

**Date:** 12/6/2024

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

**County:** Mercer County

#### GENERAL

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

#### FEE PROGRAM

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

July 1, 2025

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

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

Please see "Attachment A" for full list of hospitals located in Mercer 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)

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

Beginning with the first program year, the County, through its contractor, Eyman Partners, implemented a comprehensive process of educating, consulting with, and gathering feedback from all hospitals within the jurisdiction, and developing criteria to evaluate potential models. Those criteria continue to inform the model development process for the current year. For SFY26, the County has collected updated data from the hospitals to reevaluate the model (both assessment and payment bases) and has involved the hospitals throughout this process. Informed by insights from the original modeling process, we reviewed the impact of updated data on the current model, identified any deviations from the guidelines/priorities we set out in creating the initial model, and then reviewed targeted additional options to address those deviations. We shared this information with the hospitals by email and video call and gathered their feedback to inform design of the program for SFY26. We also provided support to the hospitals to complete the required forms.

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

The County proposes to assess a fee on inpatient hospital services, structured as a percentage of non-Medicare net inpatient service revenues for services furnished within the County's jurisdiction. Those hospitals that have provider-based facilities located outside the county, have segregated their in-county from out-of-county services and only the services provided within the County will be assessed. The County has used calendar year 2023 data, inflated through 2026, as the source for calculating the fees.

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

Yes, the fee is on net inpatient hospital service revenues excluding Medicare revenues.

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 rate will be 7.88% of non-Medicare net revenues for inpatient hospital services.

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

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

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

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

- Permissible health care-related taxes.

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

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

☒ Quarterly

☐ Monthly

☐ Biannually

☐ Other \_\_\_\_\_

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

In the event a hospital fails to remit the fee by the due date, the County may apply interest to the amount due, not to exceed 1.5% of the outstanding payment amount per month, reflected on the following quarter's invoice.

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

Upon federal approval of the program, the County will officially notify hospitals that the fee program will take effect, and of the amount of the quarterly fee they will be required to pay throughout the program. The hospitals will have 15 days from receipt of that notice to contest the fee amount, by submitting a letter, including any supporting documents, to the County specifying the basis for the appeal.

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

In addition to the annual notice notifying the hospitals that the fee program will take effect, and of the annual quarterly fee amounts they will be required to pay under the program, the County will send each hospital quarterly invoices notifying them of their fee obligation and the payment at least 20 days in advance of each quarterly due date.

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

The County proposes that the amount of the assessment collected from Princeton House, a Mercer County location of Penn Medicine-Princeton, based in Middlesex County (after taking into account applicable fee withholdings) be utilized for County Option payments made to Mercer County hospitals, as the services provided at Princeton House will be paid through the Mercer County program.

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

## PROPOSED PAYMENT PROGRAM

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

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

The County proposes a state directed payment to be implemented as a uniform increase to Medicaid Managed Care inpatient payments across two classes of hospitals: acute and non-acute hospitals to account for differences in acuity between the two classes. The County also proposes a uniform increase to Medicaid Managed Care outpatient payments for the acute class of hospitals. The increase in inpatient payments would be implemented as a per discharge add-on of \$23,945.40 for acute care hospitals with main campuses in Mercer County and \$231,354 per discharge for the non-acute care hospital with a main campus in Mercer County (Lawrence Rehabilitation). The increase in outpatient payments for the acute class would be implemented as a per visit add-on of \$894.07. While the imposition of the fee is limited to services furnished within the County, the directed payment would include all inpatient hospital services provided by the hospital, regardless of the location of the services.

The inpatient payments have been calculated using an estimated Federal Medical Assistance Percentage (FMAP) of 67.85% for the acute class and 70% for the non-acute class. The outpatient payment for the acute class of hospitals has been calculated using an estimated FMAP of 68.3%. In each case, we began by calculating the FMAP based on the mix of Medicaid, expansion and CHIP patients in the state's CY2023 data.

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

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

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

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

## OTHER COUNTY REQUIREMENTS

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

- ☒ The county has provided the state with all calculations for the fee, the proposed payments, and the statistical test.
- ☒ The county understands that the funds created from this program are to increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals in providing necessary services to low-income residents.
- ☒ The county understands that at least 90% of the fee amounts collected will be transferred to the state to be used as the non-federal share for federally matched hospital payments.
- ☒ The county understands that at least 1% of the fee amounts collected will be transferred to the state for the state's administrative costs.
- ☒ The county understands that fees to be collected may not exceed <sup>5%</sup>~~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:

CHRISTOPHER R. MARION

Full Name (Printed)

Title:

COUNTY ADMINISTRATOR

Date: 12 / 05 / 2020

Email Address:

cmarion@mercercounty.org

## **Attachment A**

### **New Jersey County Option Hospital Fee Program List of hospitals located in Mercer County**

#### **Capital Health Medical Center - Hopewell**

One Capital Way  
Pennington, NJ 08534  
General Acute  
Non-profit

#### **Capital Health Regional Medical Center**

750 Brunswick Ave  
Trenton, NJ 08638  
General Acute  
Non-profit

#### **Robert Wood Johnson University Hospital - Hamilton**

One Hamilton Health Place  
Hamilton, NJ 08690  
General Acute  
Non-profit

#### **St Lawrence Rehabilitation Center**

2381 Lawrenceville Road  
Lawrenceville, NJ 08648  
Comprehensive Rehabilitation  
Non-Profit

#### **Princeton House Behavioral Health**

905 Herrontown Road  
Princeton, NJ 08540  
Psychiatric Hospital  
Non-profit

# MERCER COUNTY HOSPITAL FEE

11/29/2024

**Fee Basis:** 7.88% of Non-Medicare Net Inpatient Service Revenue

## State Directed Medicaid Managed Care Payments

*Acute Care Hospitals* : \$23,945.40 per discharge (inpatient) and \$894.07 per visit (outpatient)

*Non-Acute Care Hospitals* : \$231,354 per discharge

<b>Total Fee Receipts</b>	<b>\$72,149,295</b>
<b>County's Resource</b>	<b>\$6,493,437</b>
State's Resource	\$721,493
<i>Non-federal Share of Medicaid Payments</i>	<i>\$64,934,365</i>

HOSPITAL	Fees Paid	Medicaid State-Directed Payments	Lost DSH Payments
Capital Health Regional MC	\$26,814,725	\$66,944,589	\$0
Capital Health MC Hopewell	\$36,846,129	\$86,418,905	\$0
RWJUH-Hamilton	\$4,536,574	\$26,055,520	\$0
Lawrence Rehabilitation (Non-acute)	\$296,251	\$1,850,838	\$0
	<b>\$68,493,679</b>	<b>\$181,269,853</b>	<b>\$0</b>
Penn Medicine - Princeton House	\$3,655,616	\$0	\$0



# MERCER COUNTY HOSPITAL FEE

11/29/2024

**Fee Basis:** 7.88% of Non-Medicare Net Inpatient Service Revenue

## State Directed Medicaid Managed Care Payments

*Acute Care Hospitals* : \$23,945.40 per discharge (inpatient) and \$894.07 per visit (outpatient)

*Non-Acute Care Hospitals* : \$231,354 per discharge

7.88%	Inpatient Fee Rate
-------	--------------------

		a	b	c = a - b	d = c * 7.88%	
	HOSPITAL	All Payer IP NPSR	Medicare IP NPSR	Revenue Basis	Fee Receipts	
INPATIENT	Capital Health Regional MC	\$395,277,781	\$54,920,548	\$340,357,233	\$26,814,725	
	Capital Health MC Hopewell	\$531,028,178	\$63,343,109	\$467,685,069	\$36,846,129	
	RWJUH-Hamilton	\$108,629,544	\$51,047,165	\$57,582,379	\$4,536,574	
	Lawrence Rehabilitation	\$19,809,269	\$16,048,974	\$3,760,295	\$296,251	
	Princeton House	\$52,622,098	\$6,221,643	\$46,400,454	\$3,655,616	
	<b>Total IP</b>	<b>\$1,107,366,869</b>	<b>\$191,581,440</b>	<b>\$915,785,430</b>	<b>\$72,149,295</b>	e
				<b>Total Fee Receipts</b>	<b>\$72,149,295</b>	f = e
				County Resource	\$6,493,437	g = f * 9%
				State Resource	\$721,493	h = f * 1%
				State Share Medicaid Payments	\$64,934,365	i = f - g - h
	State Share Medicaid Payments for Middlesex County Hospitals			\$3,290,055	j = 90% Princeton House Fee	
	State Share Medicaid Payments for Mercer County Hospitals			\$61,644,311	k = i - j	
	State Share Medicaid IPH Payments for Acute Mercer County Hospitals			\$34,052,762	l	
	Est Effective FMAP			67.85%	m	
	State + Federal Share of Medicaid Acute IPH Payments			\$105,905,503	n = l / (1 - m)	
	6% HMO Admin Fee			\$6,460,236	o = n * 6.1%	
	State + Federal Share of Medicaid IPH Payments Going to Acute Hospitals			\$99,445,267	p = n - o	
	State Share Medicaid IPH Payments for Mercer County Non-Acute Hospitals			\$591,322	r	
	Est Effective FMAP			70.00%	s	
	State + Federal Share of Medicaid Non-acute IPH Payments			\$1,971,074	t = r / (1 - s)	
	6% HMO Admin Fee			\$120,235	u = t * 6.1%	
	State + Federal Share of Medicaid IPH Payments Going to Non-Acute Hospitals			\$1,850,838	v = t - u	
	State Share Medicaid OPH Payments for Mercer County Acute Hospitals			\$27,000,227	w = k - l - r	
	Est Effective FMAP			68.30%	x	
	State + Federal Share of Medicaid Acute OPH Payments			\$85,169,060	y = w / (1 - x)	
	6% HMO Admin Fee			\$5,195,313	z = y * 6.1%	
	State + Federal Share of Medicaid OPH Payments Going to Acute Hospitals			\$79,973,747	a = y - z	

# MERCER COUNTY HOSPITAL FEE

11/29/2024

**Fee Basis:** 7.88% of Non-Medicare Net Inpatient Service Revenue

## State Directed Medicaid Managed Care Payments

*Acute Care Hospitals* : \$23,945.40 per discharge (inpatient) and \$894.07 per visit (outpatient)

*Non-Acute Care Hospitals* : \$231,354 per discharge

Total Inpatient Hospital Enhanced Payments	\$99,445,267	<i>a</i>
<i>Inpatient Hospital Add-On Payment</i>	\$23,945.41	<i>b = a / g<sub>sum</sub></i>
Total Outpatient Hospital Enhanced Payments	\$79,973,747	<i>c</i>
<i>Outpatient Hospital Add-On Payment</i>	\$894.07	<i>d = c / i<sub>sum</sub></i>
Total Inpatient Hospital Enhanced Payments	\$1,850,838	<i>e</i>
<i>Inpatient Hospital Add-On Payment</i>	\$231,354.78	<i>f = w / k<sub>sum</sub></i>
Total Outpatient Hospital Enhanced Payments		
<i>Outpatient Hospital Add-On Payment</i>		

## ACUTE HOSPITAL PAYMENT INCREASE

HOSPITAL	DISCHARGES	PAYMENTS	VISITS	PAYMENTS
Capital Health Regional MC	1,461	34,984,237	35,747	\$31,960,352
Capital Health MC Hopewell	2,166	51,865,747	38,647	\$34,553,158
RWJUH-Hamilton	526	12,595,283	15,055	\$13,460,237
	<b>4,153</b>	<b>\$99,445,267</b>	<b>89,449</b>	<b>\$79,973,747</b>

## NON-ACUTE HOSPITAL PAYMENT INCREASE

HOSPITAL	DISCHARGES	PAYMENTS	VISITS	PAYMENTS
Lawrence Rehabilitation	8	1,850,838		
	<b>8</b>	<b>\$1,850,838</b>		

HOSPITAL	Increased Medicaid Reimbursement	Fees Paid	DSH Room	Charity Care Payments	Lost DSH Payments
Capital Health Regional MC	\$66,944,589	\$26,814,725	\$85,796,390	\$6,453,169	\$0
Capital Health MC Hopewell	\$86,418,905	\$36,846,129	\$0		\$0
RWJUH-Hamilton	\$26,055,520	\$4,536,574	\$0		\$0
Lawrence Rehabilitation	\$1,850,838	\$296,251	\$0	\$0	\$0
	<b>\$181,269,853</b>	<b>\$68,493,679</b>			

*q = \$0; if m < o*

*q = -p; if m a > o AND if (m-o) > p*

*q = o - m; if m > o AND if (m-o) < p*

# MERCER COUNTY HOSPITAL FEE

11/29/2024

## State Cap Calculation

PER DATA FORM (Line 6 - Line 7)

	Inpatient	Outpatient
Capital Health Regional	\$363,882,695	\$121,825,851
Capital Health Hopewell	\$488,851,066	\$189,874,501
RWJUH-Hamilton	\$100,001,602	\$124,985,609
Lawrence Rehabilitation	\$18,235,910	\$1,675,961
Penn Med. - Princeton House	\$48,442,568	\$28,103,660

1.0863	Inflator
--------	----------

	Inpatient	Outpatient
Capital Health Regional	\$395,277,781	\$132,336,747
Capital Health Hopewell	\$531,028,178	\$206,256,501
RWJUH-Hamilton	\$108,629,544	\$135,769,122
Lawrence Rehabilitation	\$19,809,269	\$1,820,560
Penn Med. - Princeton House	\$52,622,098	\$30,528,389
	<b>\$1,107,366,869</b>	<b>\$506,711,318</b>

<b>\$1,614,078,187</b>	<b>Total Inflated NPSR</b>
<b>\$80,703,909.36</b>	<b>5% Revenue Cap</b>
<b>\$72,149,294.97</b>	<b>Max Revenue</b>

## ACR EQUIVALENT ANALYSIS

## ACUTE HOSPITALS

## Inpatient Hospital

Per Diem ACR Threshold		\$6,680.20	a
Aggregate CY23 Patient Days	23,455		
Medicaid HMO Payments	\$49,383,770.67	\$2,105.47	b
QIP-NJ	\$6,426,636.00	\$274.00	c
		\$2,379.47	d = b + c
<b>Remaining Room Under ACR Threshold (Pre County Option)</b>		<b>\$4,300.74</b>	<b>e = a - d</b>
County Option SDPs	\$99,445,267.41	\$4,239.83	f
Post County Option Remaining ACR Room		<b>\$60.90</b>	<b>g = e - f</b>

Percentage of ACR Equivalent	99.09%	$h = (d + f) / a$
------------------------------	--------	-------------------

## Outpatient Hospital

Per Diem ACR Threshold		\$1,730.87	j
Aggregate CY23 Visits	89,449		
Medicaid HMO Payments	\$59,773,742.34	\$668.24	k
Interim State Directed Payments	\$13,554,200.00	\$151.53	l
		\$819.77	m = k + l
<b>Remaining Room Under ACR Threshold (Pre County Option)</b>		<b>\$911.09</b>	<b>n = j - m</b>
County Option SDPs	\$79,973,747.03	\$894.07	o
Post County Option Remaining ACR Room		<b>\$17.02</b>	<b>p = n - o</b>

Percentage of ACR Equivalent	99.02%	$q = (m + o) / j$
------------------------------	--------	-------------------

## NON- ACUTE HOSPITALS

## Inpatient Hospital

Per Diem ACR Threshold		\$6,680.20	a
Aggregate CY23 Patient Days	826		
Medicaid HMO Payments	\$709,305.00	\$858.72	b
QIP-NJ		\$0.00	c
		\$858.72	d = b + c
<b>Remaining Room Under ACR Threshold (Pre County Option)</b>		<b>\$5,821.48</b>	<b>e = a - d</b>
County Option SDPs	\$1,850,838.20	\$2,240.72	f
Post County Option Remaining ACR Room		<b>\$3,580.76</b>	<b>g = e - f</b>

Percentage of ACR Equivalent	46.40%	$h = (d + f) / a$
------------------------------	--------	-------------------

## INFLATION FACTOR CALCULATION

**Summary Web Table - CMS Market Basket Index Levels and Four-Quarter Moving Average Percent Changes \***

Market Basket		Forecast	Forecast	Forecast
	2023	2024	2025	2026
	Q4	Q4	Q4	Q2
<b>2018-based Inpatient Hospital:</b>				
Index Levels	1.216	1.259	1.299	1.321

Inflation 1.035 1.032 1.017

**INFLATION FACTOR 1.0863**

Note: All market basket index levels do not reflect a productivity adjustment. The four-quarter moving average percent change of the 2017-based Medicare Economic Index reflects a productivity adjustment. Due to interpretation of the statute regarding the MEI update, the productivity adjustment has been shifted forward two quarters so the latest historical CY 2023 productivity adjustment is aligned with the 2024Q2 percent change in the MEI.

\* Quarterly index levels and four-quarter moving average percent changes are reported on a calendar year (CY) basis. For example, the Q4 index level corresponds with October 1 through December 31 and the Q4 four-quarter moving average percent change reflects the CY growth rate. Percent change moving averages are calculated using more than ten decimal places.

Source: IHS Global Inc. (IGI) 2024Q2 Forecast

Historical Data through 2024Q1

Released by CMS, OACT, National Health Statistics Group, dnhs@cms.hhs.gov

09/15/2024

**ATTESTATION****NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM**

**Hospital Name:** Penn Medicine Princeton Health (PMPH)

**CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR**

**On behalf of** PMPH **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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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 PMPH hospital.

Signature Gui Valladares  
Name [Handwritten Signature]  
Full Name (Printed)  
Title Sr VP Finance Date 11 / 12 / 24  
CFO

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).

## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name:

*Lawrence Rehabilitation Hospital*

### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of

*Lawrence Rehabilitation*

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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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

11/10/2024

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).

## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Roberty Wood Johson University Hospital-Hamilton

### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

**On behalf of** Roberty Wood Johson University Hospital-Hamilton **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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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 Robert Wood Johnson University Hospital-Hamilton hospital.

**Signature** Lisa Breze

**Name** Lisa Breze

Full Name (Printed)

**Title** President & CEO, Robert Wood Johnson University Hospital-Hamilton

**Date** 11 / 11 / 24

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).

## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Capital Health Medical Center - Hopewell

#### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Capital Health Medical Center - Hopewell 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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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 Capital Health Medical Center-Hopewell hospital.

Signature Deborah L Visconti

Name Deborah L Visconti  
Full Name (Printed)

Title Chief Revenue Officer Date 11 / 15 / 2024

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).



## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Capital Health Regional Medical Center

#### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Capital Health Regional Medical Center 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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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 Capital Health Regional Medical Center hospital.

Signature Deborah L Visconti

Name Deborah L Visconti  
Full Name (Printed)

Title Chief Revenue Officer Date 11 / 15 / 2024

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).