NJFAMILYCARE
Affordable health coverage. Quality care.

Date: / /

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

County: _____

GENERAL

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

FEE PROGRAM

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

2. List of all licensed hospitals located in your county:
   Please Include: Name, address, facility ownership (for profit, NFP or government owned) **and** type of facility (acute care, psychiatric, rehabilitation, children's, LTACH, Specialty)

3. Federal law and regulations require all hospitals in a jurisdiction to be taxed, unless a specific process is followed to exempt particular hospitals – a process that includes meeting a statistical test.
   Does the county plan on excluding any hospitals from the fee program? ☐ No ☐ Yes
   If so, please list name(s) and type of facility:

4. If the county plan **proposes to exempt** particular hospitals/classes of hospitals, please provide a policy justification for excluding those specific hospitals/classes of hospitals from the fee program. (If not, please leave blank)

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

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

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

8. What is the proposed fee rate or fee amount?
Please specify if different fee rates or amounts will be applied to inpatient versus outpatient services and identify respective notes/ amounts.

9. Will the same fee rate or fee amount apply to all hospitals included in the fee program? ☐ No ☐ Yes
If not, please describe which fee rate or amount is proposed to be applied to each hospital and the policy rationale.

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

Information on federally compliant statistical test (s) can be accessed at 42 CFR § 433.68
- Permissible health care-related taxes.
https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/xml/CFR-2018-title42-vol4-sec433-68.xml

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

☐ Quarterly ☐ Monthly ☐ Biannually ☐ Other _____

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

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

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

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

PROPOSED PAYMENT PROGRAM

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

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

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

OTHER COUNTY REQUIREMENTS

CHECK BOX TO CONFIRM COMPLETION AND/OR AGREEMENT

- ☐ The county has provided the state with all calculations for the fee, the proposed payments, and the statistical test.
- ☐ The county understands that the funds created from this program are to increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals in providing necessary services to low-income residents.
- ☐ The county understands that at least 90% of the fee amounts collected will be transferred to the state to be used as the non-federal share for federally matched hospital payments.
- ☐ The county understands that at least 1% of the fee amounts collected will be transferred to the state for the state's administrative costs.
- ☐ The county understands that fees to be collected may not exceed 2.5% of the net patient revenue of hospitals included in the fee program.
- ☐ The following FORMS and ATTESTATION must be submitted with the Fee and Expenditure Report for each hospital located in the county (Include all source documents)
  - ☐ **Data Form for County Option Hospital Fee Program**
  - ☐ **Preliminary DSH Calculation Template**
  - ☐ **Attestation**
    Signed by each hospital located in the county.

ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PILOT PROGRAM

FEE AND EXPENDITURE ATTESTATION

CERTIFICATION BY COUNTY OFFICER OR ADMINISTRATOR

I hereby certify that I have examined the Fee & Expenditure Report for the reporting periods specified and that to the best of my knowledge and belief it is true, correct and complete statement prepared from the county option hospital fee state data set created from reports submitted by the hospitals within the county's jurisdiction in accordance with applicable instructions, except as noted. I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.

Signed _____
County Officer or Administrator

Name: _____
Full Name (Printed)

Title: _____ **Date:** / /

Email Address: _____