

Date: 12/06/2024

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

County: Cumberland

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?

The fee program has a proposed effective date of July 1, 2025.

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

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

Attachment 1 contains a list of all hospitals licensed and located in Cumberland County.

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

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

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

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)

N/A

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.

Attachment 2 outlines the consultative activities conducted by Cumberland County to engage affected hospitals prior to submitting the Fee and Expenditure Report.

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

The fee will be assessed based on each hospital's annualized inpatient non-Medicare discharges and outpatient net patient revenue. Each hospital's inpatient non-Medicare discharges are calculated by subtracting inpatient Medicare discharges from inpatient total discharges reported on the Medicare cost report (CMS Form 2552-10) Worksheet S-3 Part I. Each hospital's net patient revenue is determined from the Medicare hospital cost report (CMS Form 2552-10) and shown on attachment 7. As applicable, reported data is adjusted to exclude activity that occurred outside the borders of Cumberland County. The proposed fee is based on Medicare hospital cost reports for fiscal years ending in calendar year 2023. Data from cost reports that are less than or more than an annual period are annualized. Net patient revenue is inflated from the mid-point of the cost report period to the mid-point of the payment period and adjusted to account for revenue anticipated from this program (see attachment 8).

The inpatient fee amount is derived by multiplying an inpatient assessment rate developed by Cumberland County by each hospital's in-county annualized non-Medicare discharges. The inpatient assessment rate is \$2,459.08 for each non-Medicare discharge. The outpatient assessment rate is six percent (6%) of each hospital's in-county annualized outpatient net patient revenue. Combined, the assessments do not exceed the maximum permissible under the authorizing state legislation of the County Option Hospital Fee Program, currently 5% of hospital net patient revenue. Inpatient and outpatient net patient revenue are derived from each hospital's Medicare hospital cost report (CMS Form 2552-10).

Attachment 3 contains the County's proposed hospital assessment fee. Attachment 4 contains the data elements used for the proposed hospital assessment fee calculation.

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

Yes; the inpatient proposed fee excludes Medicare 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.

The proposed fee rate is \$2,459.08 per inpatient non-Medicare discharge and 6% per annualized outpatient net patient revenue dollar. The proposed fee amount for each assessed hospital is equal to 5% of annualized in-county inpatient and outpatient net patient revenue. For the fee period effective July 1, 2025, the total fee is estimated to be approximately \$32.7 million.

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.

Yes, a uniform fee rate is applied across all participating hospitals.

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?

If a hospital does not pay the quarterly assessment within 10 days after the assessment payment is due, the County will impose interest penalties at a rate not to exceed 1.5 percent of the outstanding payment amount per month.

Written notice will be provided to each hospital monthly indicating the interest accrued and total interest due.

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

The county will notify each hospital in writing through a fee notification letter of the amount of the hospital's assessment. If the hospital identifies an error in the computation of the fee or an error in the Medicare hospital cost report data reported by the hospital, the hospital may request an appeal. In addition, in the event of late payment, the county will notify each hospital on a monthly basis of the amount of the hospital's assessed interest penalties. If the hospital disagrees with the amount of the interest penalty, the hospital may file an appeal. The hospital may not appeal the fee methodology or any other aspect of the fee program.

An appeal must be submitted to the county in writing and must describe the specific issues being appealed and the rationale for the hospital's position. The appeal must be signed by an authorized representative of the hospital and must be filed within fifteen (15) days after the receipt of the assessment notice or within fifteen (15) days after the receipt of the notice of interest penalties.

Upon receipt of the request for appeal, the county will evaluate the information presented. After review, the county may amend the applicable assessment or interest penalties or affirm the original decision. The county will notify the hospital of its decision in writing within thirty (30) days of the receipt of the request for appeal.

If dissatisfied with the county's response, the hospital may request a formal administrative hearing. The request for a formal administrative hearing must be filed with the county within fifteen (15) days after the receipt of the county's response to the initial appeal. The county will notify the hospital at least thirty (30) days in advance of the hearing date. Within sixty (60) days of the completion of the hearing procedures, the hearing officer will prepare a written summary of findings and make a written recommendation to the County Administrator of action to be taken by the county. The County Administrator, upon a review of the proceedings and recommendation by the hearing officer, will issue a final administrative decision.

Unless the County receives a timely and proper request for an appeal and administrative hearing from the hospital, the county decision shall not be subject to review.

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

Following notification of approval of the fee program from the Department and county adoption, the fees will be communicated to hospitals in writing. Hospitals will receive a fee notification letter communicating the fee and the amount of the required quarterly payments. The fee notification letter will be sent to hospitals prior to the beginning of each annual fee period corresponding to the state fiscal year, unless there are program delays outside of the county's control (such as delays from the Department or CMS).

The fee notification letter 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.

An invoice will be issued via e-mail to each hospital at least 20 days in advance of each payment due showing the current amount due, past due amounts, interest penalties, submission information and the due date.

Overpayments arising from an error on the part of the County (such as the assessment of an incorrect fee amount) or an error on the part of a hospital (such as payment of an incorrect fee amount) will be refunded to hospitals within 15 days of identifying the amount of the overpayment. The County will specify in its ordinance or resolution the time frame in which a hospital must identify overpayments or amounts otherwise in error.

In the event the Department returns any of the transferred funds, the 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 of the funds.

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

Quarterly, not later than 15 days before the close of each quarter of the State fiscal year, a portion of the fee proceeds will be transferred to cover State administrative costs, in the amount set forth by the State, and to be used as non-Federal share of Medicaid/NJ FamilyCare payments to hospitals in Cumberland County. Cumberland County will issue quarterly intergovernmental transfers to the State equal to 91 percent of the fee proceeds and will retain nine percent of the proceeds in the county.

This fee shall be collected by the county in accordance with its approved fee and expenditure report and 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.

If a hospital that is assessed a fee fails to remit payment to the assessing county, then the assessing county shall have no obligation to transfer funds to the State applicable to uncollected assessments. Upon collection, the State's portion of delinquent assessments will be transferred to the Department not later than 15 days after the close of the quarter in which the collections are received by the county.

In accordance with N.J.A.C. 10:52B-3.4, Cumberland County is proposing a fee based on publicly available data sources, through the Medicare hospital cost report (CMS Form 2552-10) or its successor form. The Medicare cost report will be supplemented by financial information submitted by the hospital to remove data associated with services outside of county borders.

In the Other County Requirements section of this form, below, the county must indicate completion and/or agreement with a list of statements. In the first check box, the county must attest to having provided the state with all calculations for the fee, the proposed payments, and the statistical test. The County's fee proposal is broad-based and uniform and does not require a statistical test; therefore, no statistical test is included with this submission. Furthermore, in the third and fourth check boxes, the county must attest to an understanding that at least 90 percent of the fee amounts collected will be transferred to the state to be

used as the non-federal share for federally matched hospital payments and at least one percent of the fee amounts collected will be transferred to the state for the state's administrative costs. The County confirms agreement that funds of at least 90 percent plus one percent must be transferred to the state. However, it is the county's understanding that some portion of the 90 percent may be retained for the state's or the managed care organizations' administrative costs, leaving a percentage less than 90 percent for distribution to hospitals. Finally, in the last check box, the county must confirm completion of a Data Form, a Preliminary DSH Calculation Template, and an Attestation signed by each hospital located in the county. All forms received from participating hospitals have been remitted with this report. DSH forms are included with this submission for all applicable hospitals that participate in the DSH program.

The County requests the opportunity to amend this proposed fee and expenditure report to meet the necessary requirements for participation, should the Department determine that this proposal does not meet requirements and to address comments received during the comment period that may lead to disapproval of the report.

The County reserves the right to propose an amendment of its approved fee and expenditure report annually.

PROPOSED PAYMENT PROGRAM

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

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

The fee assessed and collected as described in the Fee Program section, above, will qualify as the non-Federal share of Medicaid/NJ FamilyCare program expenditures. The proposed program payment methodology for Cumberland County hospitals is a Medicaid managed care directed payment, in compliance with federal regulations at 42 C.F.R. §438.6.

Consistent with 42 C.F.R. §438.6(c)(1)(iii)(B), Medicaid health plans will provide a uniform inpatient payment per day to Cumberland County hospitals. This fee and expenditure program is designed to enhance service delivery to New Jersey Medicaid patients through the Cumberland County hospitals.

The uniform amount per inpatient day is proposed at \$3,814.30, fixed for the state fiscal year.

Historical utilization data will be used to directly link payments to utilization of inpatient and outpatient services for plan enrollees, by hospital. The Department will calculate each Cumberland County hospital's annual payment increase by MCO using the projected number of encounters for the year. DMAHS will then issue quarterly supplemental capitation payments to each Medicaid health plan to cover the cost of the payments to hospitals, based on the volume of inpatient and outpatient services expected to be provided to the health plan's enrollees and the payment per discharge and payment per outpatient visit for the hospitals. In turn, MCOs will be directed to distribute quarterly payments to hospitals using prepared projections of inpatient and outpatient services and the applicable payment per discharge and visit.

A year-end utilization reconciliation will take place within the first two quarters of the following payment year (managed care rating year), based on updates of actual utilization for the payment year. The reconciliation will occur so that the uniform payment amounts will be distributed to MCOs, and in turn to each hospital, in accordance with actual utilization data for the payment year.

For each year of the directed payments program, the uniform payments per inpatient and outpatient unit will be calculated to ensure the available funding for this program is used for hospital payments in Cumberland County and to ensure that payments do not exceed the available funding.

The uniform dollar amount per day for inpatient services for the contract year is projected to be \$3,814.30, based on one hundred percent of the available funding through the Cumberland County hospital fee program.

To ensure compliance with 42 CFR §438.6(c), the County has prepared an estimate of commercial payments for Medicaid managed care services using hospital commercial payment data and the Medicaid managed care utilization data provided by the state. Based on an average commercial payment-per-day methodology, Cumberland County estimates that current base Medicaid managed care inpatient payments for hospitals are approximately 20% of commercial payment levels. The County

estimates that the proposed uniform inpatient dollar increase for inpatient services would result in Medicaid inpatient managed care payments for hospitals that are approximately 47% of commercial payment levels. Therefore, the proposed uniform inpatient dollar increase for inpatient services would fall below the estimated commercial upper payment limit for inpatient services.

To ensure compliance with 42 CFR §433.68(f), the fee will not create a direct or indirect guarantee to hold affected hospitals harmless. Whereas the fee will be used for funding the state match of Medicaid payments based on net patient revenues, payments to hospitals will be based on utilization using Medicaid managed care inpatient days and outpatient visits.

Attachment 5 contains Cumberland County's proposed hospital expenditures model. Attachment 6 contains the encounter data used for the proposed hospital payments calculation.

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

The additional Medicaid reimbursement generated by the County Option Hospital Fee Program will provide meaningful additional financial resources to support Cumberland County's hospitals to ensure that they continue to provide the necessary services to low-income residents. The financial impact of Cumberland County's proposed fee and expenditure report will not reduce access to Medicaid services, reduce services to the uninsured, or otherwise threaten critical health care services at any hospital within the county. In fact, the proposed fee and resulting Medicaid payments are anticipated to enhance hospitals' ability to serve low-income residents.

Each hospital will have increased incentive to serve low-income residents, due to the increased payments per inpatient discharge. The hospital payment increase will help ensure hospitals remain dedicated at the current level in providing services to Medicaid beneficiaries. The payment incentive for each Medicaid managed care hospital inpatient discharge is anticipated to maintain and improve access to hospital care and related necessary services for this population.

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 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:

Jeffrey T. Ridgway

Full Name (Printed)

Title:

CFO / Treasurer

Date:

12/6/2024

Email Address:

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