New Jersey County Option Hospital Fee Program
Operations Manual
Updated: August 2026

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 fourteen 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 expanded the eligibility criteria for participation in the program. On July 22, 2024, Governor Murphy enacted legislation increasing the cap on imposed fees and modified the definition of participating county further expanding the NJ County Option Hospital Fee Program.[3] The County Option Hospital Fee Program allows fourteen counties meeting certain criteria (Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union) 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

[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] A2264/S2552 (Approved P.L.2024, c.47

county programs. This legislation follows parameters established by federal authorities as outlined in Section 1903(w) of the Social Security Act,[4] 42 CFR 433.68,[5] and 42 CFR 433.51.[6]

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 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.

Changes to federal law via Pub. L. No. 119-21, H.R. 1, 119th Cong. (2025)[7] created limits and changes to the payments for all CMS State Directed Payments. These updates will be captured as they go into effect.

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.

Appendix A provides an exhaustive list of documents counties are required to submit for participation in the program. All documents may be found on the New Jersey County Option Hospital Fee Program website.

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

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

[5] 42 CFR 433.68 defines permissible health care-related taxes

[6] 42 CFR 433.51 authorizes the use of public funds transferred from local governments as the State share of Medicaid expenditures.

[7] Text - H.R.1 - 119th Congress (2025-2026): An act to provide for reconciliation pursuant to title II of H. Con. Res. 14. | Congress.gov | Library of Congress

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 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 hospital's 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 authorizing and outlining various details of the transfer of fees collected under the county's program to the Department to fund the non-federal share of the County Option hospital payments and Departmental administrative costs.

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

Use of Local Fee Proceeds

Subject to CMS approval, the Division of Medical Assistance and Health Services (DMAHS) will use the local hospital fees to fund Medicaid State Directed Payments (SDPs) through the State's Medicaid managed care organizations to hospitals in the participating counties. DMAHS will prepare the annual application (via preprints) for the SDPs for CMS approval, which will include a prior review by DMAHS's actuary**.**

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

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

Impact on DSH/Charity Care

Like other Medicaid payments, the SDPs funded through the NJ County Option Hospital Fee Program payments will be counted towards a hospital's DSH limit. Broadly speaking, the DSH limit represents the unreimbursed costs incurred by a hospital in serving Medicaid and uninsured clients, and above which the

federal government will not provide matching funds for DSH payments. As per guidance from the NJ Department of Health (DOH) disseminated in July 2022:

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

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

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 attest that they would forgo Charity Care payments if the receipt of County Fee Program payments is projected to generate total payments that exceed their DSH limit.

Non-Compliant Hospitals

To meet the federal standards of no hold harmless,[8] 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[9] and Ordinances/Resolutions[10] authorizing the same interest or penalties as noted above. All counties and/or their consultants should inform all hospitals in their jurisdiction if any hospital fails to submit the full amount of the assessment payment owed prior to reconciliation.

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.

[8] 42 CFR 433.68(f) defines the conditions under which a taxpayer will be considered to be held harmless under a tax program

[9] 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

[10] 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

Underpayment of IGT

If an IGT amount is less than what was expected from a specific county as outlined in the annual IGA agreement with the Department, OMB will alert the Department and their technical contractor of the actual amounts transferred. The State will temporarily fund the difference between the expected IGT, and the actual amount received so that DMAHS has sufficient funding to disburse the SDPs as approved by CMS. [11] 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.[12] The Department and the county will work together, as outlined in the IGA, to resolve any outstanding hospital assessment including interest or penalties or recouping unpaid assessment through other payments made by DMAHS.

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 and as outlined in the NJ FamilyCare Managed Care Contract[13]. Counties will be responsible annually for completing and submitting 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 B for Reconciliation/Payment Visual*

[11] N.J. Stat. § 30:4D-7tg

[12] 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

[13] NJ Medicaid & Managed Care | Division of Medical Assistance and Health Services

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) to make the SDPs to the hospitals.

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

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 measures that were mutually agreeable to all stakeholders; hospital performance on these measures for the first year of the program (SFY 2022) was reported with the SFY24 preprint submissions to capture a full program year of measures.

Quality Measures will be collected annually for CMS reporting purposes. While the landscape of the program and CMS requirements change, measures may be altered in future years as necessary.

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 quality evaluation measures, the State will be able to understand the impact of the payment arrangement over time. The State or its technical contractor request the quality measure reporting for the program year from the hospitals annually; the counties may choose to collect this information and submit it on behalf of the hospitals. DMAHS or its technical contractors can provide assistance to the hospitals in order to fulfill this program requirement. Participating hospitals (or counties on their behalf) may submit their quality reports to the Dmahs.hospcountyfee@dhs.nj.gov email address. The State's technical contractor is responsible for evaluating the quality data annually using the CMS Evaluation Findings Template.

CMS requires all directed payments to demonstrate that the payments are intended to advance at least one of the goals in the NJ State Quality Strategy.[14]

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

Future Program Years

F&E Reports Submission

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

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	Simone Valenti Daniel Bresnahan	ValentiS1@aetna.com Daniel.Bresnahan@aetna.com
Wellpoint	Eyreny Mekhaiel	eyreny.mekhaiel@wellpoint.com
Horizon	Jenny Goryachkovsky	Jenny_Goryachkovsky@horizonblue.com
United Healthcare	Ross Bauerly	ross_bauerly@uhc.com
Fidelis	Kristina Greiner	Kristina.Greiner@centene.com

Appendices

A. Required Documents
B. Reconciliation/Payment Visual

Appendix A: Required Documents

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

NJ County Option State Fiscal Year FMAP Distribution - Net of the MCO Tax
County A only (each county will have their own distribution model)

Note: All Sample Data
SFY1 = Current Fiscal Year; SFY2 = Following Fiscal Year

County A	Annual Assessment	Quarterly Assessment
Modeled Non-Federal share - Fixed Amount	**$27,367,558**	**$6,841,890**

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

Starting Point: Modeled Assessment values remain fixed for all of the submitted Fee & Expenditure (F&E) Report State Fiscal Year and are net of the County share, State share and MCO Tax.

Patient Days and/or Discharges are based on DMAHS Calendar Year (CY) MCO Encounters, through an annually defined payment date, with updated Encounter criteria to more accurately calculate days and discharges.

Annual Encounter days/discharges will be split into 4 equal quarters.

The initial SFY Medicaid Groups (Medicaid/Expansion/CHIP) were based on the Calendar Year 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.

	CY Quarterly MCO Patient Days Distribution				CY % 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		

	CY 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/SFY1 - Interim Payments

Assessment Received by the State By Mid Sept

Payment to Hospitals By Mid Oct

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	**65.00%**	$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%**
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

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 CY 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	$1,333.55	$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

1st quarterly payment, fixed Non-Fed share and 64% FMAP

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

Q2/SFY1 - Interim payments

Assessment received by State
By Mid Dec

Payment to Hospitals
By Mid Jan

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	**65.00%**	$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%**
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

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

2nd quarterly payment, fixed Non-Fed share and 64% FMAP.

Q3/SFY1 - Interim payments

Assessment received by State
By Mid March

Payment to Hospitals
By Mid April

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%**
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

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
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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/SFY1 - Interim payments

Assessment received by State
By Mid June

Payment to Hospitals
By Mid July

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%
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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 SFY1 Payments Made to Hospitals

FMAP at Year End:

Non-Federal:	$27,367,558	36.0%
Federal:	**$48,606,059**	**64.0%**
Total Quarterly payment:	$75,973,617	
Per Day payment:	**$1,333.55**	

Hospital	MCO Patient Days	Per Day payment	Payments	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	32,893	$1,333.55	$43,864,425	$4,825,087	$6,579,664	$21,932,213	$8,772,885	$1,754,577	$43,864,425
Hospital B	12,453	$1,333.55	$16,606,685	$4,151,671	$1,660,668	$4,982,005	$2,491,003	$3,321,337	$16,606,685
Hospital C	9,789	$1,333.55	$13,054,111	$1,305,411	$3,263,528	$2,610,822	$3,263,528	$2,610,822	$13,054,111
Hospital D	1,836	$1,333.55	$2,448,396	$489,679	$342,775	$367,259	$734,519	$514,163	$2,448,396
Total	56,971		$75,973,617	$10,771,848	$11,846,635	$29,892,300	$15,261,934	$8,200,899	$75,973,617

Prior to Reconciliation - Total Interim SFY payments of $75.9M made to hospitals based on the quarterly FMAPs and initial MCO Patient Days and MCO distribution. Interim SFY FMAP of 64%.

Following Q1/SFY2

Assessment received by State
By Mid Sept

Payment to Hospitals
By Mid Oct

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**

The same process will be followed in the new State Fiscal Year (SFY2). The new Interim Base Period may be updated, depending on the newly submitted F&E Reports.

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 SFY1 Utilization

	SFY1 MCO Patient Days Distribution				SFY1 % 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%

Based on the actual, updated SFY1 Day/Discharge allocation by the various Medicaid Groups, for each hospital and each MCO, a new County Average % Medicaid Group Distribution will be

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		

Average % Medicaid Group Distribution will be calculated. 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 SFY1 Interim payments totaled $75.9M and the final reconciliation will be compared to that initial payment.

SFY1 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%
Hospital D	25%	14%	10%	30%	21%

	SFY1 MCO Patient Days Distribution				SFY1 % 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		

FMAP at Quarterly payment:		**Non-Federal**	**Federal share @ Quarterly FMAP**	**Total Quarterly payment**
Medicaid	**50.0%**	$22,373,976	$22,373,976	$44,747,952
Expansion	**90.0%**	$2,548,934	$22,940,406	$25,489,340
CHIP	**65.00%**	$2,444,648	$4,540,061	$6,984,708
		$27,367,558	**$49,854,443**	**$77,222,001**

Non-Federal:	$27,367,558	35.4%
Federal:	**$49,854,443**	**64.6%**
Total Quarterly payment:	$77,222,001	100.0%
Per Day payment:	**$1,258.73**	

Weighted Avg FMAP	64.6%
Gross Payments	$77,222,001
non-Federal	$27,367,558
Federal	$49,854,443
Payment Per Day	$1,258.73

The Reconciled SFY1 FMAP is now 64.6%, based on actual SFY1 utilization.

Interim SFY1 FMAP and Payment:

64.0%

	Non-Federal	**Federal**	**Total Quarterly Payment**
Medicaid	$22,870,364	$22,870,364	$45,740,729
Expansion	$2,433,727	$21,903,541	$24,337,268
CHIP	$2,063,467	$3,832,153	$5,895,620
	$27,367,558	**$48,606,059**	**$75,973,617**

Actual SFY1 FMAP and Payment:

64.6%

	Non-Federal	**Federal @ Reconciliation**	**Total Quarterly Payment**
Medicaid	$22,373,976	$22,373,976	$44,747,952
Expansion	$2,548,934	$22,940,406	$25,489,340
CHIP	$2,444,648	$4,540,061	$6,984,708
	$27,367,558	**$49,854,443**	**$77,222,001**

	Non-Federal	Federal	Total	Total Days	Payment / Day
Interim Payments	$27,367,558	$48,606,059	$75,973,617	56,971	$1,333.55
	36.0%	64.0%	100%		

	Non-Federal	Federal	Total	Total Days	Payment / Day

An additional $1.25M will be distributed to the hospitals based on their updated Encounter Distribution. The Per Day Payment will reflect the impact of the updated Patient

Reconciliation Payments	$27,367,558	$49,854,443	$77,222,001	61,349	$1,258.73
	35.4%	64.6%	100%		
Reconciliation Impact	**$0**	**$1,248,384**	**$1,248,384**	**4,378**	

Impact of the updated Patient Days and increased FMAP. The overall actual SFY1 days increased, which caused a slight decrease in the Payment/Day.

SFY1 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	$1,258.73	$44,055,649	12%	18%	40%	25%	5%
Hospital B	13,000	$1,258.73	$16,363,527	20%	5%	35%	20%	20%
Hospital C	9,849	$1,258.73	$12,397,260	8%	20%	25%	28%	19%
Hospital D	3,500	$1,258.73	$4,405,565	25%	14%	10%	30%	21%
	61,349		$77,222,001					
	New Per Day Payment	**$1,258.73**						

New Reconciliated Annual Payment - SFY1

Hospital	**MCO 1**	**MCO 2**	**MCO 3**	**MCO 4**	**MCO 5**	Total
Hospital A	$5,286,678	$7,930,017	$17,622,260	$11,013,912	$2,202,782	$44,055,649
Hospital B	$3,272,705	$818,176	$5,727,234	$3,272,705	$3,272,705	$16,363,527
Hospital C	$991,781	$2,479,452	$3,099,315	$3,471,233	$2,355,479	$12,397,260
Hospital D	$1,101,391	$616,779	$440,556	$1,321,669	$925,169	$4,405,565
Total	$10,652,555	$11,844,424	$26,889,365	$19,079,520	$8,756,136	$77,222,001

New SFY1 payments based on actual MCO Encounter Utilization, updated Group Distribution and FMAP.

Change From Total SFY1 payment = Reconciliation - Total payment

Hospital	**MCO 1**	**MCO 2**	**MCO 3**	**MCO 4**	**MCO 5**	Total
Hospital A	$461,591	$1,350,353	($4,309,953)	$2,241,027	$448,205	$191,224
Hospital B	($878,966)	($842,492)	$745,229	$781,703	($48,632)	($243,158)
Hospital C	($313,630)	($784,076)	$488,493	$207,705	($255,343)	($656,851)
Hospital D	$611,712	$274,004	$73,297	$587,151	$411,006	$1,957,169
Total	($119,293)	($2,211)	($3,002,934)	$3,817,586	$555,237	$1,248,384

The Annual change between what was originally paid (w/FMAP changes) for SFY1 vs actual, updated SFY1 payments.

Q2/SFY2

Assessment received by State
By Mid Dec

Payment to Hospitals
By Mid Jan

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%**
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

New Net Q2/SFY2

Assessment received by State
By Mid Dec

Payment to Hospitals
By Mid Jan

Quarterly payment

Hospital	MCO 1	MCO 2	MCO 3	MCO 4	MCO 5	Total
Hospital A	$1,667,863	$2,995,269	$1,173,100	$4,434,249	$886,850	$11,157,330
Hospital B	$158,952	($427,325)	$1,990,730	$1,404,453	$781,703	$3,908,513
Hospital C	$12,722	$31,806	$1,141,198	$1,023,587	$397,363	$2,606,677
Hospital D	$734,132	$359,698	$165,112	$770,780	$539,546	$2,569,268
Total	$2,573,669	$2,959,448	$4,470,141	$7,633,069	$2,605,461	$20,241,788

Assuming that the SFY2 initial Utilization will continue to be based on CY data (see Q1/SFY2). The 2nd Quarter Payment in SFY2 would include the redistribution of the SFY1 payments based on the actual, updated SFY1 MCO Utilization.