means the payments that the state shall direct the MCOs to pay to the hospitals pursuant to 42 C.F.R. 438.6(c), consistent with this Agreement, which in the aggregate equal the MCO Payments less the MCO Fee.

"Hospitals" means the hospital facilities located within the COUNTY's borders that are subject to the COUNTY's Assessment as defined herein.

"Intergovernmental Transfer" or "IGT" means the transfer, authorized under the Social Security Act and CMS regulations (see 42 CFR 433.51 - Public Funds as the State share of financial participation and 42 CFR 433.68), of the Transferred Fee Amount from the COUNTY to the STATE.

"Managed Care Organizations" or "MCOs" means the health plans under contract with the STATE to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program that will be directed to distribute the Hospital Payments.

"MCO Payments" means the increased payments made by the State to MCOs pursuant to the Program equal to the Transferred Fee Amount, less amounts allocated to the State for Program administration, plus the accompanying Federal Financial Participation.

"MCO Fee" means the portion of the MCO Payments retained by the MCOs, not to exceed the amount specified in P.L. 2020, c. 96 or any similar or successor law plus amounts as may be required to cover administrative and other unavoidable costs directly resulting from the Program.

"Program" means the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136.

"Program Year" means each 12-month period that corresponds with the contract year of the STATE's contracts with the MCOs, for which the implementation of the Program is approved, generally from July 1 through June 30 of each year.

"Transferred Fee Amount" means the funds transferred by the COUNTY to the STATE, equal to 91 percent of the proceeds of the Fee.

2. Program Description: The Program shall raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income and to provide participating counties with new fiscal resources. The Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining 91 percent of proceeds to the STATE by way of this Agreement. The Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents. The Transferred Fee Amount (less amounts allocated to the STATE for Program administration) shall be combined with matching Federal Medicaid dollars and distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement.

3. CMS Approval Required: The Hospital Payments set forth in this Agreement are contingent upon CMS approval. To obtain CMS approval, the STATE shall submit a preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c). The COUNTY shall make the IGTs provided for hereunder only after the STATE receives approval from CMS for the Hospital Payments.

4. Voluntariness: The COUNTY attests that it entered voluntarily into this Agreement to make the IGTs described hereunder. The COUNTY further attests that it and its representatives have independently analyzed the validity of the IGTs and Hospital Payments, and in making the final determination to enter into this Agreement, relied upon the advice of their advisors and legal counsel.

5. Permissible Sources: The COUNTY shall provide IGT funds to the STATE that satisfy the requirements of 42 CFR 433.51 and 42 CFR 433.68, and that are not derived from an impermissible source, including federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations. At the time the COUNTY makes an IGT to the STATE, the COUNTY shall certify to the STATE that the IGT funds are derived from the Fee as authorized under N.J.S.A. 30:4D-7r et seq. and specified in the COUNTY's Fee & Expenditure Report approved by the STATE on February 2, 2022.

6. Transfer and Use of Funds: The parties shall transfer and use the proceeds of the Fee as specified below:

a. The COUNTY shall retain 9 percent of the proceeds of the Fee for its discretionary use.

b. The COUNTY shall make four quarterly IGTs per year, each equal to $19,718,433 for the first year of the program (25 percent of the annual Transferred Fee Amount of $78,873,732) unless the COUNTY receives less than the full Fee from Hospitals, in which case the IGTs shall be reduced by 91% of the total shortfall amount. For years after the first year of the program, the annual Transferred Fee Amounts will be equal to amounts reported in the approved annual preprint application for that year. The COUNTY shall make the IGT no later than 15 business days prior to the close of each quarter of the State fiscal year.

c. In the event federal approval of the Program is obtained less than 45 calendar days prior to a regularly scheduled IGT due date, the COUNTY will make its first quarterly IGT (and any subsequent IGTs not yet transferred) no later than 45 calendar days after being notified of the approval from the STATE. If, pursuant to that 45-day schedule, the revised IGT due date lands within 15 days prior to a regularly scheduled IGT due date, the COUNTY will make a consolidated IGT on the regularly scheduled due date.

d. The COUNTY's failure to make the IGT 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 IGT amount per month and/or removal from the Program.

e. The COUNTY shall transfer the Transferred Fee Amount to the STATE via the Automated Clearing House, or via wire transfer, to an account designated by the STATE.

f. The STATE shall use the Transferred Fee Amount less amounts allocated to the State for Program administration for the sole purpose of funding the non-federal share of the MCO Payments for each fiscal year that the program is in effect, as authorized by the aforementioned CMS approval.

g. From the Transferred Fee Amount, the STATE shall receive at least one percent of the Fee proceeds for the cost of administering the Program. Should the State's direct administrative costs for the program exceed the total value of funding transferred by the participating counties for the cost of administering the program, documentation of the STATE's direct administrative costs shall be provided to the COUNTY and remaining costs shall be subtracted from amounts otherwise available as the non-Federal share of Medicaid payments, consistent with N.J.A.C. 10:52B-3.3(a)3.

13. Rights and Responsibilities: This Agreement is only intended to establish the IGT set forth above, and nothing in this Agreement shall be construed to limit, restrict or modify the respective rights and responsibilities of either party under federal or state law and policies, including the right of the STATE to recover overpayments made to Hospitals within the COUNTY, other than the Hospital Payments set forth above.

The parties, by their authorized representatives, have duly executed this agreement and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

STATE	ESSEX COUNTY
Printed Name: BRIAN FRANCZ	Printed Name: Robert D. Jackson
Title: CHIEF FINANCIAL OFFICER	Title: Essex County Administrator
By:	By:
Date: 5/18/22	Date: 5/10/22

INTERGOVERNMENTAL AGREEMENT
BETWEEN
STATE OF NEW JERSEY, DEPARTMENT OF HUMAN SERVICES
AND
COUNTY OF PASSAIC

This Intergovernmental Agreement ("Agreement"), by and between the State of New Jersey, Department of Human Services (the "STATE") and the County of Passaic, New Jersey (the "COUNTY"), a public body corporate and politic of the State of New Jersey, provides for intergovernmental transfers of funds to the STATE in order implement the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136. This Agreement and the intergovernmental transfer of funds it authorizes are made pursuant to N.J.S.A 30:4D-7r et seq., N.J.A.C. 10:52-1.1 et seq., N.J.S.A. 30:4D-19.4 et seq., 42 U.S.C. 1396b(w)(6) and 42 C.F.R. 433.51.

RECITALS

WHEREAS, the Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ Family Care program to support local hospitals and to ensure that those local hospitals continue to provide necessary services to residents with low income; and

WHEREAS, the Program authorizes the COUNTY to impose a Fee on hospitals within its borders, to retain up to 9 percent of the proceeds of the Fee for its own purposes, and to transfer the remaining proceeds to the STATE by way of this Agreement; and

WHEREAS, the Transferred Fee Amount will be used to secure additional Federal funding to benefit residents with low income by providing additional funding to the hospitals in the COUNTY that serve these residents; and

WHEREAS, the Transferred Fee Amount will be combined with matching Federal Medicaid dollars as specified in the Fee & Expenditure report and distributed to hospitals in the COUNTY through the MCOs pursuant to this Agreement; and

WHEREAS, N.J.S.A 30:4D-7v(d) restricts funds generated by the Fee from supplanting or offsetting any current or future State funds allocated to the COUNTY; and

WHEREAS, N.J.S.A 30:4D-7v(e) et seq. restricts Hospital Payments from supplanting or offsetting any current or future funds paid to hospitals through other State or federal funding mechanisms or pools; and

WHEREAS, the COUNTY and the STATE wish to enter into this Agreement in order to facilitate the transfer of the Fee to serve as the non-federal share of the MCO Payments authorized under the Program;

NOW, THEREFORE, the COUNTY and the STATE, (collectively referred to as "the parties") agree as follows:

1. Definitions: When used in this Agreement, the following terms have the meanings assigned to them in this section:

   "Fee" means the local health care-related fee imposed by the COUNTY on hospitals located within its borders as authorized under N.J.S.A. 30:4D-7r et seq. and described in the Fee & Expenditure Report.

   "CMS" means the Centers for Medicare and Medicaid Services, a federal agency within the U.S. Department of Health and Human Services.

   "Federal Financial Participation" or "FFP" means the federal matching funds received by the STATE for expenditures for medical assistance, including expenditures under the Program.

   "Fee & Expenditure Report" means the proposal submitted by the COUNTY, including any modifications necessary to secure STATE and CMS approval of the Program, detailing the COUNTY's Fee on the Hospitals, the use of such funds, and how the proposal satisfies the purpose and requirements of the Program.

   "Hospital Payments" means the payments that the STATE will direct the MCOs to pay to the hospitals pursuant to 42 C.F.R. 438.6(c), consistent with this Agreement, which in the aggregate equal the MCO Payments less the MCO Fee.

   "Hospitals" means the hospital facilities located within the COUNTY's borders that are subject to the COUNTY's Assessment as defined herein.

   "Intergovernmental Transfer" or "IGT" means the transfer, authorized under the Social Security Act and CMS regulations (see 42 CFR 433.51 - Public Funds as the State share of financial participation and 42 CFR 433.68), of the Transferred Fee Amount from the COUNTY to the STATE.

   "Managed Care Organizations" or "MCOs" means the health plans under contract with the STATE to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program that will be directed to distribute the Hospital Payments.

   "MCO Payments" means the increased payments made by the STATE to MCOs to enable the MCOs to make the Hospital Payments as specified in the Fee & Expenditure Report and modified as suggested by CMS through the annual approval process.

   "MCO Fee" means the portion of the MCO Payments retained by the MCOs, not to exceed the amount specified in P.L. 2020, c. 96 or any similar or successor

law, to cover their incremental costs of such fees resulting from the MCO Payments.

"Program" means the County Option Hospital Fee Pilot Program created by P.L. 2018, c. 136.

"Program Year" means each 12-month period that corresponds with the contract year of the STATE's contracts with the MCOs, for which the implementation of the Program is approved, generally from July 1 through June 30 of each year.

"Transferred Fee Amount" means the funds transferred by the COUNTY to the STATE as specified in the Fee & Expenditure Report, equal to not less than 91 percent of the proceeds of the Fee.

2. CMS Approval Required: The Hospital Payments set forth in this Agreement are contingent upon CMS approval. To obtain CMS approval, the STATE will submit a preprint application for directed managed care payments as required by CMS pursuant to 42 CFR 438.6(c). The COUNTY will make the IGTs provided for hereunder only after the STATE receives approval from CMS for the Hospital Payments.

3. Voluntariness: The COUNTY attests that it entered voluntarily into this Agreement to make the IGTs described hereunder. The COUNTY further attests that it and its representatives have independently analyzed the validity of the IGTs and Hospital Payments, and in making the final determination to enter into this Agreement, relied upon the advice of their advisors and legal counsel.

4. Permissible Sources: The COUNTY will provide IGT funds to the STATE that satisfy the requirements of 42 CFR 433.51 and 42 CFR 433.68, and that are not derived from an impermissible source, including federal money precluded from use as the non-federal share, impermissible taxes, and non-bona fide provider-related donations. At the time the COUNTY makes an IGT to the STATE, the COUNTY will certify to the STATE that the IGT funds are derived from the Fee as authorized under N.J.S.A. 30:4D-7r et seq. and specified in the COUNTY's Fee & Expenditure Report.

5. Transfer and Use of Funds: The parties will transfer and use the proceeds of the Fee as specified below:

    a. The COUNTY will retain 9 percent of the proceeds of the Fee for its discretionary use.

    b. The COUNTY will make four quarterly IGTs per year, each equal to $4,758,422 (25 percent of the annual Transferred Fee Amount of $19,033,688) unless the COUNTY receives less than the full Fee from Hospitals, in which case the IGTs will be reduced by 91% of the total

shortfall amount. The COUNTY will make the IGT no later than 15 business days prior to the close of each quarter of the State fiscal year.

c. In the event federal approval of the Program is obtained less than 45 calendar days prior to a regularly scheduled IGT due date, the COUNTY will make its first quarterly IGT (and any subsequent IGTs not yet transferred) no later than 45 calendar days after being notified of the approval from the STATE. If, pursuant to that 45-day schedule, the revised IGT due date lands within 15 days prior to a regularly scheduled IGT due date, the COUNTY will make a consolidated IGT on the regularly scheduled due date.

d. The COUNTY's failure to make the IGT within this timeframe will result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding IGT amount per month and/or removal from the Program.

e. The COUNTY will transfer the Transferred Fee Amount to the STATE via the Automated Clearing House, or via wire transfer, to an account designated by the STATE.

f. The STATE will use the Transferred Fee Amount (less amounts allocated to the STATE for Program administration) as specified in the Fee & Expenditure Report for the sole purpose of funding the non-federal share of the MCO Payments for each fiscal year that the program is in effect, as authorized by the aforementioned CMS approval.

g. From the Transferred Fee Amount, the STATE will receive at least one percent of the Fee proceeds for the cost of administering the Program. Should the STATE's direct administrative costs for the program exceed the total value of funding transferred by the participating counties for the cost of administering the program, the STATE will provide to the COUNTY documentation of the STATE's direct administrative costs and the remaining costs will be subtracted from amounts otherwise available to fund the non-federal share of Medicaid payments, consistent with N.J.A.C. 10:52B-3.3(a)3.

h. The STATE will make the MCO Payments through its then-existing payment process and ensure that the Hospitals receive the Hospital Payments within 30 calendar days of the receipt of the IGT, barring exceptional circumstances.

i. Should the total of all quarterly IGTs made by the COUNTY to the STATE differ from the Transferred Fee Amount (specified in Section 6.b) due to hospital non-payment, or any other reason, the value of this difference will be subtracted from the amounts otherwise available to fund the non-federal share of enhanced payments in the subsequent Program Year. If the value of this difference is collected in a subsequent Program Year, that value will

be added to the amounts otherwise available to fund the non-federal share of MCO Payments in the following Program Year.

6. Deferrals and Disallowances:

   a. The STATE will notify the COUNTY within 5 business days if CMS defers or disallows FFP in any of the payments under the Program. The STATE will consult with the COUNTY and consider the COUNTY's feedback in preparing any STATE response to the CMS deferral or disallowance. The STATE will provide the COUNTY a copy of any STATE response to the CMS deferral or disallowance.

   b. If the STATE determines that meritorious grounds exist to appeal the disallowance of FFP, the STATE will file an appeal with the United States Department of Health & Human Services Departmental Appeals Board contesting the CMS' disallowance. In the event the STATE files such an appeal, the STATE may, upon request by the COUNTY, allow the COUNTY to intervene in and to appear with STATE as a party to the appeal subject to Appeals Board approval.

   c. If, after any appeals are exhausted, a CMS disallowance of FFP in the Hospital Payments is finalized,

      i. The STATE will recoup the amount of Hospital Payments disallowed, and related interest and penalties, if any, from the recipient hospitals, offsetting the recouped amount from payments otherwise due to the hospitals; and

      ii. The STATE will return to the COUNTY the non-federal share of the recouped payments, refunding the federal share to CMS; and

      iii. The COUNTY will refund such returned non-federal share to Hospitals in proportion to their share of the Fee.

7. If, after the COUNTY has made an IGT but before the STATE makes the related MCO Payments, CMS, for any reason, does not permit or revokes approval of the Program described herein, the STATE will return the IGT funds to the COUNTY within 15 business days of STATE receiving such notification.

8. Record Maintenance: The parties will maintain necessary records and supporting documentation applicable to the Fee, the IGTs, the MCO Payments and the Hospital Payments to assure that claims for total funds and federal funds are in accordance with applicable State and federal requirements.

9. Records Access and Cooperation:
   a. The COUNTY will provide the STATE or its designee access to the COUNTY's records and the supporting documentation relating to the IGTs and will

cooperate and assist the STATE, as requested, in any Federal or STATE review or audit of the IGTs or payments funded with those IGTs.

b. If the STATE's costs for administering the Program exceed 1% of the Transfer Amount (as specified in Section 5.g), the STATE will provide the COUNTY or its designee cooperation and access to the State's records and the supporting documentation relating to the STATE's costs for administering the Program.

10. Notice: Any written notice required by the Agreement will be sent to:

For the Department	For Passaic County
Name: Brian Francz, CFO	Name: Anthony J. DeNova III
E-mail address: Brian.Francz@dhs.nj.gov	E-mail address: adenova@passaiccountynj.org
Mailing address:	Mailing address:
222 S Warren St, Trenton, NJ 08608	401 Grand Street, Room 205 Paterson, NJ 07505

11. Term/Termination: This Agreement will become effective on the earliest date it is fully executed by both parties and the Program is approved by CMS. In the event CMS withdraws or fails to extend its approval of the Program or the Program is otherwise determined to be unlawful in a final determination under County, State, or Federal law, this agreement will terminate immediately, except that applicable procedures in Sections 7 through 12 will survive such termination. Notwithstanding the foregoing, either party may terminate this Agreement for an upcoming Program Year by providing written notice received by the other party prior to April 1 preceding that Program Year.

12. Rights and Responsibilities: This Agreement is only intended to establish the IGT set forth above, and nothing in this Agreement will be construed to limit, restrict or modify the respective rights and responsibilities of either party under federal or state law and policies, including the right of the STATE to recover overpayments made to Hospitals within the COUNTY other than the Hospital Payments set forth in above.

The parties, by their authorized representatives, have duly executed this agreement and each party acknowledges the receipt of a duly executed copy of this agreement with original signatures.

STATE

Printed Name: BRIAN FRANCZ

Title: DHS - CFO

By:

Date: 6/22/2021

Passaic County

Printed Name: Anthony J. DeNova III

Title: County Administrator

By:

Date: 5.18.21

APPROVED AS TO FORM AND LEGALITY

BY:

MATTHEW P. JORDAN, ESQ.
COUNTY COUNSEL

DATE: May 18, 2021

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 22, 2022

Jennifer Langer Jacobs
Assistant Commissioner
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
PO Box 712
Trenton, NJ 08625-0712

Dear Jennifer Langer Jacobs:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 14, 2022, and a revised proposal was received on July 8, 2022. The proposal has a control name of NJ_Fee_IPH.BHI_Renewal_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- The uniform dollar increase for inpatient hospital services provided by general acute care hospitals and freestanding psychiatric hospitals in Camden County for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment

arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this preprint with the requirement that the state provide full evaluation results for SFY 2021 with submission of the SFY 2024 preprint for CMS prior approval under 42 CFR 438.6(c). Please work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox if any questions arise.

If you have questions concerning this approval or state directed payments in general, please contact Pooja A. Regmi, Division of Managed Care Policy, at (410) 786-8409, pooja.regmi@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2022 - June 30, 2023
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2022
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $140,152,536
   a. Identify the estimated federal share of this state directed payment: $92,796,101
   b. Identify the estimated non-federal share of this state directed payment: $47,356,435

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
SFY22

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

New Jersey proposes to direct Medicaid Managed Care Organizations (MCOs) to issue a per (diem/discharge) add-on payment to two classes of Camden County hospitals from set funding pools established for this purpose. Class A will encompass general acute care hospitals and Class B will encompass freestanding psychiatric hospitals. The per (diem/discharge) will be paid on an interim basis in four quarterly installments during the contract year. The interim payments will be based on historical utilization using a set annual dollar amount translated into a uniform dollar add-on amount per (day/discharge). The per (day/discharge) amount will be adjusted and certified after the contract year to reflect actual utilization during the program year reconciled to the total dollar amount available in the predetermined pool. Hospitals will be required to provide covered inpatient services to enrollees in order to receive payments, and the amount of their payments will depend on the number of (days/discharges) of service provided. In basing payments on the number of (days/discharges), the payments are directly tied to the utilization and delivery of services for enrollees.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$1,597 per diem (Class A hospitals); $2,822 per discharge (Class B hospitals)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MCOs will make four quarterly payments to hospitals in each defined class, each equal to 25% of the interim annual payments due, based on the hospital's interim number of days or discharges of inpatient service (interim defined as historic utilization during a base year). After the end of the year, the state will conduct a reconciliation to actual days or discharges provided during the year and re-calculate the per diem or per discharge amount.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The New Jersey Legislature authorized the new payments as part of a pilot program to provide additional resources to hospitals in economically challenged communities to support those hospitals in serving their large Medicaid populations. To carry out this legislative objective, the state established a pool of funds for the hospitals in each county, including Camden County, based on available resources.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Hospitals will be divided into the following classes:
Class A: General acute hospitals located in Camden County (4 hospitals)
Class B: Freestanding psychiatric hospitals located in Camden County (1 hospital)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Camden County is one of seven New Jersey counties that meet the eligibility criteria defined in the legislation, because of its size (population in excess of 250,000) and because it contains a municipality ranking high on the Municipal Revitalization Index (which measures municipal distress based on indicators of diverse aspects of social, economic, physical and fiscal conditions). As such, hospitals in the county are deemed to have a high need for additional support. As of December 2021, 7.8% of NJ Medicaid beneficiaries reside in Camden County. By comparison, the average of the NJ Medicaid Population residing in the other 14 counties not eligible for this program is 3.2% (http://www.njfamilycare.org/analytics/elig_explorer.html). The state has developed this pilot initiative to test the impact of additional resources on these distressed counties. Further, due to the unique differences in populations served and services furnished between general acute hospitals and psychiatric hospitals in Camden County, the State has established two distinct classes to account for the significant variance in levels of acuity and average lengths of stay between the two types of hospitals.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payments will be set at the same amount per day or per discharge for each hospital in the class, and the total payments for each hospital will be based on the total number of days or discharges of inpatient service provided during the contract year.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Camden County General Acute Hospitals	38.00%	29.00%	1.00%		68.00%
b. Camden County Psychiatric Hospitals	15.00%	3.00%	0.00%		18.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define: commercial equivalent

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on Average Payment Per Day compared to the commercial equivalent Payment Per Day. Average Base Payment from Plan to Providers is based on CY2019 MCO encounter payments. State Directed Payment (SDP) is the proposed new payment to facilities. All other SDPs are incorporated. All values are a percentage of the total commercial equivalent payments for each facility, per their respective Annual - Acute Care Hospital (ACH) Cost Reports.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As noted above, the total funding amount was established based on resources authorized by the Legislature. In comparing the resulting total payments to commercial equivalent payment levels and considering the substantial challenges facing hospitals serving these distressed communities, the state determined that the directed payment is appropriate and reasonable.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 8.5.16 (SFY22 contract)

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The legislation requires that the funding be used "for the benefit of local hospitals within the participating county's borders to ensure that the hospitals continue to provide necessary services to low-income citizens." The use of a separate payment term is essential in order to comply with this legislative directive and ensure that all of the funding is used to support hospitals. This maximizes transparency in the payment process, allowing both the state and hospitals to identify the enhanced payments and ensure that they are directed to the hospitals the program is intended to support.

33. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ■ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ■ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Camden County	County	$ 47,882,618.00	Yes	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

*The non-federal share listed in Question 4.b is the non-federal share of the directed payments described in this preprint. The county transfer in Table 4 includes an additional amount to cover the state administrative costs.

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Camden County hospital fee	Providers of inpatient hospital services in Camden County	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf
- **b.** The effective date of quality strategy. June 12, 2014

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):Mar-22
- **b.** Note any potential changes that might be made to the goals and objectives.

  In the March 2022 draft Quality Strategy, the majority of the goals/objectives were modified from the June 2014 version.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	8
b. Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	8
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The program aims to provide more resources to county hospitals to ensure that they can maintain and expand access and quality of care. The specific quality metrics to be monitored during the project were chosen as representative of overall improvements in quality of care, delivery, and services. Reducing patient wait times between entering the Emergency Department (ED) and discharge will lead to greater fiscal accountability, hold partners accountable for providing a continuously improving program, and improve overall quality of ED services. Reducing rates of infection during a patient's hospital stay will improve the quality of care furnished to admitted patients, help to manage risk (fiscal and infection risk), and ensure that partners offer a continuously improving program. By directing these payments to hospitals within Camden County, (considering the substantial challenges facing hospitals serving these distressed communities), underserved Medicaid managed care members will be afforded more equitable access to care and services.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	CY2019	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.	Hospital Compare Metric ID: OP_18b Payer: All Payer Steward: CMS
ii. Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	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.	Hospital Compare Metric ID: Long term: L_014_01_SIR; Rehab: I_015_01_SIR Payer: All Payer Steward: CDC Standardized Infection Ratio (SIR) = observed / predicted)
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

44(c) - N/A. Program Year 1 (NJ SFY22) findings will be reported in the SFY24 preprint submission

Continued from Question 44 (b) above. Notes on TABLE 8.
Measure NQF #0496 will be reported by acute hospitals. Measure NQF #1717 will be reported by non-acute hospitals

OP-18b (Median ED Time)
This measure shows the average (median) time in minutes that patients spent in the emergency department – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.

NQF: Quality Positioning System ™ (qualityforum.org) CDI (C. Diff Infection)
NQF: Quality Positioning System ™ (qualityforum.org)
Will be in VBP/HAC through CY 2024 data, possibly further

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 22, 2022

Jennifer Langer Jacobs
Assistant Commissioner
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
PO Box 712
Trenton, NJ 08625-0712

Dear Jennifer Langer Jacobs:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 14, 2022, and a revised proposal was received on July 8, 2022. The proposal has a control name of NJ_Fee_IPH1_Renewal_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- The uniform dollar increase for inpatient hospital services provided by Atlantic County hospitals for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the

aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this preprint with the requirement that the state provide full evaluation results for SFY 2021 with submission of the SFY 2024 preprint for CMS prior approval under 42 CFR 438.6(c). Please work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox if any questions arise.

If you have questions concerning this approval or state directed payments in general, please contact Pooja A. Regmi, Division of Managed Care Policy, at (410) 786-8409, pooja.regmi@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   -
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $140,152,536
   a. Identify the estimated federal share of this state directed payment: $92,796,101
   b. Identify the estimated non-federal share of this state directed payment: $47,356,435

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
SFY22

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

New Jersey proposes to direct Medicaid Managed Care Organizations (MCOs) to issue a per (diem/discharge) add-on payment to two classes of Camden County hospitals from set funding pools established for this purpose. Class A will encompass general acute care hospitals and Class B will encompass freestanding psychiatric hospitals. The per (diem/discharge) will be paid on an interim basis in four quarterly installments during the contract year. The interim payments will be based on historical utilization using a set annual dollar amount translated into a uniform dollar add-on amount per (day/discharge). The per (day/discharge) amount will be adjusted and certified after the contract year to reflect actual utilization during the program year reconciled to the total dollar amount available in the predetermined pool. Hospitals will be required to provide covered inpatient services to enrollees in order to receive payments, and the amount of their payments will depend on the number of (days/discharges) of service provided. In basing payments on the number of (days/discharges), the payments are directly tied to the utilization and delivery of services for enrollees.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$1,597 per diem (Class A hospitals); $2,822 per discharge (Class B hospitals)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MCOs will make four quarterly payments to hospitals in each defined class, each equal to 25% of the interim annual payments due, based on the hospital's interim number of days or discharges of inpatient service (interim defined as historic utilization during a base year). After the end of the year, the state will conduct a reconciliation to actual days or discharges provided during the year and re-calculate the per diem or per discharge amount.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The New Jersey Legislature authorized the new payments as part of a pilot program to provide additional resources to hospitals in economically challenged communities to support those hospitals in serving their large Medicaid populations. To carry out this legislative objective, the state established a pool of funds for the hospitals in each county, including Camden County, based on available resources.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Hospitals will be divided into the following classes:
Class A: General acute hospitals located in Camden County (4 hospitals)
Class B: Freestanding psychiatric hospitals located in Camden County (1 hospital)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Camden County is one of seven New Jersey counties that meet the eligibility criteria defined in the legislation, because of its size (population in excess of 250,000) and because it contains a municipality ranking high on the Municipal Revitalization Index (which measures municipal distress based on indicators of diverse aspects of social, economic, physical and fiscal conditions). As such, hospitals in the county are deemed to have a high need for additional support. As of December 2021, 7.8% of NJ Medicaid beneficiaries reside in Camden County. By comparison, the average of the NJ Medicaid Population residing in the other 14 counties not eligible for this program is 3.2% (http://www.njfamilycare.org/analytics/elig_explorer.html). The state has developed this pilot initiative to test the impact of additional resources on these distressed counties. Further, due to the unique differences in populations served and services furnished between general acute hospitals and psychiatric hospitals in Camden County, the State has established two distinct classes to account for the significant variance in levels of acuity and average lengths of stay between the two types of hospitals.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payments will be set at the same amount per day or per discharge for each hospital in the class, and the total payments for each hospital will be based on the total number of days or discharges of inpatient service provided during the contract year.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Camden County General Acute Hospitals	38.00%	29.00%	1.00%		68.00%
b. Camden County Psychiatric Hospitals	15.00%	3.00%	0.00%		18.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define: commercial equivalent

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on Average Payment Per Day compared to the commercial equivalent Payment Per Day. Average Base Payment from Plan to Providers is based on CY2019 MCO encounter payments. State Directed Payment (SDP) is the proposed new payment to facilities. All other SDPs are incorporated. All values are a percentage of the total commercial equivalent payments for each facility, per their respective Annual - Acute Care Hospital (ACH) Cost Reports.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As noted above, the total funding amount was established based on resources authorized by the Legislature. In comparing the resulting total payments to commercial equivalent payment levels and considering the substantial challenges facing hospitals serving these distressed communities, the state determined that the directed payment is appropriate and reasonable.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 8.5.16 (SFY22 contract)

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The legislation requires that the funding be used "for the benefit of local hospitals within the participating county's borders to ensure that the hospitals continue to provide necessary services to low-income citizens." The use of a separate payment term is essential in order to comply with this legislative directive and ensure that all of the funding is used to support hospitals. This maximizes transparency in the payment process, allowing both the state and hospitals to identify the enhanced payments and ensure that they are directed to the hospitals the program is intended to support.

33. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ■ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ■ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Camden County	County	$ 47,882,618.00	Yes	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

*The non-federal share listed in Question 4.b is the non-federal share of the directed payments described in this preprint. The county transfer in Table 4 includes an additional amount to cover the state administrative costs.

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Camden County hospital fee	Providers of inpatient hospital services in Camden County	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf
- **b.** The effective date of quality strategy.

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

  In the March 2022 draft Quality Strategy, the majority of the goals/objectives were modified from the June 2014 version.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	8
b. Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	8
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The program aims to provide more resources to county hospitals to ensure that they can maintain and expand access and quality of care. The specific quality metrics to be monitored during the project were chosen as representative of overall improvements in quality of care, delivery, and services. Reducing patient wait times between entering the Emergency Department (ED) and discharge will lead to greater fiscal accountability, hold partners accountable for providing a continuously improving program, and improve overall quality of ED services. Reducing rates of infection during a patient's hospital stay will improve the quality of care furnished to admitted patients, help to manage risk (fiscal and infection risk), and ensure that partners offer a continuously improving program. By directing these payments to hospitals within Camden County, (considering the substantial challenges facing hospitals serving these distressed communities), underserved Medicaid managed care members will be afforded more equitable access to care and services.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	CY2019	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.	Hospital Compare Metric ID: OP_18b Payer: All Payer Steward: CMS
ii. Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	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.	Hospital Compare Metric ID: Long term: L_014_01_SIR; Rehab: I_015_01_SIR Payer: All Payer Steward: CDC Standardized Infection Ratio (SIR) = observed / predicted)
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

44(c) - N/A. Program Year 1 (NJ SFY22) findings will be reported in the SFY24 preprint submission

Continued from Question 44 (b) above. Notes on TABLE 8.
Measure NQF #0496 will be reported by acute hospitals. Measure NQF #1717 will be reported by non-acute hospitals

OP-18b (Median ED Time)
This measure shows the average (median) time in minutes that patients spent in the emergency department – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.

NQF: Quality Positioning System ™ (qualityforum.org) CDI (C. Diff Infection)
NQF: Quality Positioning System ™ (qualityforum.org)
Will be in VBP/HAC through CY 2024 data, possibly further

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 22, 2022

Jennifer Langer Jacobs
Assistant Commissioner
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
PO Box 712
Trenton, NJ 08625-0712

Dear Jennifer Langer Jacobs:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 14, 2022, with revised proposals received on June 7, 2022 and July 8, 2022. The proposal has a control name of NJ_Fee_IPH2_Renewal_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- The uniform dollar increase for inpatient hospital services provided by Hudson County hospitals for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the

aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this preprint with the requirement that the state provide full evaluation results for SFY 2021 with submission of the SFY 2024 preprint for CMS prior approval under 42 CFR 438.6(c). Please work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox if any questions arise.

If you have questions concerning this approval or state directed payments in general, please contact Pooja A. Regmi, Division of Managed Care Policy, at (410) 786-8409, pooja.regmi@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   -
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $140,152,536
   a. Identify the estimated federal share of this state directed payment: $92,796,101
   b. Identify the estimated non-federal share of this state directed payment: $47,356,435

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
SFY22

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

New Jersey proposes to direct Medicaid Managed Care Organizations (MCOs) to issue a per (diem/discharge) add-on payment to two classes of Camden County hospitals from set funding pools established for this purpose. Class A will encompass general acute care hospitals and Class B will encompass freestanding psychiatric hospitals. The per (diem/discharge) will be paid on an interim basis in four quarterly installments during the contract year. The interim payments will be based on historical utilization using a set annual dollar amount translated into a uniform dollar add-on amount per (day/discharge). The per (day/discharge) amount will be adjusted and certified after the contract year to reflect actual utilization during the program year reconciled to the total dollar amount available in the predetermined pool. Hospitals will be required to provide covered inpatient services to enrollees in order to receive payments, and the amount of their payments will depend on the number of (days/discharges) of service provided. In basing payments on the number of (days/discharges), the payments are directly tied to the utilization and delivery of services for enrollees.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$1,597 per diem (Class A hospitals); $2,822 per discharge (Class B hospitals)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MCOs will make four quarterly payments to hospitals in each defined class, each equal to 25% of the interim annual payments due, based on the hospital's interim number of days or discharges of inpatient service (interim defined as historic utilization during a base year). After the end of the year, the state will conduct a reconciliation to actual days or discharges provided during the year and re-calculate the per diem or per discharge amount.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The New Jersey Legislature authorized the new payments as part of a pilot program to provide additional resources to hospitals in economically challenged communities to support those hospitals in serving their large Medicaid populations. To carry out this legislative objective, the state established a pool of funds for the hospitals in each county, including Camden County, based on available resources.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Hospitals will be divided into the following classes:
Class A: General acute hospitals located in Camden County (4 hospitals)
Class B: Freestanding psychiatric hospitals located in Camden County (1 hospital)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Camden County is one of seven New Jersey counties that meet the eligibility criteria defined in the legislation, because of its size (population in excess of 250,000) and because it contains a municipality ranking high on the Municipal Revitalization Index (which measures municipal distress based on indicators of diverse aspects of social, economic, physical and fiscal conditions). As such, hospitals in the county are deemed to have a high need for additional support. As of December 2021, 7.8% of NJ Medicaid beneficiaries reside in Camden County. By comparison, the average of the NJ Medicaid Population residing in the other 14 counties not eligible for this program is 3.2% (http://www.njfamilycare.org/analytics/elig_explorer.html). The state has developed this pilot initiative to test the impact of additional resources on these distressed counties. Further, due to the unique differences in populations served and services furnished between general acute hospitals and psychiatric hospitals in Camden County, the State has established two distinct classes to account for the significant variance in levels of acuity and average lengths of stay between the two types of hospitals.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payments will be set at the same amount per day or per discharge for each hospital in the class, and the total payments for each hospital will be based on the total number of days or discharges of inpatient service provided during the contract year.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Camden County General Acute Hospitals	38.00%	29.00%	1.00%		68.00%
b. Camden County Psychiatric Hospitals	15.00%	3.00%	0.00%		18.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define: commercial equivalent

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on Average Payment Per Day compared to the commercial equivalent Payment Per Day. Average Base Payment from Plan to Providers is based on CY2019 MCO encounter payments. State Directed Payment (SDP) is the proposed new payment to facilities. All other SDPs are incorporated. All values are a percentage of the total commercial equivalent payments for each facility, per their respective Annual - Acute Care Hospital (ACH) Cost Reports.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As noted above, the total funding amount was established based on resources authorized by the Legislature. In comparing the resulting total payments to commercial equivalent payment levels and considering the substantial challenges facing hospitals serving these distressed communities, the state determined that the directed payment is appropriate and reasonable.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 8.5.16 (SFY22 contract)

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The legislation requires that the funding be used "for the benefit of local hospitals within the participating county's borders to ensure that the hospitals continue to provide necessary services to low-income citizens." The use of a separate payment term is essential in order to comply with this legislative directive and ensure that all of the funding is used to support hospitals. This maximizes transparency in the payment process, allowing both the state and hospitals to identify the enhanced payments and ensure that they are directed to the hospitals the program is intended to support.

33. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ■ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ■ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Camden County	County	$ 47,882,618.00	Yes	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

*The non-federal share listed in Question 4.b is the non-federal share of the directed payments described in this preprint. The county transfer in Table 4 includes an additional amount to cover the state administrative costs.

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Camden County hospital fee	Providers of inpatient hospital services in Camden County	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf
- **b.** The effective date of quality strategy.

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

  In the March 2022 draft Quality Strategy, the majority of the goals/objectives were modified from the June 2014 version.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	8
b. Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	8
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The program aims to provide more resources to county hospitals to ensure that they can maintain and expand access and quality of care. The specific quality metrics to be monitored during the project were chosen as representative of overall improvements in quality of care, delivery, and services. Reducing patient wait times between entering the Emergency Department (ED) and discharge will lead to greater fiscal accountability, hold partners accountable for providing a continuously improving program, and improve overall quality of ED services. Reducing rates of infection during a patient's hospital stay will improve the quality of care furnished to admitted patients, help to manage risk (fiscal and infection risk), and ensure that partners offer a continuously improving program. By directing these payments to hospitals within Camden County, (considering the substantial challenges facing hospitals serving these distressed communities), underserved Medicaid managed care members will be afforded more equitable access to care and services.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	CY2019	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.	Hospital Compare Metric ID: OP_18b Payer: All Payer Steward: CMS
ii. Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	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.	Hospital Compare Metric ID: Long term: L_014_01_SIR; Rehab: I_015_01_SIR Payer: All Payer Steward: CDC Standardized Infection Ratio (SIR) = observed / predicted)
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

44(c) - N/A. Program Year 1 (NJ SFY22) findings will be reported in the SFY24 preprint submission

Continued from Question 44 (b) above. Notes on TABLE 8.
Measure NQF #0496 will be reported by acute hospitals. Measure NQF #1717 will be reported by non-acute hospitals

OP-18b (Median ED Time)
This measure shows the average (median) time in minutes that patients spent in the emergency department – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.

NQF: Quality Positioning System ™ (qualityforum.org) CDI (C. Diff Infection)
NQF: Quality Positioning System ™ (qualityforum.org)
Will be in VBP/HAC through CY 2024 data, possibly further

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 22, 2022

Jennifer Langer Jacobs
Assistant Commissioner
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
PO Box 712
Trenton, NJ 08625-0712

Dear Jennifer Langer Jacobs:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 14, 2022, with revised proposals received on June 7, 2022 and July 8, 2022. The proposal has a control name of NJ_Fee_IPH4_Renewal_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- The uniform dollar increase for inpatient hospital services provided by hospitals in Mercer County, for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must

certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this preprint with the requirement that the state provide full evaluation results for SFY 2021 with submission of the SFY 2024 preprint for CMS prior approval under 42 CFR 438.6(c). Please work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox if any questions arise.

If you have questions concerning this approval or state directed payments in general, please contact Pooja A. Regmi, Division of Managed Care Policy, at (410) 786-8409, pooja.regmi@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   -
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $140,152,536
   a. Identify the estimated federal share of this state directed payment: $92,796,101
   b. Identify the estimated non-federal share of this state directed payment: $47,356,435

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
SFY22

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

New Jersey proposes to direct Medicaid Managed Care Organizations (MCOs) to issue a per (diem/discharge) add-on payment to two classes of Camden County hospitals from set funding pools established for this purpose. Class A will encompass general acute care hospitals and Class B will encompass freestanding psychiatric hospitals. The per (diem/discharge) will be paid on an interim basis in four quarterly installments during the contract year. The interim payments will be based on historical utilization using a set annual dollar amount translated into a uniform dollar add-on amount per (day/discharge). The per (day/discharge) amount will be adjusted and certified after the contract year to reflect actual utilization during the program year reconciled to the total dollar amount available in the predetermined pool. Hospitals will be required to provide covered inpatient services to enrollees in order to receive payments, and the amount of their payments will depend on the number of (days/discharges) of service provided. In basing payments on the number of (days/discharges), the payments are directly tied to the utilization and delivery of services for enrollees.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$1,597 per diem (Class A hospitals); $2,822 per discharge (Class B hospitals)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MCOs will make four quarterly payments to hospitals in each defined class, each equal to 25% of the interim annual payments due, based on the hospital's interim number of days or discharges of inpatient service (interim defined as historic utilization during a base year). After the end of the year, the state will conduct a reconciliation to actual days or discharges provided during the year and re-calculate the per diem or per discharge amount.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The New Jersey Legislature authorized the new payments as part of a pilot program to provide additional resources to hospitals in economically challenged communities to support those hospitals in serving their large Medicaid populations. To carry out this legislative objective, the state established a pool of funds for the hospitals in each county, including Camden County, based on available resources.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Hospitals will be divided into the following classes:
Class A: General acute hospitals located in Camden County (4 hospitals)
Class B: Freestanding psychiatric hospitals located in Camden County (1 hospital)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Camden County is one of seven New Jersey counties that meet the eligibility criteria defined in the legislation, because of its size (population in excess of 250,000) and because it contains a municipality ranking high on the Municipal Revitalization Index (which measures municipal distress based on indicators of diverse aspects of social, economic, physical and fiscal conditions). As such, hospitals in the county are deemed to have a high need for additional support. As of December 2021, 7.8% of NJ Medicaid beneficiaries reside in Camden County. By comparison, the average of the NJ Medicaid Population residing in the other 14 counties not eligible for this program is 3.2% (http://www.njfamilycare.org/analytics/elig_explorer.html). The state has developed this pilot initiative to test the impact of additional resources on these distressed counties. Further, due to the unique differences in populations served and services furnished between general acute hospitals and psychiatric hospitals in Camden County, the State has established two distinct classes to account for the significant variance in levels of acuity and average lengths of stay between the two types of hospitals.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payments will be set at the same amount per day or per discharge for each hospital in the class, and the total payments for each hospital will be based on the total number of days or discharges of inpatient service provided during the contract year.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Camden County General Acute Hospitals	38.00%	29.00%	1.00%		68.00%
b. Camden County Psychiatric Hospitals	15.00%	3.00%	0.00%		18.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define: commercial equivalent

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on Average Payment Per Day compared to the commercial equivalent Payment Per Day. Average Base Payment from Plan to Providers is based on CY2019 MCO encounter payments. State Directed Payment (SDP) is the proposed new payment to facilities. All other SDPs are incorporated. All values are a percentage of the total commercial equivalent payments for each facility, per their respective Annual - Acute Care Hospital (ACH) Cost Reports.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As noted above, the total funding amount was established based on resources authorized by the Legislature. In comparing the resulting total payments to commercial equivalent payment levels and considering the substantial challenges facing hospitals serving these distressed communities, the state determined that the directed payment is appropriate and reasonable.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 8.5.16 (SFY22 contract)

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The legislation requires that the funding be used "for the benefit of local hospitals within the participating county's borders to ensure that the hospitals continue to provide necessary services to low-income citizens." The use of a separate payment term is essential in order to comply with this legislative directive and ensure that all of the funding is used to support hospitals. This maximizes transparency in the payment process, allowing both the state and hospitals to identify the enhanced payments and ensure that they are directed to the hospitals the program is intended to support.

33. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ■ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ■ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Camden County	County	$ 47,882,618.00	Yes	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

*The non-federal share listed in Question 4.b is the non-federal share of the directed payments described in this preprint. The county transfer in Table 4 includes an additional amount to cover the state administrative costs.

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Camden County hospital fee	Providers of inpatient hospital services in Camden County	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf
- **b.** The effective date of quality strategy.

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

  In the March 2022 draft Quality Strategy, the majority of the goals/objectives were modified from the June 2014 version.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	8
b. Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	8
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The program aims to provide more resources to county hospitals to ensure that they can maintain and expand access and quality of care. The specific quality metrics to be monitored during the project were chosen as representative of overall improvements in quality of care, delivery, and services. Reducing patient wait times between entering the Emergency Department (ED) and discharge will lead to greater fiscal accountability, hold partners accountable for providing a continuously improving program, and improve overall quality of ED services. Reducing rates of infection during a patient's hospital stay will improve the quality of care furnished to admitted patients, help to manage risk (fiscal and infection risk), and ensure that partners offer a continuously improving program. By directing these payments to hospitals within Camden County, (considering the substantial challenges facing hospitals serving these distressed communities), underserved Medicaid managed care members will be afforded more equitable access to care and services.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	CY2019	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.	Hospital Compare Metric ID: OP_18b Payer: All Payer Steward: CMS
ii. Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	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.	Hospital Compare Metric ID: Long term: L_014_01_SIR; Rehab: I_015_01_SIR Payer: All Payer Steward: CDC Standardized Infection Ratio (SIR) = observed / predicted)
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

44(c) - N/A. Program Year 1 (NJ SFY22) findings will be reported in the SFY24 preprint submission

Continued from Question 44 (b) above. Notes on TABLE 8.
Measure NQF #0496 will be reported by acute hospitals. Measure NQF #1717 will be reported by non-acute hospitals

OP-18b (Median ED Time)
This measure shows the average (median) time in minutes that patients spent in the emergency department – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.

NQF: Quality Positioning System ™ (qualityforum.org) CDI (C. Diff Infection)
NQF: Quality Positioning System ™ (qualityforum.org)
Will be in VBP/HAC through CY 2024 data, possibly further

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 22, 2022

Jennifer Langer Jacobs
Assistant Commissioner
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
PO Box 712
Trenton, NJ 08625-0712

Dear Jennifer Langer Jacobs:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 14, 2022, with revised proposals received on June 7, 2022 and July 8, 2022. The proposal has a control name of NJ_Fee_IPH5_Renewal_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- The uniform dollar increase for inpatient hospital services provided by hospitals in Middlesex County, for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must

certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this preprint with the requirement that the state provide full evaluation results for SFY 2021 with submission of the SFY 2024 preprint for CMS prior approval under 42 CFR 438.6(c). Please work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox if any questions arise.

If you have questions concerning this approval or state directed payments in general, please contact Pooja A. Regmi, Division of Managed Care Policy, at (410) 786-8409, pooja.regmi@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   -
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $140,152,536
   a. Identify the estimated federal share of this state directed payment: $92,796,101
   b. Identify the estimated non-federal share of this state directed payment: $47,356,435

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
SFY22

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

New Jersey proposes to direct Medicaid Managed Care Organizations (MCOs) to issue a per (diem/discharge) add-on payment to two classes of Camden County hospitals from set funding pools established for this purpose. Class A will encompass general acute care hospitals and Class B will encompass freestanding psychiatric hospitals. The per (diem/discharge) will be paid on an interim basis in four quarterly installments during the contract year. The interim payments will be based on historical utilization using a set annual dollar amount translated into a uniform dollar add-on amount per (day/discharge). The per (day/discharge) amount will be adjusted and certified after the contract year to reflect actual utilization during the program year reconciled to the total dollar amount available in the predetermined pool. Hospitals will be required to provide covered inpatient services to enrollees in order to receive payments, and the amount of their payments will depend on the number of (days/discharges) of service provided. In basing payments on the number of (days/discharges), the payments are directly tied to the utilization and delivery of services for enrollees.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$1,597 per diem (Class A hospitals); $2,822 per discharge (Class B hospitals)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MCOs will make four quarterly payments to hospitals in each defined class, each equal to 25% of the interim annual payments due, based on the hospital's interim number of days or discharges of inpatient service (interim defined as historic utilization during a base year). After the end of the year, the state will conduct a reconciliation to actual days or discharges provided during the year and re-calculate the per diem or per discharge amount.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The New Jersey Legislature authorized the new payments as part of a pilot program to provide additional resources to hospitals in economically challenged communities to support those hospitals in serving their large Medicaid populations. To carry out this legislative objective, the state established a pool of funds for the hospitals in each county, including Camden County, based on available resources.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Hospitals will be divided into the following classes:
Class A: General acute hospitals located in Camden County (4 hospitals)
Class B: Freestanding psychiatric hospitals located in Camden County (1 hospital)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Camden County is one of seven New Jersey counties that meet the eligibility criteria defined in the legislation, because of its size (population in excess of 250,000) and because it contains a municipality ranking high on the Municipal Revitalization Index (which measures municipal distress based on indicators of diverse aspects of social, economic, physical and fiscal conditions). As such, hospitals in the county are deemed to have a high need for additional support. As of December 2021, 7.8% of NJ Medicaid beneficiaries reside in Camden County. By comparison, the average of the NJ Medicaid Population residing in the other 14 counties not eligible for this program is 3.2% (http://www.njfamilycare.org/analytics/elig_explorer.html). The state has developed this pilot initiative to test the impact of additional resources on these distressed counties. Further, due to the unique differences in populations served and services furnished between general acute hospitals and psychiatric hospitals in Camden County, the State has established two distinct classes to account for the significant variance in levels of acuity and average lengths of stay between the two types of hospitals.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payments will be set at the same amount per day or per discharge for each hospital in the class, and the total payments for each hospital will be based on the total number of days or discharges of inpatient service provided during the contract year.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Camden County General Acute Hospitals	38.00%	29.00%	1.00%		68.00%
b. Camden County Psychiatric Hospitals	15.00%	3.00%	0.00%		18.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define: commercial equivalent

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on Average Payment Per Day compared to the commercial equivalent Payment Per Day. Average Base Payment from Plan to Providers is based on CY2019 MCO encounter payments. State Directed Payment (SDP) is the proposed new payment to facilities. All other SDPs are incorporated. All values are a percentage of the total commercial equivalent payments for each facility, per their respective Annual - Acute Care Hospital (ACH) Cost Reports.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As noted above, the total funding amount was established based on resources authorized by the Legislature. In comparing the resulting total payments to commercial equivalent payment levels and considering the substantial challenges facing hospitals serving these distressed communities, the state determined that the directed payment is appropriate and reasonable.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 8.5.16 (SFY22 contract)

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The legislation requires that the funding be used "for the benefit of local hospitals within the participating county's borders to ensure that the hospitals continue to provide necessary services to low-income citizens." The use of a separate payment term is essential in order to comply with this legislative directive and ensure that all of the funding is used to support hospitals. This maximizes transparency in the payment process, allowing both the state and hospitals to identify the enhanced payments and ensure that they are directed to the hospitals the program is intended to support.

33. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ■ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ■ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Camden County	County	$ 47,882,618.00	Yes	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

*The non-federal share listed in Question 4.b is the non-federal share of the directed payments described in this preprint. The county transfer in Table 4 includes an additional amount to cover the state administrative costs.

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Camden County hospital fee	Providers of inpatient hospital services in Camden County	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf
- **b.** The effective date of quality strategy.

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

  In the March 2022 draft Quality Strategy, the majority of the goals/objectives were modified from the June 2014 version.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	8
b. Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	8
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The program aims to provide more resources to county hospitals to ensure that they can maintain and expand access and quality of care. The specific quality metrics to be monitored during the project were chosen as representative of overall improvements in quality of care, delivery, and services. Reducing patient wait times between entering the Emergency Department (ED) and discharge will lead to greater fiscal accountability, hold partners accountable for providing a continuously improving program, and improve overall quality of ED services. Reducing rates of infection during a patient's hospital stay will improve the quality of care furnished to admitted patients, help to manage risk (fiscal and infection risk), and ensure that partners offer a continuously improving program. By directing these payments to hospitals within Camden County, (considering the substantial challenges facing hospitals serving these distressed communities), underserved Medicaid managed care members will be afforded more equitable access to care and services.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	CY2019	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.	Hospital Compare Metric ID: OP_18b Payer: All Payer Steward: CMS
ii. Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	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.	Hospital Compare Metric ID: Long term: L_014_01_SIR; Rehab: I_015_01_SIR Payer: All Payer Steward: CDC Standardized Infection Ratio (SIR) = observed / predicted)
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

44(c) - N/A. Program Year 1 (NJ SFY22) findings will be reported in the SFY24 preprint submission

Continued from Question 44 (b) above. Notes on TABLE 8.
Measure NQF #0496 will be reported by acute hospitals. Measure NQF #1717 will be reported by non-acute hospitals

OP-18b (Median ED Time)
This measure shows the average (median) time in minutes that patients spent in the emergency department – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.

NQF: Quality Positioning System ™ (qualityforum.org) CDI (C. Diff Infection)
NQF: Quality Positioning System ™ (qualityforum.org)
Will be in VBP/HAC through CY 2024 data, possibly further

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 22, 2022

Jennifer Langer Jacobs
Assistant Commissioner
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
PO Box 712
Trenton, NJ 08625-0712

Dear Jennifer Langer Jacobs:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 14, 2022, with revised proposals received on June 7, 2022 and July 8, 2022. The proposal has a control name of NJ_Fee_IPH6_Renewal_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- The uniform dollar increase for inpatient hospital services provided by hospitals in Passaic County for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must

certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this preprint with the requirement that the state provide full evaluation results for SFY 2021 with submission of the SFY 2024 preprint for CMS prior approval under 42 CFR 438.6(c). Please work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox if any questions arise.

If you have questions concerning this approval or state directed payments in general, please contact Pooja A. Regmi, Division of Managed Care Policy, at (410) 786-8409, pooja.regmi@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   -
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $140,152,536
   a. Identify the estimated federal share of this state directed payment: $92,796,101
   b. Identify the estimated non-federal share of this state directed payment: $47,356,435

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
SFY22

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

New Jersey proposes to direct Medicaid Managed Care Organizations (MCOs) to issue a per (diem/discharge) add-on payment to two classes of Camden County hospitals from set funding pools established for this purpose. Class A will encompass general acute care hospitals and Class B will encompass freestanding psychiatric hospitals. The per (diem/discharge) will be paid on an interim basis in four quarterly installments during the contract year. The interim payments will be based on historical utilization using a set annual dollar amount translated into a uniform dollar add-on amount per (day/discharge). The per (day/discharge) amount will be adjusted and certified after the contract year to reflect actual utilization during the program year reconciled to the total dollar amount available in the predetermined pool. Hospitals will be required to provide covered inpatient services to enrollees in order to receive payments, and the amount of their payments will depend on the number of (days/discharges) of service provided. In basing payments on the number of (days/discharges), the payments are directly tied to the utilization and delivery of services for enrollees.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$1,597 per diem (Class A hospitals); $2,822 per discharge (Class B hospitals)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MCOs will make four quarterly payments to hospitals in each defined class, each equal to 25% of the interim annual payments due, based on the hospital's interim number of days or discharges of inpatient service (interim defined as historic utilization during a base year). After the end of the year, the state will conduct a reconciliation to actual days or discharges provided during the year and re-calculate the per diem or per discharge amount.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The New Jersey Legislature authorized the new payments as part of a pilot program to provide additional resources to hospitals in economically challenged communities to support those hospitals in serving their large Medicaid populations. To carry out this legislative objective, the state established a pool of funds for the hospitals in each county, including Camden County, based on available resources.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Hospitals will be divided into the following classes:
Class A: General acute hospitals located in Camden County (4 hospitals)
Class B: Freestanding psychiatric hospitals located in Camden County (1 hospital)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Camden County is one of seven New Jersey counties that meet the eligibility criteria defined in the legislation, because of its size (population in excess of 250,000) and because it contains a municipality ranking high on the Municipal Revitalization Index (which measures municipal distress based on indicators of diverse aspects of social, economic, physical and fiscal conditions). As such, hospitals in the county are deemed to have a high need for additional support. As of December 2021, 7.8% of NJ Medicaid beneficiaries reside in Camden County. By comparison, the average of the NJ Medicaid Population residing in the other 14 counties not eligible for this program is 3.2% (http://www.njfamilycare.org/analytics/elig_explorer.html). The state has developed this pilot initiative to test the impact of additional resources on these distressed counties. Further, due to the unique differences in populations served and services furnished between general acute hospitals and psychiatric hospitals in Camden County, the State has established two distinct classes to account for the significant variance in levels of acuity and average lengths of stay between the two types of hospitals.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payments will be set at the same amount per day or per discharge for each hospital in the class, and the total payments for each hospital will be based on the total number of days or discharges of inpatient service provided during the contract year.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Camden County General Acute Hospitals	38.00%	29.00%	1.00%		68.00%
b. Camden County Psychiatric Hospitals	15.00%	3.00%	0.00%		18.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define: commercial equivalent

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on Average Payment Per Day compared to the commercial equivalent Payment Per Day. Average Base Payment from Plan to Providers is based on CY2019 MCO encounter payments. State Directed Payment (SDP) is the proposed new payment to facilities. All other SDPs are incorporated. All values are a percentage of the total commercial equivalent payments for each facility, per their respective Annual - Acute Care Hospital (ACH) Cost Reports.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As noted above, the total funding amount was established based on resources authorized by the Legislature. In comparing the resulting total payments to commercial equivalent payment levels and considering the substantial challenges facing hospitals serving these distressed communities, the state determined that the directed payment is appropriate and reasonable.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Section 8.5.16 (SFY22 contract)

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The legislation requires that the funding be used "for the benefit of local hospitals within the participating county's borders to ensure that the hospitals continue to provide necessary services to low-income citizens." The use of a separate payment term is essential in order to comply with this legislative directive and ensure that all of the funding is used to support hospitals. This maximizes transparency in the payment process, allowing both the state and hospitals to identify the enhanced payments and ensure that they are directed to the hospitals the program is intended to support.

33. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ■ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ■ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Camden County	County	$ 47,882,618.00	Yes	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

*The non-federal share listed in Question 4.b is the non-federal share of the directed payments described in this preprint. The county transfer in Table 4 includes an additional amount to cover the state administrative costs.

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Camden County hospital fee	Providers of inpatient hospital services in Camden County	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf
- **b.** The effective date of quality strategy.

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

  In the March 2022 draft Quality Strategy, the majority of the goals/objectives were modified from the June 2014 version.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	8
b. Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	8
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The program aims to provide more resources to county hospitals to ensure that they can maintain and expand access and quality of care. The specific quality metrics to be monitored during the project were chosen as representative of overall improvements in quality of care, delivery, and services. Reducing patient wait times between entering the Emergency Department (ED) and discharge will lead to greater fiscal accountability, hold partners accountable for providing a continuously improving program, and improve overall quality of ED services. Reducing rates of infection during a patient's hospital stay will improve the quality of care furnished to admitted patients, help to manage risk (fiscal and infection risk), and ensure that partners offer a continuously improving program. By directing these payments to hospitals within Camden County, (considering the substantial challenges facing hospitals serving these distressed communities), underserved Medicaid managed care members will be afforded more equitable access to care and services.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	CY2019	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.	Hospital Compare Metric ID: OP_18b Payer: All Payer Steward: CMS
ii. Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	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.	Hospital Compare Metric ID: Long term: L_014_01_SIR; Rehab: I_015_01_SIR Payer: All Payer Steward: CDC Standardized Infection Ratio (SIR) = observed / predicted)
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

44(c) - N/A. Program Year 1 (NJ SFY22) findings will be reported in the SFY24 preprint submission

Continued from Question 44 (b) above. Notes on TABLE 8.
Measure NQF #0496 will be reported by acute hospitals. Measure NQF #1717 will be reported by non-acute hospitals

OP-18b (Median ED Time)
This measure shows the average (median) time in minutes that patients spent in the emergency department – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.

NQF: Quality Positioning System ™ (qualityforum.org) CDI (C. Diff Infection)
NQF: Quality Positioning System ™ (qualityforum.org)
Will be in VBP/HAC through CY 2024 data, possibly further

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 5, 2022

Jennifer Langer Jacobs
Assistant Commissioner
Division of Medical Assistance and Health Services
New Jersey Department of Human Services
PO Box 712 Trenton, NJ 08625-0712

Dear Jennifer Langer Jacobs:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on April 14, 2022. The proposal has a control name of NJ_Fee_IPH3_Renewal_20220701-20230630.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Uniform dollar increase for inpatient hospital services provided by hospitals in Essex County, for the rating period covering July 1, 2022 through June 30, 2023.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Note that this payment arrangement and all state directed payments must be addressed in the applicable rate certifications. Documentation of all state directed payments must be included in the initial rate certification as outlined in Section I, Item 4 of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification may cause delays in CMS review. CMS is happy to provide technical assistance to states and their actuaries.

As part of the preprint, the state indicated that this state directed payment will be incorporated into the state's rate certification through a separate payment term. As the payment arrangement is addressed through a separate payment term, CMS has several requirements related to this payment arrangement, including but not limited to the requirement that the state's actuary must certify the aggregate amount of the separate payment term and an estimate of the magnitude of the payment

on a per member per month (PMPM) basis for each rate cell. Failure to provide all required documentation in the rate certification may cause delays in CMS review. As the PMPM magnitude is an estimate in the initial rate certification, no later than 12 months after the rating period is complete, the state must submit documentation to CMS that incorporates the total amount of the state directed payment into the rate certification's rate cells consistent with the distribution methodology described in the initial rate certification, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed. Please submit this documentation to statedirectedpayment@cms.hhs.gov and include the control name listed for this review along with the rating period.

Additionally, if the total amount of the state directed payment or distribution methodology is changed from the initial rate certification, CMS requires the state to submit both a state directed payment preprint amendment and an amendment to the rate certification(s) for the rating period, and clearly describe the magnitude of and the reason for the change.

CMS is able to approve this preprint with the requirement that the state provide full evaluation results for SFY 2021 with submission of the SFY 2024 preprint for CMS prior approval under 42 CFR 438.6(c). We defer to the state to work with the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov mailbox if any questions arise.

If you have questions concerning this approval or state directed payments in general, please contact Pooja A. Regmi, Division of Managed Care Policy, at (410) 786-8409, pooja.regmi@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   -
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.*
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $140,152,536
   a. Identify the estimated federal share of this state directed payment: $92,796,101
   b. Identify the estimated non-federal share of this state directed payment: $47,356,435

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.
5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☐ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☐ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
SFY22

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

New Jersey proposes to direct Medicaid Managed Care Organizations (MCOs) to issue a per (diem/discharge) add-on payment to two classes of Camden County hospitals from set funding pools established for this purpose. Class A will encompass general acute care hospitals and Class B will encompass freestanding psychiatric hospitals. The per (diem/discharge) will be paid on an interim basis in four quarterly installments during the contract year. The interim payments will be based on historical utilization using a set annual dollar amount translated into a uniform dollar add-on amount per (day/discharge). The per (day/discharge) amount will be adjusted and certified after the contract year to reflect actual utilization during the program year reconciled to the total dollar amount available in the predetermined pool. Hospitals will be required to provide covered inpatient services to enrollees in order to receive payments, and the amount of their payments will depend on the number of (days/discharges) of service provided. In basing payments on the number of (days/discharges), the payments are directly tied to the utilization and delivery of services for enrollees.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

$1,597 per diem (Class A hospitals); $2,822 per discharge (Class B hospitals)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

The MCOs will make four quarterly payments to hospitals in each defined class, each equal to 25% of the interim annual payments due, based on the hospital's interim number of days or discharges of inpatient service (interim defined as historic utilization during a base year). After the end of the year, the state will conduct a reconciliation to actual days or discharges provided during the year and re-calculate the per diem or per discharge amount.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The New Jersey Legislature authorized the new payments as part of a pilot program to provide additional resources to hospitals in economically challenged communities to support those hospitals in serving their large Medicaid populations. To carry out this legislative objective, the state established a pool of funds for the hospitals in each county, including Camden County, based on available resources.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☒ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

Hospitals will be divided into the following classes:
Class A: General acute hospitals located in Camden County (4 hospitals)
Class B: Freestanding psychiatric hospitals located in Camden County (1 hospital)

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

Camden County is one of seven New Jersey counties that meet the eligibility criteria defined in the legislation, because of its size (population in excess of 250,000) and because it contains a municipality ranking high on the Municipal Revitalization Index (which measures municipal distress based on indicators of diverse aspects of social, economic, physical and fiscal conditions). As such, hospitals in the county are deemed to have a high need for additional support. As of December 2021, 7.8% of NJ Medicaid beneficiaries reside in Camden County. By comparison, the average of the NJ Medicaid Population residing in the other 14 counties not eligible for this program is 3.2% (http://www.njfamilycare.org/analytics/elig_explorer.html). The state has developed this pilot initiative to test the impact of additional resources on these distressed counties. Further, due to the unique differences in populations served and services furnished between general acute hospitals and psychiatric hospitals in Camden County, the State has established two distinct classes to account for the significant variance in levels of acuity and average lengths of stay between the two types of hospitals.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

The payments will be set at the same amount per day or per discharge for each hospital in the class, and the total payments for each hospital will be based on the total number of days or discharges of inpatient service provided during the contract year.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☐ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Camden County General Acute Hospitals	38.00%	29.00%	1.00%		68.00%
b. Camden County Psychiatric Hospitals	15.00%	3.00%	0.00%		18.00%
c.	0.00%	0.00%	0.00%		0.00%
d.	0.00%	0.00%	0.00%		0.00%
e.	0.00%	0.00%	0.00%		0.00%
f.	0.00%	0.00%	0.00%		0.00%
g.	0.00%	0.00%	0.00%		0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☐ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Percentage comparisons are based on Average Payment Per Day compared to the commercial equivalent Payment Per Day. Average Base Payment from Plan to Providers is based on CY2019 MCO encounter payments. State Directed Payment (SDP) is the proposed new payment to facilities. All other SDPs are incorporated. All values are a percentage of the total commercial equivalent payments for each facility, per their respective Annual - Acute Care Hospital (ACH) Cost Reports.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As noted above, the total funding amount was established based on resources authorized by the Legislature. In comparing the resulting total payments to commercial equivalent payment levels and considering the substantial challenges facing hospitals serving these distressed communities, the state determined that the directed payment is appropriate and reasonable.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

The legislation requires that the funding be used "for the benefit of local hospitals within the participating county's borders to ensure that the hospitals continue to provide necessary services to low-income citizens." The use of a separate payment term is essential in order to comply with this legislative directive and ensure that all of the funding is used to support hospitals. This maximizes transparency in the payment process, allowing both the state and hospitals to identify the enhanced payments and ensure that they are directed to the hospitals the program is intended to support.

33. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ■ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ■ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. Camden County	County	$ 47,882,618.00	Yes	N/A	No
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

*The non-federal share listed in Question 4.b is the non-federal share of the directed payments described in this preprint. The county transfer in Table 4 includes an additional amount to cover the state administrative costs.

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. Camden County hospital fee	Providers of inpatient hospital services in Camden County	Yes	Yes	Yes		No
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf
- **b.** The effective date of quality strategy.

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

  In the March 2022 draft Quality Strategy, the majority of the goals/objectives were modified from the June 2014 version.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	8
b. Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	8
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The program aims to provide more resources to county hospitals to ensure that they can maintain and expand access and quality of care. The specific quality metrics to be monitored during the project were chosen as representative of overall improvements in quality of care, delivery, and services. Reducing patient wait times between entering the Emergency Department (ED) and discharge will lead to greater fiscal accountability, hold partners accountable for providing a continuously improving program, and improve overall quality of ED services. Reducing rates of infection during a patient's hospital stay will improve the quality of care furnished to admitted patients, help to manage risk (fiscal and infection risk), and ensure that partners offer a continuously improving program. By directing these payments to hospitals within Camden County, (considering the substantial challenges facing hospitals serving these distressed communities), underserved Medicaid managed care members will be afforded more equitable access to care and services.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes[1]**
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	CY2019	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.	Hospital Compare Metric ID: OP_18b Payer: All Payer Steward: CMS
ii. Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	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.	Hospital Compare Metric ID: Long term: L_014_01_SIR; Rehab: I_015_01_SIR Payer: All Payer Steward: CDC Standardized Infection Ratio (SIR) = observed / predicted)
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

44(c) - N/A. Program Year 1 (NJ SFY22) findings will be reported in the SFY24 preprint submission

Continued from Question 44 (b) above. Notes on TABLE 8.
Measure NQF #0496 will be reported by acute hospitals. Measure NQF #1717 will be reported by non-acute hospitals

OP-18b (Median ED Time)
This measure shows the average (median) time in minutes that patients spent in the emergency department – from the time they arrived to the time they were sent home. It does not include patients who were later admitted to the hospital as inpatients, admitted for observation, transferred to another acute care hospital, or who left without being seen by a licensed provider.

NQF: Quality Positioning System ™ (qualityforum.org) CDI (C. Diff Infection)
NQF: Quality Positioning System ™ (qualityforum.org)
Will be in VBP/HAC through CY 2024 data, possibly further

NJ County Option SFY23 FMAP Distribution - Net of the MCO Tax **Note: All Sample Data**

County A only (each county will have their own distribution model)

County A	Annual Assessment	Quarterly Assessment
Modeled Non-Federal share - Fixed Amount	$27,367,558	$6,841,890

Starting Point: Modeled Assessment values remain fixed for all of SFY23 and are net of the County share, State share and MCO Tax.

Patient Days based on DMAHS CY2019 MCO Encounters, through payment date 12/3/2020, with updated Encounter criteria to more accurately calculate days and discharges.

Annual Encounter days/discharges will be split into 4 equal quarters.

Hospital	Annual MCO Patient Days	Avg Quarterly MCO Patient Days
Hospital A	32,893	8,223
Hospital B	12,453	3,113
Hospital C	9,789	2,447
Hospital D	1,836	459
Total	56,971	14,243

The initial SFY23 Medicaid Groups (Medicaid/Expansion/CHIP) were based on the CY2019 Day/Discharge allocation by the various Program Status Codes for each hospital and each MCO. A weighted average will be calculated every quarter to determine the 'blended' FMAP and Total Gross Payment amount for each county. This will be the County Average % Medicaid Group Distribution below, which will be the same for each quarter since it would be the annual counts divided by 4, multiplied by the respective Medicaid Group's actual FMAP at the time of payment. This 'blended' FMAP will be used to gross up the fixed, non-federal share to determine the total funds available for each quarter.
During the SFY23 payment cycle, the first and second quarter's payment will be slightly higher (but identical) due to the additional COVID PHE FMAP. The third and fourth quarter payments will be slightly lower (but identical) due to the normal NJ FMAP. If the COVID PHE is extended past CY22, SFY23 payments for third and fourth quarters could receive the ehnanced FMAP as well.

	CY2019 Quarterly MCO Patient Days Distribution				CY2019 % Medicaid Group Distribution		
Hospital	Medicaid [a]	Expansion [b]	CHIP [c]	Total [d]	Medicaid [= a/d]	Expansion [= b/d]	CHIP [= c/d]
Hospital A	4,875	2,500	848	8,223	59.3%	30.4%	10.3%
Hospital B	1,775	1,300	38	3,113	57.0%	41.8%	1.2%
Hospital C	1,625	625	197	2,447	66.4%	25.5%	8.1%
Hospital D	300	138	22	459	65.4%	30.0%	4.7%
	8,575	4,563	1,105	14,243	**60.2%**	**32.0%**	**7.8%**
					County Average % Medicaid Group Distribution		

	CY2019 MCO Encounter Distribution				
Hospital	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5
Hospital A	11%	15%	50%	20%	4%
Hospital B	25%	10%	30%	15%	20%
Hospital C	10%	25%	20%	25%	20%
Hospital D	20%	14%	15%	30%	21%

Q1/SFY23 - Interim Payments

Assessment Received by the State on 9/12/22

Payment to Hospitals by 10/12/22

FMAP at Quarterly payment:		Non-Federal	Federal share @ Quarterly FMAP	Total Quarterly payment
Medicaid	**56.2%**	$5,646,513	$7,245,070	$12,891,583
Expansion	**90.0%**	$685,922	$6,173,302	$6,859,224
CHIP	**69.34%**	$509,454	$1,152,170	$1,661,624
		$6,841,890	**$14,570,541**	**$21,412,431**

Non-Federal:	$6,841,890	32.0%
Federal:	**$14,570,541**	**68.0%**
Total Quarterly payment:	$21,412,431	100.0%
Per Day payment:	**$1,503.39**	

Weighted Avg FMAP	68.0%
Gross Payments	$21,412,431
non-Federal	$6,841,890
Federal	$14,570,541
Payment Per Day	$1,503.39

The County Average % Medicaid Group Distribution would be multiplied by its respective FMAP at time of payment to calculate the Total Quarterly payment available for distribution.

The calculated County Per Day Payment will be multiplied by the respective hospital MCO Encounter Patient Days and that hospital's quarterly payment will be allocated based on the respective CY2019 MCO Encounter Distribution.

Quarterly payment

Hospital	Quarterly MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	8,223	$1,503.39	$12,362,765	$1,359,904	$1,854,415	$6,181,382	$2,472,553	$494,511	$12,362,765
Hospital B	3,113	$1,503.39	$4,680,434	$1,170,108	$468,043	$1,404,130	$702,065	$936,087	$4,680,434
Hospital C	2,447	$1,503.39	$3,679,175	$367,918	$919,794	$735,835	$919,794	$735,835	$3,679,175
Hospital D	459	$1,503.39	$690,057	$138,011	$96,608	$103,509	$207,017	$144,912	$690,057
Total	14,243		$21,412,431	$3,035,941	$3,338,860	$8,424,856	$4,301,429	$2,311,344	$21,412,431

1st quarterly payment, fixed Non-Fed share and 68% FMAP

Q2/SFY23 - Interim payments

Assessment received by State on 12/12/22

Payment to Hospitals by 1/11/23

FMAP at Quarterly payment:		Non-Federal	Federal share @ Quarterly FMAP	Total Quarterly payment
Medicaid	**56.2%**	$5,646,513	$7,245,070	$12,891,583
Expansion	**90.0%**	$685,922	$6,173,302	$6,859,224
CHIP	**69.34%**	$509,454	$1,152,170	$1,661,624
		$6,841,890	**$14,570,541**	**$21,412,431**

Non-Federal:	$6,841,890	32.0%
Federal:	**$14,570,541**	**68.0%**
Total Quarterly payment:	$21,412,431	100.0%
Per Day payment:	**$1,503.39**	

Weighted Avg FMAP	68.0%
Gross Payments	$21,412,431
non-Federal	$6,841,890
Federal	$14,570,541
Payment Per Day	$1,503.39

The payment for SFY23 Q2 will be similar to the payment in SFY23 Q1, since the payments to the MCOs will be prior to 12/31/22 and the COVID PHE FMAP will still be available and the same County Average % Medicaid Group Distribution would be used to calculate the Total Quarterly payment available for distribution.

Quarterly payment

Hospital	MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	8,223	$1,503.39	$12,362,765	$1,359,904	$1,854,415	$6,181,382	$2,472,553	$494,511	$12,362,765
Hospital B	3,113	$1,503.39	$4,680,434	$1,170,108	$468,043	$1,404,130	$702,065	$936,087	$4,680,434
Hospital C	2,447	$1,503.39	$3,679,175	$367,918	$919,794	$735,835	$919,794	$735,835	$3,679,175
Hospital D	459	$1,503.39	$690,057	$138,011	$96,608	$103,509	$207,017	$144,912	$690,057
Total	14,243		$21,412,431	$3,035,941	$3,338,860	$8,424,856	$4,301,429	$2,311,344	$21,412,431

2nd quarterly payment, fixed Non-Fed share and 68% FMAP.

Q3/SFY23 - Interim payments

Assessment received by State on 3/13/23

Payment to Hospitals by 4/13/23

FMAP at Quarterly payment:		Non-Federal	Federal share @ Quarterly FMAP	Total Quarterly payment
Medicaid	**50.0%**	$5,646,513	$5,717,591	$11,435,182
Expansion	**90.0%**	$685,922	$5,475,885	$6,084,317
CHIP	**65.0%**	$509,454	$958,038	$1,473,905
		$6,841,890	**$12,151,515**	**$18,993,404**

Non-Federal:	$6,841,890	36.0%
Federal:	**$12,151,515**	**64.0%**
Total Quarterly payment:	$18,993,404	100.0%
Per Day payment:	**$1,333.55**	

Weighted Avg FMAP	64.0%
Gross Payments	$18,993,404
non-Federal	$6,841,890
Federal	$12,151,515
Payment Per Day	$1,333.55

In SFY23 Q3, assumption that the enhanced COVID PHE FMAP will no longer be available and NJ returns to its normal FMAP. The normal FMAP will remain in effect for the rest of SFY23. The same County Average % Medicaid Group Distribution would be used to calculate the Total Quarterly payment available for distribution. This same process would happen for Q3 and Q4.

Quarterly payment

Hospital	MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	8,223	$1,333.55	$10,966,106	$1,206,272	$1,644,916	$5,483,053	$2,193,221	$438,644	$10,966,106
Hospital B	3,113	$1,333.55	$4,151,671	$1,037,918	$415,167	$1,245,501	$622,751	$830,334	$4,151,671
Hospital C	2,447	$1,333.55	$3,263,528	$326,353	$815,882	$652,706	$815,882	$652,706	$3,263,528
Hospital D	459	$1,333.55	$612,099	$122,420	$85,694	$91,815	$183,630	$128,541	$612,099
Total	14,243		$18,993,404	$2,692,962	$2,961,659	$7,473,075	$3,815,484	$2,050,225	$18,993,404

3rd quarterly payment, fixed non-fed share and 64% FMAP.

Q4/SFY23 - Interim payments

Assessment received by State on 6/10/23

Payment to Hospitals by 7/10/23

FMAP at Quarterly payment:		Non-Federal	Federal share @ Quarterly FMAP	Total Quarterly payment
Medicaid	**50.0%**	$5,717,591	$5,717,591	$11,435,182
Expansion	**90.0%**	$608,432	$5,475,885	$6,084,317
CHIP	**65.0%**	$515,867	$958,038	$1,473,905
		$6,841,890	**$12,151,515**	**$18,993,404**

Non-Federal:	$6,841,890	36.0%
Federal:	**$12,151,515**	**64.0%**

The payment for SFY23 Q4 will be similar to the payment in SFY23 Q3: assuming that the enhanced COVID PHE FMAP will no longer be available and the same County Average % Medicaid Group Distribution would be used to calculate the Total Quarterly payment available for distribution.

Total Quarterly payment:	$18,993,404	100.0%
Per Day payment:	**$1,333.55**	

Quarterly payment

Hospital	MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	8,223	$1,333.55	$10,966,106	$1,206,272	$1,644,916	$5,483,053	$2,193,221	$438,644	$10,966,106
Hospital B	3,113	$1,333.55	$4,151,671	$1,037,918	$415,167	$1,245,501	$622,751	$830,334	$4,151,671
Hospital C	2,447	$1,333.55	$3,263,528	$326,353	$815,882	$652,706	$815,882	$652,706	$3,263,528
Hospital D	459	$1,333.55	$612,099	$122,420	$85,694	$91,815	$183,630	$128,541	$612,099
Total	14,243		$18,993,404	$2,692,962	$2,961,659	$7,473,075	$3,815,484	$2,050,225	$18,993,404

4th quarterly payment, fixed non-fed share and 64% FMAP

Total Interim SFY23 payments Made to Hospitals

FMAP at Year End:		
Non-Federal:	$27,367,558	33.9%
Federal:	**$53,444,111**	**66.1%**
Total Quarterly payment:	$80,811,670	
Per Day payment:	**$1,418.47**	

Hospital	MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	32,893	$1,418.47	$46,657,742	$5,132,352	$6,998,661	$23,328,871	$9,331,548	$1,866,310	$46,657,742
Hospital B	12,453	$1,418.47	$17,664,210	$4,416,053	$1,766,421	$5,299,263	$2,649,632	$3,532,842	$17,664,210
Hospital C	9,789	$1,418.47	$13,885,405	$1,388,541	$3,471,351	$2,777,081	$3,471,351	$2,777,081	$13,885,405
Hospital D	1,836	$1,418.47	$2,604,311	$520,862	$364,604	$390,647	$781,293	$546,905	$2,604,311
Total	56,971		$80,811,670	$11,457,807	$12,601,037	$31,795,862	$16,233,825	$8,723,138	$80,811,670

Prior to Reconciliation - Total Interim SFY23 payments of $80.8M made to hospitals based on the various quarterly FMAPs and initial MCO Patient Days and MCO distribution. Interim SFY23 FMAP of 66.1%.

Q1/SFY24

Assessment received by State on 9/12/23

Payment to Hospitals by 10/12/23

FMAP at Quarterly payment:		Non-Federal	Federal share @ Quarterly FMAP	Total Quarterly payment
Medicaid	**50.0%**	$5,717,591	$5,717,591	$11,435,182
Expansion	**90.0%**	$608,432	$5,475,885	$6,084,317
CHIP	**65.0%**	$515,867	$958,038	$1,473,905
		$6,841,890	**$12,151,515**	**$18,993,404**

Currently assuming that the SFY24 base period will continue to be CY2019 - this includes using the same CY2019 Medicaid Group and MCO Distribution and Allocation. With no Enhanced COVID PHE FMAP, this SFY24 Q1 payment will be similar to the SFY23 Q3 and Q4 payments - using the same weighted average 'blended' FMAP methodology.

Non-Federal:	$6,841,890	36.0%
Federal:	**$12,151,515**	**64.0%**
Total Quarterly payment:	$18,993,404	100.0%
Per Day payment:	$1,333.55	

Quarterly payment

Hospital	MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	8,223	$1,333.55	$10,966,106	$1,206,272	$1,644,916	$5,483,053	$2,193,221	$438,644	$10,966,106
Hospital B	3,113	$1,333.55	$4,151,671	$1,037,918	$415,167	$1,245,501	$622,751	$830,334	$4,151,671
Hospital C	2,447	$1,333.55	$3,263,528	$326,353	$815,882	$652,706	$815,882	$652,706	$3,263,528
Hospital D	459	$1,333.55	$612,099	$122,420	$85,694	$91,815	$183,630	$128,541	$612,099
Total	14,243		$18,993,404	$2,692,962	$2,961,659	$7,473,075	$3,815,484	$2,050,225	$18,993,404

Reconciliation

Actual SFY23 Utilization

SFY23 MCO Patient Days Distribution

SFY23 % Medicaid Group Distribution

Hospital	Medicaid [a]	Expansion [b]	CHIP [c]	Total [d]	Medicaid [= a/d]	Expansion [= b/d]	CHIP [= c/d]
Hospital A	20,500	12,000	2,500	35,000	58.6%	34.3%	7.1%
Hospital B	6,250	5,250	1,500	13,000	48.1%	40.4%	11.5%
Hospital C	7,300	1,350	1,199	9,849	74.1%	13.7%	12.2%
Hospital D	1,500	1,650	350	3,500	42.9%	47.1%	10.0%
	35,550	20,250	5,549	61,349	**57.9%**	**33.0%**	**9.0%**
					County Average % Medicaid Group Distribution		

SFY23 MCO Encounter Distribution

Hospital	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5
Hospital A	12%	18%	40%	25%	5%
Hospital B	20%	5%	35%	20%	20%
Hospital C	8%	20%	25%	28%	19%

Based on the actual, updated SFY23 Day/Discharge allocation by the various Medicaid Groups, for each hospital and each MCO, a new County Average % Medicaid Group Distribution will be calculated. Since the FMAP at time of payment was different for Q1-Q2 versus Q3-Q4 (assuming no extension of the COVID PHE), they will be calculated separately. These new County Average % Medicaid Group Distributions will be used to calculate a new 'blended' rate and gross payment amount to compare to the interim values used to make the interim payments. The SFY23 Interim payments totaled $80.8M and the final reconciliation will be compared to that initial payment.

Hospital D	25%	14%	10%	30%	21%

Calculation of the Actual SFY23 'blended' FMAP - Q1 and Q2 calculated together and Q3 and Q4 calculated together.

SFY23 Q1 and Q2 MCO Patient Days Distribution

Hospital	Medicaid [a]	Expansion [b]	CHIP [c]	Total [d]
Hospital A	10,455	6,000	1,275	17,730
Hospital B	3,188	2,678	735	6,600
Hospital C	3,723	689	611	5,023
Hospital D	765	842	179	1,785
	18,131	10,208	2,800	31,138

SFY23 % Medicaid Group Distribution

Medicaid = a/d	Expansion = b/d	CHIP = c/d
59.0%	33.8%	7.2%
48.3%	40.6%	11.1%
74.1%	13.7%	12.2%
42.9%	47.1%	10.0%
58.2%	**32.8%**	**9.0%**

County Average % Medicaid Group Distribution

FMAP at Quarterly payment:		Non-Federal	Federal share @ Quarterly FMAP	Total Quarterly payment
Medicaid	**56.2%**	$11,065,254	$14,197,883	$25,263,137
Expansion	**90.0%**	$1,422,319	$12,800,867	$14,223,186
CHIP	**69.34%**	$1,196,206	$2,705,315	$3,901,521
		$13,683,779	**$29,704,065**	**$43,387,844**

Non-Federal:	$13,683,779	31.5%
Federal:	**$29,704,065**	**68.5%**
Total Quarterly payment:	$43,387,844	100.0%
Per Day payment:	**$1,393.41**	

Weighted Avg FMAP	68.5%
Gross Payments	$43,387,844
non-Federal	$13,683,779
Federal	$29,704,065
Payment Per Day	$1,393.41

For Q1 and Q2, a final 'blended ' FMAP is calculated based on actual SFY23 Encounters.
For Q3 and Q4, a final 'blended' FMAP is also calculated to reflect elimination of the COVID PHE FMAP.

SFY23 Q3 and Q4 MCO Patient Days Distribution

Hospital	Medicaid [a]	Expansion [b]	CHIP [c]	Total [d]
Hospital A	10,045	6,000	1,225	17,270
Hospital B	3,063	2,573	765	6,400
Hospital C	3,577	662	588	4,826
Hospital D	735	809	172	1,715
	17,420	10,043	2,749	30,211

SFY23 % Medicaid Group Distribution

Medicaid = a/d	Expansion = b/d	CHIP = c/d
58.2%	34.7%	7.1%
47.9%	40.2%	12.0%
74.1%	13.7%	12.2%
42.9%	47.1%	10.0%
57.7%	**33.2%**	**9.1%**

County Average % Medicaid Group Distribution

FMAP at Quarterly payment:		Non-Federal	Federal share @ Quarterly FMAP	Total Quarterly payment
Medicaid	**50.0%**	$11,163,411	$11,163,411	$22,326,823
Expansion	**90.0%**	$1,287,162	$11,584,455	$12,871,616
CHIP	**65.00%**	$1,233,206	$2,290,240	$3,523,446
		$13,683,779	**$25,038,106**	**$38,721,885**

Non-Federal:	$13,683,779	35.3%
Federal:	**$25,038,106**	**64.7%**
Total Quarterly payment:	$38,721,885	100.0%
Per Day payment:	**$1,281.71**	

Weighted Avg FMAP	64.7%
Gross Payments	$38,721,885
non-Federal	$13,683,779
Federal	$25,038,106
Payment Per Day	$1,281.71

Interim SFY23 FMAP and Payment:

66.13%	Non-Federal	Federal	Total Quarterly Payment

Medicaid	$22,657,131	$25,925,321	$48,653,530
Expansion	$2,666,199	$23,298,374	$25,887,082
CHIP	$2,044,228	$4,220,416	$6,271,057
	$27,367,558	**$53,444,111**	**$80,811,670**

Actual SFY23 FMAP and Payment:

66.7%

	Non-Federal	**Federal @ Reconciliation**	**Total Quarterly Payment**
Medicaid	$22,228,665	$25,361,294	$47,589,960
Expansion	$2,709,480	$24,385,322	$27,094,802
CHIP	$2,429,412	$4,995,554	$7,424,967
	$27,367,558	**$54,742,171**	**$82,109,729**

	Non-Federal	Federal	Total	Total Days	Payment / Day
Interim Payments	$27,367,558	$53,444,111	$80,811,670	56,971	$1,418.47
	33.9%	66.1%	100%		
	Non-Federal	Federal	Total	Total Days	Payment / Day
Reconciliation Payments	$27,367,558	$54,742,171	$82,109,729	61,349	$1,338.40
	33.3%	66.7%	100%		
Reconciliation Impact	**$0**	**$1,298,059**	**$1,298,059**	**4,378**	

An additional $1.29M will be distributed to the hospitals based on their updated Encounter Distribution. The Per Day Payment will reflect the impact of the updated Patient Days and increased FMAP. The overall actual SFY23 days increased, which caused a slight decrease in the Payment/Day.

SFY23 Utilization - MCO and Hospital

Revised Utilization - County A

				Encounter Distribution				
Hospital	**MCO Patient Days**	**Per Day payment**	**Payments**	**MCO 1**	**MCO 2**	**MCO 3**	**MCO 4**	**MCO 5**
Hospital A	35,000	$1,338.40	$46,844,130	12%	18%	40%	25%	5%
Hospital B	13,000	$1,338.40	$17,399,248	20%	5%	35%	20%	20%
Hospital C	9,849	$1,338.40	$13,181,938	8%	20%	25%	28%	19%
Hospital D	3,500	$1,338.40	$4,684,413	25%	14%	10%	30%	21%
	61,349		$82,109,729					
New Per Day Payment	**$1,338.40**							

New Reconciliated Annual Payment - SFY23

Hospital	**MCO 1**	**MCO 2**	**MCO 3**	**MCO 4**	**MCO 5**	Total
Hospital A	$5,621,296	$8,431,943	$18,737,652	$11,711,032	$2,342,206	$46,844,130
Hospital B	$3,479,850	$869,962	$6,089,737	$3,479,850	$3,479,850	$17,399,248
Hospital C	$1,054,555	$2,636,388	$3,295,485	$3,690,943	$2,504,568	$13,181,938
Hospital D	$1,171,103	$655,818	$468,441	$1,405,324	$983,727	$4,684,413
Total	$11,326,803	$12,594,111	$28,591,315	$20,287,149	$9,310,351	$82,109,729

New SFY23 payments based on actual MCO Encounter Utilization, updated Group Distribution and FMAP.

Change From Total SFY23 payment = Reconciliation - Total payment

Hospital	**MCO 1**	**MCO 2**	**MCO 3**	**MCO 4**	**MCO 5**	Total
Hospital A	$488,944	$1,433,282	($4,591,219)	$2,379,484	$475,897	$186,387
Hospital B	($936,203)	($896,459)	$790,474	$830,218	($52,992)	($264,962)
Hospital C	($333,985)	($834,964)	$518,403	$219,591	($272,513)	($703,467)
Hospital D	$650,241	$291,214	$77,795	$624,030	$436,821	$2,080,102
Total	($131,004)	($6,926)	($3,204,548)	$4,053,324	$587,213	$1,298,059

The Annual change between what was originally paid (w/FMAP changes) for SFY23 vs actual, updated SFY23 payments.

Q2/SFY24

FMAP at Quarterly payment:		**Non-Federal**	**Federal share @ Quarterly FMAP**	**Total Quarterly Payment**
Medicaid	**50.0%**	$5,717,591	$5,717,591	$11,435,182
Expansion	**90.0%**	$608,432	$5,475,885	$6,084,317
CHIP	**65.0%**	$515,867	$958,038	$1,473,905
		$6,841,890	**$12,151,515**	**$18,993,404**

Currently assuming that the SFY24 base period will continue to be CY2019 - this includes using the same CY2019 Medicaid Group and MCO Distribution and Allocation.

Non-Federal:	$6,841,890	36.0%
Federal:	**$12,151,515**	**64.0%**
Total Quarterly payment:	$18,993,404	100.0%
Per Day payment:	$1,333.55	

Quarterly payment

Hospital	MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	8,223	$1,333.55	$10,966,106	$1,206,272	$1,644,916	$5,483,053	$2,193,221	$438,644	$10,966,106
Hospital B	3,113	$1,333.55	$4,151,671	$1,037,918	$415,167	$1,245,501	$622,751	$830,334	$4,151,671
Hospital C	2,447	$1,333.55	$3,263,528	$326,353	$815,882	$652,706	$815,882	$652,706	$3,263,528
Hospital D	459	$1,333.55	$612,099	$122,420	$85,694	$91,815	$183,630	$128,541	$612,099
Total	14,243		$18,993,404	$2,692,962	$2,961,659	$7,473,075	$3,815,484	$2,050,225	$18,993,404

Right now assuming the same initial payment distribution as in Q1/SFY23.

New Net Q2/SFY24

Assessment received by State on 12/12/23

Payment to Hospitals by 1/11/24

Quarterly payment

Hospital	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	$1,695,216	$3,078,198	$891,834	$4,572,705	$914,541	$11,152,494
Hospital B	$101,715	($481,291)	$2,035,975	$1,452,969	$777,342	$3,886,709
Hospital C	($7,633)	($19,082)	$1,171,109	$1,035,473	$380,193	$2,560,060
Hospital D	$772,661	$376,908	$169,609	$807,660	$565,362	$2,692,201
Total	$2,561,958	$2,954,733	$4,268,527	$7,868,807	$2,637,438	$20,291,464

Assuming that the SFY24 initial Utilization will continue to be based on CY2019 data (see Q1/SFY24). The 2nd Quarter Payment in SFY24 would include the redistribution of the SFY23 payments based on the actual, updated SFY23 MCO Utilization.

NJ County Option Hospital Fee Program List

of Key Dates

Key Dates: SFY2023

Month	Deliverable	Notes
September		
9/12/2022	Counties IGT taxes to OMB and State provides payment charts to MCOs	Payment charts to include payment amounts per facility
9/25/2022	OMB transfers money to DMAHS DMAHS pulls down federal match DMAHS provides funds to MCOs	
October		
10/12/2022	MCOs make Q1 payments to hospitals	
November		
11/1/2022	State's technical contractor will submit the amount of expected new federal matching funds per quarter to the State	State will use this data to complete the required CMS 37 form
December		
12/2/2022	Participating hospitals return mandatory, updated DSH Calculation Template and Hospital Attestation Participating counties return optional, amended F&E Report, if making changes to assessments	
12/12/2022	Counties IGT taxes to OMB and State provides payment charts to MCOs	Payment charts to include payment amounts per facility
12/27/2022	OMB transfers money to DMAHS DMAHS pulls down federal match DMAHS provides funds to MCOs	
January 2023		
1/11/2023	MCOs make Q2 payments to hospitals	
February		
2/1/2023	State and its technical contractor will use county-supplied models and draft preprints for each participating county State's technical contractor will submit the amount of expected new federal matching funds per quarter to the State	These are the SFY23 preprints State will use this data to complete the required CMS 37 form
March		
3/13/2023	Counties IGT taxes to OMB and State provides payment charts to MCOs	Payment charts to include payment amounts per facility

3/15/2023	Estimates of the Program's spending of federal Medicaid monies due to the State from the State's technical contractor	
3/25/2023	OMB transfers money to DMAHS DMAHS pulls down federal match DMAHS provides funds to MCOs	
3/31/2023	NJ submits SFY23 preprints, contract language to CMS	
April		
4/10/2023	MCOs make Q3 payments to hospitals	
May		
5/1/2023	State's technical contractor will submit the amount of expected new federal matching funds per quarter to the State	State will use this data to complete the required CMS 37 form
June		
6/12/2023	Counties IGT taxes to OMB and State provides payment charts to MCOs	Payment charts to include payment amounts per facility
6/25/2023	OMB transfers money to DMAHS DMAHS pulls down federal match DMAHS provides funds to MCOs	
July		
7/10/2023	MCOs make Q4 payments to hospitals	Within SFY23

8.5.16 NJ COUNTY OPTION HOSPITAL FEE PILOT PROGRAM

In accordance with P.L. 2018, Chapter 136 and N.J.A.C. 10:52B and contingent on CMS and local approval, the Contractor shall make state-directed payments to participating hospitals included in the NJ County Option Hospital Fee Pilot Program (County Option Program). Seven counties are eligible for participation in the County Option Program:

- Atlantic
- Camden
- Essex
- Hudson
- Mercer
- Middlesex
- Passaic

The State intends to use a separate payment term approach to make these state-directed supplemental hospital payments. Payments will be made by DMAHS to the Contractor on a quarterly basis. A quarterly payment schedule with exact amounts per participating hospital will be provided to the Contractor not less than fifteen (15) days prior to each payment by DMAHS to the Contractor. The Contractor shall make the state-directed payments to the participating hospitals within fifteen (15) days of the payment from DMAHS.

Should a CMS approved County Option Program be disallowed or discontinued, DMAHS reserves the right to recoup any payments made by DMAHS to the Contractor for the purposes of this program.

Appendix N

NJ County Option – SFY22

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NJ DMAHS

Managed Care Organizations Briefing

August 2021

NJ COUNTY OPTION INTRODUCTION

- July 16, 2021 – Approved by CMS (will be renewed annually)
- With CMS and state approval, seven eligible NJ counties have enacted a local hospital fee program[1] in their jurisdiction. The fee amount will be used to secure additional Federal funding through the NJ FamilyCare Program to benefit residents with low income by providing additional Medicaid payments to the hospitals in the counties that serve these residents.
- 40 participating hospitals (Acute Care, Rehabs, IMDs)
- Hospital payments will be made through the MCOs, with the MCOs receiving funding from the state outside of the standard capitation process.
- Payments will be made by DMAHS to the MCOs on a quarterly basis.

[1]November 1, 2018 - (S2758/A4212, Rule N.J.A.C. 10:52B), March 2021 - P.L. 2021 c.41/S3252

NJ COUNTY OPTION MCO CONTRACT REQUIREMENTS

- Contract Article 8.5.16
- As approved by CMS, the State intends to use a separate payment term approach to make these state-directed supplemental hospital payments.
- A quarterly payment schedule with exact amounts per participating hospital will be provided to the Contractor **not less than fifteen (15) days prior to each payment** by DMAHS to the Contractor. The Contractor shall make the state-directed payments to the participating hospitals **within fifteen (15) days of the payment from DMAHS**.

SFY22 PAYMENT SCHEDULE

Q1	
Date	**Event**
NLT Sept. 10	State provides payment charts to MCOs (which hospitals get which amounts)
Sept. 25	MCOs receive funds
Oct. 10	Q1 Payments Due to Hospitals from MCOs

Q2	
Date	**Event**
NLT Dec. 13	State provides payment charts to MCOs (which hospitals get which amounts)
Dec. 28	MCOs receive funds
Jan. 12	Q2 Payments Due to Hospitals from MCOs

Q3	
Date	**Event**
NLT March 11	State provides payment charts to MCOs (which hospitals get which amounts)
March 25	MCOs receive funds
April 10	Q3 Payments Due to Hospitals from MCOs

Q4	
Date	**Event**
NLT June 10	State provides payment charts to MCOs (which hospitals get which amounts)
June 25	MCOs receive funds
July 10	Q4 Payments Due to Hospitals from MCOs

- All NJ County Option hospital payments to be paid via EFT.
- During the SFY23 second quarter, a reconciliation of SFY22 payments will occur based on actual utilization, which may result in a reallocation of SFY22 payments. This will coincide with payments made to hospitals as part of the SFY23 program year, contingent on CMS approval.
- FIDE SNP population included in NJFC payments.

EXAMPLE PAYMENT CHART – MCO 1

	Total Gross Payment (Q1) to MCO 1	MCO Tax^	Net Payments to Hospitals
MCO 1	$2,765,032	$141,016.63	$2,624,015.37

Medicare ID	Hospital*	NPI Number	Hospital Payment Point of Contact	Hospital Payment Contact Phone Number	Hospital Payment Contact Mailing Address	SFY22, Q1 Hospital Payment
310002	Hospital 1	1629982550	Name 1	Phone 1	Address 1	$298,629.60
310009	Hospital 2	1013110984	Name 2	Phone 2	Address 2	$1,100,035.41
312042	Hospital 3	1568619774	Name 3	Phone 3	Address 3	$419,690.43
313060	Hospital 4	1770229506	Name 4	Phone 4	Address 4	$411,506.40
310081	Hospital 5	1456882299	Name 5	Phone 5	Address 5	$394,153.53
					Total	**$2,624,015.37**

*40 total hospitals

^DMAHS will process a gross payment to each MCO, who will then make the hospital specific payments, net of the MCO tax.

- Chart is populated with sample data
- MCOs will receive their own breakdowns by hospital each quarter
- While hospitals may have multiple billing providers, the NPI provided in the chart must be used. Location of specific facilities is not a factor in MCO payments.

NJ COUNTY OPTION CONTACTS

- NJ DMAHS – Rob Durborow, Robert.Durborow@dhs.nj.gov
- Sellers Dorsey – Jason Green, jgreen@sellersdorsey.com

Please provide your 2019 baseline statistic. nc
Please add statistics for all related measures for **SFY2022** to be compared to the 2019 National Target.

Average (median) time patients spent in the ED before leaving from the visit (NQF #0496):

Numerator: Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

Denominator: This measure is reported as a continuous variable statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.

Clostridium difficile (C.diff.) intestinal infections (NQF #1717):

Numerator: Total number of observed hospital-onset incident CDI LabID events among all inpatients in the facility, excluding NICU, Special Care Nursery, babies in LDRP, well-baby nurseries, or well-baby clinics.

Denominator: Total number of predicted hospital-onset CDI LabID events, calculated using the facility´s number of inpatient days, facility type, CDI event reporting from Emergency Department and 24 hour observation units, bed size, ICU bed size, affiliation with medical school, microbiological test method used to identify C. difficile, and community-onset CDI admission prevalence rate.

If the quality measure does not relate to your hospital, please ignore.

NJ CO QUALITY MEASURES

Hospital:

Measure Name	NCQA Definition	Numerator	Denominator	eCQM #	Performance Target	Baseline Year	Baseline Statistic	FY2022 Statistic	FY2023 Statistic
Average (median) time patients spent in the ED before leaving from the visit (NQF #0496)	NQF #0496 calculates the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department (ED). The measure is calculated using chart-abstracted data, on a rolling quarterly basis, and is publically reported in aggregate for one calendar year.	Continuous Variable Statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.	This measure is reported as a continuous variable statement: Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.		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.	CY2019	Acute: 142 minutes (National Average)		
Clostridium difficile (C.diff.) intestinal infections (NQF #1717)	Standardized infection ratio (SIR) of hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility	Total number of observed hospital-onset incident CDI LabID events among all inpatients in the facility, excluding NICU, Special Care Nursery, babies in LDRP, well-baby nurseries, or well-baby clinics.	Total number of predicted hospital-onset CDI LabID events, calculated using the facility´s number of inpatient days, facility type, CDI event reporting from Emergency Department and 24 hour observation units, bed size, ICU bed size, affiliation with medical school, microbiological test method used to identify C. difficile, and community-onset CDI admission prevalence rate.		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.	Long Term: FFY 2019 Rehab: FFY 2019	Long Term: 0.537 Rehab: 0.557 (National Average)		

CY19 Extract Criteria

Overall:

- Gainwell Paid status
- Managed Care Encounter Submissions
- NJ Acute Care FFS Medicaid Number or accredited NPI listing
- Discharge Dates: 01/01/2019 – 12/31/2019
- Gainwell Payment Dates: prior to December 5, 2020
- Patient Payer = 012 (Medicaid Primary)
- TPL Amount = $0 (exclude TPL)
- Inpatient Claims (Bill types 11X, 12X & 18X)

General Acute Care Facilities:

- NPI's / provider numbers grouped into single entity
- Discharges: Unique count of claim submissions
- Days: Discharge – Admit Date (If Admit equals Discharge = 1)
- Payments: sum of all Medicaid payments

Freestanding and Excluded Units (Psych / Rehab)

- NPI's / provider numbers grouped into single entity
- Discharges: Unique Recipient count with a consistent unbroken service date range
- Days:
    - Bill (111, 121 or 181) (Admit thru Discharge)
        - Discharge – Admit Date (If Admit equals Discharge = 1)
    - Bill Type (114,124 or 184) (Continuous Claim – Final)
        - Extract first corresponding recipient & stay. Bill type 112, 122 or 182 (Continuous Claim – First)
        - Identify Discharge Date (Bill Type 114,124,184)
        - Subtract Discharge Date - Admit Date (Bill type 112, 122, 182)
    - Payments: Sum all payments associated with recipients discharges during the designated timeframe

students as possible who might be able to benefit to have the opportunity to do so. It is with these goals in mind that the adopted amendments were developed by the EOF Board of Directors. It is hoped that the adopted amendments will continue to allow many students from all walks of life to continue to participate in EOF.

COMMENT: Dr. Jenice Sabb, President of the Educational Opportunity Fund Professional Association, shared that she was in support of the proposed amendments as they exemplify the intent of the EOF legislation. Dr. Sabb thanked the EOF Board of Directors for their acknowledgement of the needs of this student population.

RESPONSE: The EOF Board of Directors thanks Dr. Jenice Sabb for her support.

Federal Standards Statement

The adopted amendments do not require a Federal standards analysis under Executive Order No. 27 (1994) and N.J.S.A. 52:14B-22 et seq., because the EOF was established by New Jersey legislation, is wholly supported by State appropriations, and is not subject to any Federal requirements or standards.

Full text of the adoption follows:

SUBCHAPTER 2. UNDERGRADUATE EOF ACADEMIC AND FINANCIAL ELIGIBILITY

9A:11-2.8 Duration of student eligibility

(a)-(b) (No change.)

(c) Students enrolled at senior institutions may receive a maximum of 12 semesters of Article III undergraduate grant payments to complete a baccalaureate degree, as long as they continue to meet the eligibility requirements for the program and are making satisfactory academic progress as stipulated at N.J.A.C. 9A:11-2.13. Undergraduate grant recipients may not pursue more than one baccalaureate degree within the maximum 12 semesters of Article III undergraduate grant payments.

(d) (No change.)

(e) Except for as provided in subsection (f) below, students enrolled at institutions that award associate degrees may receive a maximum of eight semesters of Article III undergraduate grant payments to complete an associate degree, as long as they continue to meet the eligibility requirements for the program and are making satisfactory academic progress as stipulated at N.J.A.C. 9A:11-2.13. Undergraduate grant recipients may not pursue more than one associate degree within the maximum eight semesters of Article III undergraduate grant payments.

(f) Undergraduate grant recipients who are enrolled in a three plus one degree program established pursuant to section 1 of P.L. 2018, c. 144 (N.J.S.A. 18A:3B-78), shall be eligible for eight semesters of Article III undergraduate grant payments to complete an associate degree and an additional two semesters of Article III undergraduate grant payments while enrolled in the third academic year of the program, as long as they continue to meet the eligibility requirements of the program and are making satisfactory academic progress as stipulated at N.J.A.C. 9A:11-2.13.

Recodify existing (f)-(i) as (g)-(j) (No change in text.)

SUBCHAPTER 5. SUMMER PROGRAM AND WINTER SESSION

9A:11-5.4 Student eligibility

(a) (No change.)

(b) Based upon the assessment of students' preparation and readiness for collegiate study, institutions may require eligible students to participate in a pre-first year summer program as a condition of their admission and/or eligibility to receive EOF grants and support services during the academic year. The EOF pre-first year summer program is intended to assist students that have been admitted to the institution as identified at N.J.A.C. 9A:11-6.1(h)2 and 3. Institutions may permit students to enroll without participating in a summer program, as long as the institution provides, during the academic year, alternative activities for such students consistent with the goals of N.J.A.C. 9A:11-5.1 and the requirements of N.J.A.C. 9A:11-5.3.

(c) EOF program applicants who have earned 24 or more college credits while in high school or earned an associate's degree as part of their high school graduation requirements are eligible for participation in the pre-first year summer program. Furthermore, these students must be considered for the EOF program based on the EOF Article III student grant funding priorities outlined at N.J.A.C. 9A:11-6.1(h), and if they meet all of the eligibility requirements set forth at N.J.A.C. 9A:11-2.2 and 2.3.

(d) (No change.)

SUBCHAPTER 6. OPERATIONAL PROCEDURES FOR ACADEMIC YEAR, WINTER SESSION, AND SUMMER ARTICLE III STUDENT GRANTS AND ARTICLE IV PROGRAM SUPPORT SERVICES FUNDS

9A:11-6.1 Renewal application process for Article III student grants and Article IV program support funds

(a)-(g) (No change.)

(h) Based on an institution's annual academic year EOF Article III allocation, student grant funds shall be awarded to eligible students in the following priority order:

1.-2. (No change.)

3. Students that have earned 24 or more college credits while in high school or who participated in a dual enrollment program and have earned an associate's degree as part of their high school graduation requirements and have no prior history of EOF funding support;

Recodify existing 3.-5. as 4.-6. (No change in text.)

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

The County Option Hospital Fee Pilot Program

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

Proposed: October 7, 2019, at 51 N.J.R. 1493(a).
Adopted: February 20, 2020, by Carole Johnson, Commissioner, Department of Human Services.
Filed: February 24, 2020, as R.2020 d.036, **with a non-substantial change** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

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

Agency Control Number: 19-A-03.

Effective Date: March 16, 2020.
Expiration Date: March 16, 2027.

Summary of Public Comments and Agency Responses:

Comments were received from:
East Orange General Hospital, East Orange, NJ;
Fair Share Hospitals Collaborative, Trenton, NJ;
Hackensack Meridian Health, Hackensack, NJ;
Hospital Alliance of New Jersey, Trenton, NJ;
New Jersey Hospital Association, Princeton, NJ;
RWJBarnabas Health, West Orange, NJ;
Saint Peter's University Hospital, New Brunswick, NJ; and
University Hospital, Newark, NJ.

1. COMMENT: The Department of Human Services (Department) received numerous comments of general support for the County Option Hospital Fee Program, including some of the following language:

> "It is imperative that New Jersey consider all avenues to maximize federal matching dollars, especially at a time when federal funding remains in jeopardy for healthcare providers…Vulnerable patients are at risk through federal changes to the Medicaid programs that can lead to patients having limited or no coverage and being forced to utilize hospital emergency rooms for primary care and certain specialty services."

"Administered at the county level, this innovative program will serve as a workable vehicle to allow participating hospitals to maximize their Medicaid funding. The program allows that the assessment selected by each county can be tailored to best fit the hospitals in that county. Allowing the counties to enter into intergovernmental transfer agreements with the State in order to maximize federal matching funds will be beneficial for New Jersey's safety net hospitals as they continue to adapt to an evolving healthcare landscape."

"… supports the program's goal of enhancing federal Medicaid resources to support our hospitals' sustained efforts to provide the highest quality services to low income and uninsured residents while also establishing a method for equitable distribution of funds amongst the hospitals."

"On behalf of our eligible hospitals, we commend the State of New Jersey and the Department of Human Services on this innovative program … that will allow local needs and differences to shape and influence the design of successful programs."

There were no comments in opposition to the proposed program.

RESPONSE: The Department appreciates the comments in support of this program, which will increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals in providing necessary services to low-income residents.

2. COMMENT: Commenters asked which hospitals can participate in the program. The commenters noted that the definition included in proposed N.J.A.C. 10:52B-1.2 for hospital includes "a hospital that is licensed pursuant to P.L.1971, c. 136 and is located within the borders of the participating county." They further noted that proposed N.J.A.C. 10:52B-3.1(c)2 requires a participating county to include in its proposed Fee and Expenditure Report a list of all hospitals within the jurisdiction and their facility type (acute care, psychiatric, rehabilitation, long-term acute care hospital, etc.). Therefore, it is unclear if this rulemaking would apply to all hospitals or just general acute care hospitals. The commenters asked that the Department clarify eligible "hospitals" and/or provide a list of the eligible "hospitals" for the seven eligible counties.

3. COMMENT: A commenter suggested that the regulations should define and provide examples as to what is meant by "classes" of hospitals.

RESPONSE TO COMMENTS 2 AND 3: The County Option Hospital Fee Pilot Program (Pilot Program) authorizes eligible counties to impose a local health care-related fee on all hospitals within its borders. The Fee and Expenditure Report must list these facilities by type to ensure compliance with Federal rules and State law that all hospital services be taken into consideration. Federal regulations at 42 CFR 433.56 define 19 classes of health care providers or services for which a health care-related tax as discussed at 42 CFR 433.68 may be imposed, of which only two of those classes, inpatient hospital services and outpatient hospital services, are authorized to be assessed under the County Option Fee Pilot Program pursuant to P.L. 2018, c. 136. Inpatient and outpatient hospital services are further defined in Federal regulations at 42 CFR 440.10 and 440.20, respectively. The Federal rules do not distinguish between acute, psychiatric, rehabilitation, or other types of hospitals.

4. COMMENT: Proposed N.J.A.C. 10:52B-3.1(c)6, states that the county can request to exclude facilities from the fee. The commenters asked the Department to define an allowable rationale for exclusion to assist the counties in developing their Fee and Expenditure Reports. The commenters note that "classes" of hospitals are permitted within the confines of 42 CFR 433.68 and that proposed N.J.A.C. 10:52B-3.1(d)2 states that exemptions must comply with 42 CFR 433.68 and that "classes" of hospitals may need to be considered to maximize funds, encourage participation, and/or account for different facility types within the confines of 42 CFR 433.68. The commenters additionally suggest that the regulations should provide clarity as to what hospitals can participate and/or be excluded, providing a list of the eligible "hospitals" for the seven eligible counties. The industry should be given the opportunity to comment on the definition developed through the regulation.

RESPONSE: Although N.J.A.C. 10:52B-3.1(d)2 does not use the term "class," as noted in the Response to Comment 3, for health care-related tax purposes, "classes" are the types of health care services for which a health care-related tax may be imposed. The participating county may choose to exclude certain hospital facility types. However, if a county chooses to exclude certain hospital facility types from the county assessment, the Federal Centers for Medicare and Medicaid Services (CMS) must approve of the exclusion in the form of a waiver of the broad-based requirements in Federal regulations. The State does not intend to define which hospitals, if any, to exclude from any proposed county assessment. Any decision to exclude certain hospital facility types would be part of the consultation and discussion with local hospitals in the jurisdiction as required at N.J.A.C. 10:52B-3.1(b). However, if hospitals are excluded from the county assessment, the Department must assure that the resultant assessment complies with the requirements of 42 CFR 433.68(c) and that approval of a waiver of the broad-based requirements is received from CMS. In addition, if a county were to propose assessing hospitals included in the county fee program at different levels, a waiver of the Federal uniformity requirement at 42 CFR 433.68(d) must also be submitted and approved by CMS before the county program could be implemented.

5. COMMENT: Several commenters suggested that due to the delay in program initiation the Department should petition the Legislature to extend the pilot program to a full five years of operation subject to hospital willingness to participate.

RESPONSE: The legislation creating the County Option Hospital Fee Pilot Program (P.L. 2018, c. 136) specifies the end date of the program to be April 30, 2024. The Department believes everyone's efforts are best focused on launching the pilot.

6. COMMENT: Commenters noted that at N.J.A.C. 10:52B-3.3(b)1 and 2, the proposal indicates the distribution of funds to hospitals is at the discretion of the Department: "The Department may: (1) Increase Medicaid/NJ FamilyCare fee-for-service (FFS) payments to hospitals located in the participating county; (2) Make payments to Medicaid/NJ FamilyCare managed care organizations (MCOs) operating in participating counties for increased hospital or hospital-related payments"; or (3) Use a combination of the two mechanisms.

The commenters state that preferably, distributions to the hospitals should be an aggregate flow-thru payment, not an add-on to Medicaid FFS or MCO rates and paid on a quarterly basis in conjunction with the county fee assessment to mitigate hospital cash flow issues. The commenters also state that the distribution of funds to the hospitals must be timely, minimizing the time between a hospital's assessed payment and return of funds through the MCOs, FFS, or both.

7. COMMENT: A commenter stated that for MCOs, payments should be calculated using actual encounter data from the prior quarter and should not be combined with regular payments from MCOs. The commenter maintains that quarterly payments will allow for easier tracking of the payments funded by the assessment and could also reduce cash flow uncertainty caused by the time separation of the tax payments from receipt of the supplemental payments.

RESPONSE TO COMMENTS 6 AND 7: As the single state agency for the Medicaid/NJ FamilyCare Program, the role of the Department of Human Services is to review the proposed program to assure that the assessment design and proposed payment methodology, if provided, are in compliance with Federal regulation governing such programs. The most appropriate method of distribution is dependent upon, among other things, the aggregate value of the proposed plans submitted by the counties and, therefore, the Commissioner of the Department of Human Services will distribute the funds in the most cost effective and efficient manner as allowable by Federal statute, regulation, and guidance. The counties, in consultation with the hospitals, have the option of recommending to the Commissioner the manner of distribution of the Medicaid/NJ FamilyCare payments in their proposed Fee and Expenditure Report. Such recommendations may include the methods suggested by the commenters.

8. COMMENT: Several commenters noted that at N.J.A.C. 10:52B-3.3, the rule does not indicate or impose a cap on the amount the Medicaid MCOs can charge for an administrative fee. The commenters suggested that the Department should establish sufficient oversight and cap MCO fees at an amount to cover actual administrative fees and costs. The commenters stated that doing so will ensure that the legislative intent of supporting hospitals' efforts in providing care to the most vulnerable residents will be maximized.

RESPONSE: The statute creating the County Option Hospital Fee Pilot Program expressly forbids any MCO from retaining funds generated by the fee other than to offset increased administrative costs incurred as a result of the pilot program. In the event the payments under the pilot program are distributed through an MCO, the Department will review and approve the MCOs' administrative costs through the existing rate setting process to ensure compliance with this provision.

9. COMMENT: Several commenters noted that at N.J.A.C. 10:52B-3.3(a)3, if the State's administrative costs exceed the total value of funding, the State's costs will be subtracted from the hospitals' payments (from the non-Federal share of dollars). The commenters state that there should be a limit to the amount of remaining administrative costs that the Department can subtract from the non-Federal share.

RESPONSE: The Department will operationalize the Pilot Program as efficiently as possible, so that the maximum amount of the fee proceeds are used to provide necessary services to residents with low-incomes. However, as the Department does not have separate resources appropriated for this purpose, all administrative costs must be provided from fee proceeds.

10. COMMENT: A commenter noted that at N.J.A.C. 10:52B-3.3(d), all hospitals shall be required to maintain records regarding the expenditure of funds and make such records available to the Department or any authorized agent of the Department upon request. For the purpose of clarification, can the Department further articulate what is meant by "expenditure of funds." It is assumed these are the funds paid by the hospital to the county for the local health care-related fees.

RESPONSE: The expenditures addressed in this section refer to the additional Medicaid/NJ FamilyCare funds received by the hospital. Providing records regarding the expenditure of such funds upon the Department's request will help to ensure that the legislative intent of the Pilot Program has been satisfied and expenditures are consistent with the description provided within the Fee and Expenditure Report.

11. COMMENT: Several commenters noted that at N.J.A.C. 10:52B-3.3(d), all hospitals shall maintain records regarding expenditure of funds and make such records available upon request to the Department or any authorized agent of the Department. Commenters asked what the required retention date is and if there are penalties for failure to retain records.

RESPONSE: Records must be kept and available, in line with Federal and State guidelines, to maintain compliance with any Federal and State audit that may be conducted. Please refer to N.J.A.C. 15:3 for State guidelines and the CMS Record Schedule at www.cms.gov for Federal guidelines. Records must be kept in accordance with prudent business practice to ensure that records are available for any and all audits to which hospitals are routinely subject. Such audits may include penalties depending on their findings and the authority and scope of the audit. Counties should maintain all records in accordance with N.J.A.C. 15:3 and the County Agency General Records Retention Schedule (See https://www.nj.gov/treasury/revenue/rms/retention.shtml).

12. COMMENT: The commenters stated that the Department plans to provide an example of the required Fee and Expenditure Report as indicated at N.J.A.C. 10:52B notice of proposal Summary, at paragraph 7; however, no timeline is provided. The commenters state that the example Fee and Expenditure Report should be distributed to the hospitals and county to review and provide comments before they are finalized.

RESPONSE: The description of the Fee and Expenditure Report is provided at N.J.A.C. 10:52B-3.1 and the opportunity to comment on the elements of the Fee and Expenditure Report was available during the comment period of the proposed rules. The template of the Fee and Expenditure Report will be made accessible to the hospitals and counties through the New Jersey Department of Human Services/Division of Medical Assistance and Health Services website for completion.

13. COMMENT: The commenters indicated that at N.J.A.C. 10:52B-2.1(h)1, a participating county may amend its approved Fee and Expenditure Report annually with the approval of the Commissioner and with any required Federal approvals before any changes are implemented. The commenters stated that hospitals should be included in the review and approval process of a participating county's request to amend its approved Fee and Expenditure Report.

RESPONSE: If a county chooses to amend its approved Fee and Expenditure Report, the proposed amended report must go through the complete review and approval process, which includes the requirement that the affected hospitals and interested parties be provided a 21-day period during which to review and comment on the Fee and Expenditure Report.

14. COMMENT: The commenters noted that at N.J.A.C. 10:52B-3.1(b), participating counties shall consult with affected hospitals to develop their proposed Fee and Expenditure Report prior to submission to the Department. The commenters stated that there is nothing to specify the degree, or amount, of consulting required between the county and the hospital.

RESPONSE: N.J.A.C. 10:52B-2.2(a)1 requires that the county ordinance or resolution include a description of the process for communicating with the affected hospitals and collecting feedback and comments on the county proposal. As this communication will vary based on the complexity of the proposed report and the positions of the involved parties, the Department does not believe a change to the rule is necessitated.

15. COMMENT: A commenter noted that N.J.A.C. 10:52B-2.1(a)2 requires the Department to 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 to consider comments received in its review of the proposed report. The commenter stated that the rulemaking does not describe the method whereby the Department will make the proposed Fee and Expenditure Report available for review. The commenter suggested the Department include an explicit process for doing so in the final adopted regulations. In line with this, the commenter strongly recommended the Department include as part of the proposed Fee and Expenditure Report available for comment, its own validated modeling so affected hospitals can compare the data and respond accordingly.

RESPONSE: The Department will make the Fee and Expenditure Report available electronically to all impacted hospitals and interested parties and include a mechanism that allows submission of comments on these reports to the Department. The Department will include a description of the payment distribution model. The Department intends to review and analyze each Fee and Expenditure Report with the data and assessment modeling submitted by the county for compliance with Federal regulations.

Because the electronic means may change with technology, the Department declines to specify a particular platform or method in the rule.

16. COMMENT: A commenter noted that while the proposed regulations require the Department to consider comments received, the process by which this would occur is not expressly stated. The commenter believes that the Department should respond in writing to comments submitted on the proposed Fee and Expenditure Report. This would resemble the currently existing process required by the Administrative Procedures Act for regulatory proposals.

RESPONSE: The Department will consider all comments received as part of the plan approval process but will not issue written responses to such comments. In the event the comments point to over-arching confusion or implementation issues, the Department may determine to release written clarification or consider further rulemaking.

17. COMMENT: Commenters noted that N.J.A.C. 10:52B-3.1(d)3 states that fees will be assessed consistent with Federal rules on the basis of any of the following: net or gross revenues, discharges, encounters, days, beds, visits, and may exclude revenue or utilization of Medicaid/NJ Family Care, Medicare, or both. The commenters state that the County Fee Assessment data must be based on audited data to ensure accuracy of assessment. The latest common year audited cost report should be used and we urge that audits are completed timely. Hospitals must be permitted to review and appeal any Medicaid MCO day discrepancies.

18. COMMENT: A commenter stated that additional items should be required for submission to produce an accurate, verifiable, and transparent Fee and Expenditure Report: (1) Methodology Description—The Fee and Expenditure Report must include a detailed description of the methodology used to levy assessments on all affected hospitals and the methodology concerning the distribution of funds generated by the program. An "overview of the fee and expenditure plan" is insufficient; (2) Modeling—The report must include a detailed model that demonstrates the flows of funds to and from all affected hospitals;

(3) Data Sources—The county must cite and provide references to all data sources used to produce the model, including, but not limited to, the following: new or gross revenues; discharges; encounters; days; beds; visits; and excluded revenue or utilization of Medicaid/NJ FamilyCare and/or Medicare; (4) Validation—The Department should review the model as presented by the county to verify the accuracy of the data used to produce the Fee and Expenditure Report, including reproducing the county's model and results; and (5) Accessibility—The Department must provide access to the data used to produce and verify the model to affected hospitals so they have sufficient time to review and potentially appeal any determination.

RESPONSE TO COMMENTS 17 AND 18: The hospitals will provide their own audited and verifiable data (including the source documents) as attested by the hospital's chief executive officer to the county.

The county will use this information to develop the Fee and Expenditure Report in consultation with the hospitals. How the county chooses to design the fee is within its discretion, subject to the Department's review and CMS approval. The Fee and Expenditure Report detailing the assessment, along with accompanying source data and attestations, shall be submitted to the Department.

The Department would, therefore, have the required source documents from the hospitals to verify the data and the assessment plan (modeling) submitted by the county. Following an initial review by the Department, the Fee and Expenditure Reports will be made available to affected hospitals and interested parties for a period of 21 days for review and comment.

19. COMMENT: A commenter stated that the distribution base and methodology should be based on the latest audited Medicare or Medicaid cost report to ensure fair distribution of funds. Other sources as listed will not provide for the level of dependability and comparability that will be needed. On the Medicaid Submitted Cost Report, there are reporting inconsistencies among hospitals. For example, one hospital may be using estimated days while another may be using actual matched days or even including appeal days, thus creating potential economic advantages for one hospital versus another. Regarding the State's 24-month Medicaid Fee-for-Service and Managed Care Encounter Reports, this commenter maintained that often times MCO encounter reports are not complete and could be riddled with errors.

20. COMMENT: A commenter suggested that the Department impose standards governing the distribution of funds to the participating hospitals in participating counties. The commenter suggested that the standards include the distribution base and the requirement that methodologies use audited data, such as the State's 24-month Medicaid FFS and Managed Care Encounter Reports, when feasible and allowable under Federal rules. The commenter stated that, additionally, the Department should develop a mechanism to allow hospitals to review and appeal any data discrepancies, including variances between hospital FFS and Medicaid MCO data, and that hospitals must be permitted to review and appeal any Medicaid MCO day discrepancies.

RESPONSE TO COMMENTS 19 AND 20: As codified at N.J.A.C. 10:52B-3.1(c)5, the Fee and Expenditure Report must, at the minimum, include source documentation of the data used to create the Fee and Expenditure Report (for example, Medicare or Medicaid/NJ Family Care cost report, survey data, etc.). The comments submitted reflect varying experience related to the reliability and accuracy with 24-month Medicaid FFS and Managed Care Encounter Reports. For this reason, data submitted by the hospitals will need to be certified by the hospital's chief executive officer and will serve as the basis for supporting the fee assessment. Acceptable sources of data submitted by the hospital must be supported through Medicare cost reports and other audited documents and/or their source materials. The Department will request additional documentation as needed should a discrepancy be noted during the review and approval process. Please also see the Response to Comments 17 and 18.

21. COMMENT: Commenters noted that in accordance with 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. The commenter suggests that the hospitals should be provided a 10-day grace period beyond the due date, before any penalties or interest are imposed.

22. COMMENT: The commenters noted that at N.J.A.C. 10:52B-3.6(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. The commenters suggested that the hospitals should be provided 15 or 30 working days to prepare and file an appeal with the county.

23. COMMENT: A commenter stated that to ensure a transparent process and that hospitals have an adequate amount of time to receive, review, and process payments to the counties, it is recommended the regulations be revised to require the due date to be included in the ordinance or resolution. The county should be required to provide written notice of the fee amount at least 30 days in advance of the due date.

24. COMMENT: A commenter stated that the hospitals should be provided 15 business days to file an appeal with the county regarding both the assessed fee amount and any decision related to imposition of penalties.

25. COMMENT: A commenter stated that the counties should also be required to respond in writing to a hospital's appeal.

26. COMMENT: Several commenters asked what happens once an appeal is filed with the county and the recourse the hospitals have.

RESPONSE TO COMMENTS 21 THROUGH 26: Required elements of the county ordinance and resolution are cited in N.J.A.C. 10:52B-2.2. Hospitals may address these issues with their respective counties as the ordinances are developed. The rules set baseline parameters for counties regarding these issues as the contents of the ordinance is not the responsibility of the Department and should be the result of the collaboration between the counties and the hospitals.

27. COMMENT: A commenter stated that the proposed regulations do not detail what would constitute adequate consultation between the counties and the impacted providers. The commenter recommended that the Department require that counties actively consult with all impacted providers and allow all impacted providers to comment to the county in writing on proposed Fee and Expenditure Reports. The process should include a requirement for counties to respond in writing to all comments, similar to the requirements for State agencies pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. Subsequently, a participating county should be required to submit all comments and responses it received during the consultation process to the Department. This would allow the Department to ensure any consultation undertaken at the county level is not cursory. If the Department is not satisfied with county responses to impacted provider comments, the Department should require further county consultations prior to approving or denying a proposed Fee and Expenditure Report.

RESPONSE: The rules set baseline parameters for counties. Hospitals and counties may coordinate additional local processes. Affected hospitals will have the opportunity to provide comments to the Department during the 21-day Fee and Expenditure Report review and comment period.

28. COMMENT: The commenters noted that the county's proposed Fee and Expenditure Report must include the financial calculation for the Department to determine whether payments under the proposed plan, when combined with other Medicaid and disproportionate share (DSH) payments, are expected to exceed the hospital specific DSH limit. At N.J.A.C. 10:52B-3.1(c)8, hospitals must provide the supporting documentation for the DSH limit calculation. If a hospital's Medicaid and DSH payment are expected to exceed the hospital specific DSH limit, the hospital's CEO must provide attestation agreeing to authorize a payment reduction to DSH payments including Charity Care payments to mitigate the risk of non-compliance with Federal DSH Limits.

The commenter asked about the process and timing for the reduction in DSH payments using the example that if a hospital utilized the State fiscal year (SFY) 2016 Medicaid DSH Audit as the basis to determine whether the payment under the proposed plan, when combined with other Medicaid and disproportionate share (DSH) payment, is expected to exceed the hospital specific DSH limit in 2020, the actual SFY 2020 Medicaid DSH Audit would not be available until sometime in 2023.

29. COMMENT: The commenters stated that the assessment must be a direct offset on the Medicaid DSH Audit. For hospitals to minimize the

potential of exceeding their Medicaid DSH Limit, the hospital assessment must be a direct offset against the funds distributed back to the hospital for Medicaid DSH Audit reporting.

RESPONSE TO COMMENTS 28 AND 29: Section 1923(g)(1) of the Social Security Act imposes a limit on the amount a hospital may receive in DSH payments. Any increased Medicaid payments created from an assessment program will count towards a hospital's DSH limit. If payments from an assessment program accrue to a point that the hospital's DSH payments (that is, charity care) would exceed that limit, the Department is required to reduce the hospital's DSH payments to avoid loss of Federal funds.

Under P.L. 2018, c. 136, the stated purpose of the County Option Hospital Fee Pilot Program is "to increase financial resources through the Medicaid program to support local hospitals …" Since the purpose of the program is to provide additional Medicaid funding to hospitals to serve residents, the funding must be in compliance with all applicable rules and regulations related to the Medicaid program. As the single state agency administering the Medicaid program, the Department is obligated to comply with these Federal rules, including the Federal limits imposed on DSH payments.

In regard to the timing of the DSH limit projections, please also see the Response to Comment 30. There will be a multiple year gap from the implementation of the program to the most recent DSH audit. Hospitals will provide projections of their DSH limit. In calculating the DSH limit, the Department will accept a hospital's use of 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, as referenced at N.J.A.C. 10:52B-3.1(c)8i(3).

30. COMMENT: The commenters asked if there is a reconciliation process in the event the hospital's actual DSH payments do not exceed the Federal DSH Limits.

RESPONSE: The Department does not intend to create a separate reconciliation process for DSH payments and, therefore, is not including such a process in this rulemaking.

CMS requires the DSH limits to be audited once the actual data for the fiscal year is available. This is required regardless of whether the hospitals do projections. The audit is typically two to three years after the year for which the projected DSH limit was calculated. If CMS finds through these audits that a hospital received DSH payments in excess of the audited DSH limit, the State will recoup the excess payment from the hospital and refund the Federal share to CMS. While a projected DSH limit is unlikely to match the audited calculation with precision, the accuracy of the preliminary DSH limit is critical to avoid potential overpayments or underpayments, as the hospitals will bear the risk, not the State.

31. COMMENT: A commenter suggested that when hospitals exceed the allowable Federal DSH limit, the incremental funding that becomes available as a result should be redirected first to those hospitals currently not considered safety net providers under current legislation providing the highest level of documented charity care.

RESPONSE: The proposed new rules do not alter the provisions for DSH payments or the formula for Charity Care. The comment is beyond the scope of the rulemaking.

32. COMMENT: Several commenters asked if the hospital is entitled to recoup the forfeited DSH payments and what happens to the forfeited DSH Funds, are they held in reserve or they distributed to other hospitals. Additionally, it was stated that when the pilot program ends on April 30, 2024, the regulations should indicate that hospitals that forfeited DSH payments will be able to resume their full DSH payments.

RESPONSE: The new rules do not alter the provisions for DSH payments, the formula for Charity Care, or outline the disposition of DSH payment reduction. There is no mechanism for a recoupment of reduced DSH funds.

The comments regarding the forfeited DSH funds are outside the scope of this rulemaking. When the authorization period of the County Option Hospital Fee Pilot Program, pursuant to P.L. 2018, c. 136, sunsets (April 2024), then the authority for the program parameter to forfeit DSH payments for the Medicaid payments associated with the County Option Hospital Fee Pilot Program will no longer exist.

33. COMMENT: The commenters asked if the hospital authorized reduction in the DSH payments is an annual authorization or for the entire program period.

RESPONSE: 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 potential reduction to the hospital's Medicaid DSH payments, including Charity Care payments, to the extent necessary to comply with payment limits outlined at Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4). This attestation will cover the entire program period unless the county proposes "to amend its approved Fee and Expenditure Report … by submitting a proposed amendment to its Fee and Expenditure Report to the Commissioner for review and approval," which it may choose to do annually. Each subsequent submission of the Fee and Expenditure Report must contain all necessary documents, including updated attestations.

34. COMMENT: A commenter stated that the anticipated flexibility provided to counties to develop their own county-specific proposed Fee and Expenditure Report is supported. For the purpose of clarification, can the Department confirm that the use of the phrase "at the Department's discretion" within the 3rd paragraph of the notice of proposal Summary (complete sentence for reference: "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 organization (MCO) or directly to hospitals using fee-for-service payments, or a combination of the two mechanisms, at the Department's discretion.") indicates that the Department will be reviewing and approving the county's proposed allocation (between FFS and MCO) and hospital payment methodology and does not mean the Department will set the allocation nor develop the hospital payment methodology?

35. COMMENT: A commenter asked for clarification and confirmation that the Department will not determine the allocation between Medicaid fee-for-service and/or Medicaid managed care, nor develop the payment methodology in either delivery system. But rather, the Department will implement the county-designed allocation and hospital payment methodology as developed by the county, described within the Fee and Expenditure Report and approved by the Department and CMS.

RESPONSE TO COMMENTS 34 AND 35: The Department is not planning to proactively set allocations or methodologies. 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. The Department will notify counties of non-compliance with Federal rules as part of its review of the proposed Fee and Expenditure Report and may seek to amend the proposed Fee and Expenditure Report, as necessary.

36. COMMENT: A commenter noted that proposed N.J.A.C. 10:52B-2.1(c) through (g) outlines the State's approval determination process and specifies a fee may only be collected from an assessed hospital to the extent, and for the period, that the Department has determined the fee proceeds qualify as the non-Federal share of Medicaid expenditures. For the purpose of clarification, can the Department confirm what documents CMS needs to review and approve prior to county assessment and program implementation?

RESPONSE: The documents submitted to CMS depend on how the assessment program and the Medicaid payments are designed. For fee-for-service payments created under a pilot program, a State Plan Amendment must be submitted to CMS for approval. If payments are to be made through an MCO under the pilot program, a pre-print describing the payment and its rationale, in detail, must be submitted to CMS for approval. If the design of the fee is either non-broad based or non-uniform, a waiver must be submitted to CMS for approval.

37. COMMENT: A commenter noted that 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. For the purpose of clarification, can the Department confirm that the list of the three items are not exclusive of each other and that the use of "or" at the

end of paragraph (b)2, could be replaced with "and/or" as is articulated in the notice of proposal Summary.

RESPONSE: The commenter is correct and the rule will be changed upon adoption to replace "or" with "and/or" to be consistent with, and for the reasons stated in, the notice of proposal Summary.

38. COMMENT: A commenter noted that proposed N.J.A.C. 10:52B-3.3(c) regulates the statute language of P.L. 2018, c. 136, specifically prohibiting the Department from using the proceeds to supplant or offset current or future State funds allocated to a participating county. For the purpose of clarification, can the Department provide the citation and language that is included in the proposed regulation that implements the similar statutory language of P.L. 2018, c. 136, as it pertains to hospital funding, specifically "Payments distributed to hospitals pursuant to this act shall not supplant or offset any current or future funds paid to hospitals through other State or federal funding mechanisms or pools."

RESPONSE: P.L. 2018, c. 136, provides that payments through a pilot program shall not supplant or offset other hospital payments. However, under Federal law hospitals are not permitted to receive DSH payments in excess of their hospital specific DSH limits. Under P.L. 2018, c. 136, the stated purpose of the County Option Hospital Fee Pilot Program is "to increase financial resources through the Medicaid program to support local hospitals …" Since the purpose of the program is to provide additional Medicaid funding to hospitals to serve residents, the funding must comply with all applicable rules and regulations related to the Medicaid program. As the single state agency administering the Medicaid program, the Department is obligated to comply with these Federal rules, including the Federal limits imposed on DSH payments.

39. COMMENT: A commenter noted that CMS recently proposed a fiscal accountability rule designed to increase oversight and transparency in Medicaid supplemental payment programs and states' financing of these programs including intergovernmental transfer (IGT) programs. 84 Fed. Reg. 63722 (Nov. 18, 2019). Considering the rule's potential impact on the County Option Hospital Fee Pilot Program, most specifically on New Jersey's use of provider assessments and an intergovernmental tax to draw down enhanced Federal dollars, the Department should consider the potential impact of the rule and create a mechanism to reevaluate the State's program and its appropriateness when the rule is adopted.

RESPONSE: Because the Department always monitors legislation, rules, and guidance to ensure Medicaid-related programs meet the requirements of both State and Federal law, there is no need currently to alter the rule, but will do so in the future if needed.

40. COMMENT: A commenter suggested that all acute care hospitals should be held to the same formula when calculating assessments and allowed payment distributions, giving no one hospital an economic advantage based on a defined exception, such as a Level One Trauma Center, a school of medicine located in a defined county, etc.

RESPONSE: Under the County Option Hospital Fee Pilot Program, the assessment is designed by the county. The county may choose to treat distinct types of hospitals differently, as well as to include or exclude hospitals from its assessment program, so long as the overall design is in compliance with the Federal rules related to health care-related taxes and a waiver of the broad-based requirements is secured from CMS.

The county may also propose the basis and formula for the distribution of payments created under its assessment program. However, these payments are also subject to Federal Medicaid rules and payment limitations such as the Medicare upper payment limit under fee-for-service and actuarial soundness under managed care.

41. COMMENT: A commenter stated that the rules and regulations should continue to be developed in conjunction with the hospitals. Hospitals should continue to be included and work with the Department of Human Services Division of Medical Assistance and Health Services (DMAHS) on design and implementation of the program.

RESPONSE: The Department will maintain communication regarding this program with the counties and the hospitals and if the need for additional guidance is identified, the agency will work to provide it in a timely manner.

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 adopted 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.

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

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]* ***and/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.

(a)

OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY

Notice of Readoption

Manual of Standards for Community Care Residences

Readoption: N.J.A.C. 10:44B

Authority: N.J.S.A. 30:11B-1 et seq., specifically 30:11B-4.4.

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

Effective Date: February 19, 2020.

New Expiration Date: February 19, 2027.

Take notice that this chapter, which was scheduled to expire on March 19, 2020, pursuant to N.J.S.A. 52:14B-5.1.c, is being readopted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. This chapter contains the rules to establish minimum requirements for the provision of residential services to individuals with developmental disabilities residing in Community Care Residences.

The Department of Human Services (Department) recognizes that further rulemaking is necessary to update this chapter to be consistent with best practices and to include the provisions of the Fee for Services Initiative; the Centers for Medicare and Medicaid Services guidelines for funding; the Central Registry of Offenders Against Individuals with Developmental Disabilities (N.J.S.A. 30:4D-77); P.L. 2017 c. 328 (an act concerning background checks and licensing of certain entities); Stephen Komninos' Law (P.L. 2017 c. 238); and updated organizational changes. To that end, the Department is preparing a rulemaking with substantive amendments to be published in a future issue of the New Jersey Register.

The Department has reviewed the rules and has determined them to be necessary, reasonable, and proper for the purposes for which they were originally promulgated. The rules set minimum requirements that are necessary to implement the Department's statutory mandate to license Community Care Residences for individuals with developmental disabilities. In accordance with N.J.S.A. 52:14B-5.1.c(1), these rules should be readopted and continue in effect for a seven-year period (and as anticipated to be revised).

The following are summaries of the subchapters of N.J.A.C. 10:44B:

Subchapter 1, General Provisions, provides the purpose and scope of the chapter which is to protect the health, safety, welfare, and rights of individuals with developmental disabilities when living in community care residences. Terms used throughout the chapter are defined. The subchapter also includes rules for licensing, including inspection, as well as negative licensing actions, such as: denial, suspension, or revocation due to non-compliance with State and/or Federal laws that govern community care residences.

Subchapter 2, Management of the Residence, includes rules that detail the requirements for licensees, the process and boundaries for the placement and departure of a community care resident, the requirements regarding an alternate who will assume the role and responsibility of a community care residence when the licensee is absent, as well as the licensee's reporting/disclosure requirements including, but not limited to: mistreatment, hospitalization, death, police activity in the residence, changes to the contact information of the residence, and/or whether the licensee has plans to voluntarily discontinue operation of a community care residence.

Subchapter 2A, Records, includes rules setting forth the requirements for maintaining licensee records that must be kept at the residence, as well as the documentation, maintenance, and confidentiality requirements for the records of the community care residents.

Subchapter 3, Care of the Individual, provides rules to ensure individuals in community residences are not prohibited from exercising their human, legal, and civil rights and that they are provided information about their rights. This subchapter also includes rules governing the community care resident's personal funds, health, and hygiene, as well as the provision of food and clothing.

Subchapter 4, Habilitation, includes rules that provide the requirements for service plans developed for each community care individual by the interdisciplinary team, as well as guidance for daily activities, such as education, employment, rehabilitation, and/or chores in the home.

Subchapter 5, Health Services, sets forth requirements for medical and health care including requirements that individuals in the community care residences have appropriate medical providers (that is, doctors, advance practice nurses, dentists, etc.), have had the appropriate medical screening exams and keep up with necessary follow ups, as well as the compliance with the requirement for the residence to have a first aid kit available on-site. This subsection also provides requirements for medication including administration when the IDT and service plan state that the individual cannot take their medication on their own, storage, and documentation and recordkeeping.

SFY23 – NJ County Option

Counties/Participating Hospitals:

- Atlantic
  - Acuity Specialty Hospital of NJ
  - Atlanticare Regional Medical Center - City Campus and Mainland Campus
  - Bacharach Institute for Rehabilitation
  - Shore Medical Center
- Camden
  - Cooper University Hospital Medical Center
  - Jefferson Cherry Hill Hospital/Jefferson Stratford Hospital
  - Northbrook Behavioral Health Hospital
  - Virtua Our Lady of Lourdes Hospital
  - Virtua – West Jersey Hospital Voorhees
- Essex
  - Clara Maass Medical Center
  - East Orange General Hospital
  - Hackensack UMC Mountainside
  - Kessler Institute for Rehabilitation – West Orange
  - Newark Beth Israel Medical Center
  - St. Barnabas Medical Center
  - St. Michael's Medical Center
  - Silver Lake Hospital LTACH
  - University Hospital
- Hudson
  - CarePoint Health - Bayonne Medical Center
  - CarePoint Health - Christ Hospital
  - CarePoint Health - Hoboken University Medical Center
  - Hudson Regional Hospital
  - Jersey City Medical Center
  - Palisades Medical Center
- Mercer
  - Capital Health Medical Center – Hopewell
  - Capital Health Regional Medical Center
  - Princeton House Behavioral Health
  - Robert Wood Johnson University Hospital at Hamilton
  - St. Francis Medical Center
  - St. Lawrence Rehabilitation Center
- Middlesex
  - Children's Specialized Hospital
  - JFK Medical Center
  - LTACH CareOne at St. Peter's University Hospital
  - Penn Medicine Princeton Medical Center
  - Raritan Bay Medical Center - Perth Amboy and Old Bridge

    - Robert Wood Johnson University Hospital
    - St. Peter's University Hospital
- Passaic
    - Kindred Hospital New Jersey-Wayne
    - St. Joseph's - University Medical Center and Wayne Medical Center
    - St. Mary's General Hospital

Appendix S

County	Hospital Name	Medicare ID	Primary NPI Number for the Hospital	Billing NPI to Which Aetna Should Issue Payment	Billing NPI to Which Amerigroup Should Issue Payment	Billing NPI to Which Horizon Should Issue Payment	Billing NPI to Which United Should Issue Payment	Billing NPI to Which Wellcare Should Issue Payment	Hospital / System Name to Which Payments Will be Issued	Contact Name of Hospital Personnel Responsible for Payment Processing	Contact Phone Number of Hospital Personnel Responsible for Payment Processing	Contact Mailing Address of Hospital Personnel Responsible for Payment Processing