New Jersey County Option Hospital Fee Pilot Program

Operations Manual – SFY22 Program Year

Updated: November 2021

Scope of Manual

This document provides a detailed description of New Jersey's implementation of the NJ County Option Hospital Fee Pilot Program within the New Jersey Medicaid program, NJ FamilyCare. As outlined by enabling State statute, the County Pilot Program allows a maximum of seven 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 Pilot Program.

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Introduction

On November 1, 2018, Governor Murphy signed the County Option Hospital Fee Pilot Program Act (Act)[1] allowing seven counties meeting certain criteria (Atlantic, Camden, Essex, Hudson, Mercer, Middlesex, and Passaic) the option of enacting a local hospital fee program in their jurisdiction for the purposes of (1) increasing Medicaid payments to hospitals by securing additional Federal funding through the NJ FamilyCare Program; and (2) providing participating counties with new fiscal resources. These counties were deemed eligible to participate in the program, in part, based on the Municipal Revitalization Index rankings of the municipalities within their borders, which measure municipal distress based on indicators of diverse aspects of social, economic, physical, and fiscal conditions. The legislation for this County Pilot Program will expire five years after each participating county has collected a local health care-related fee (June 2026). Collection of the local hospital fees is contingent on CMS approval of the Medicaid payments that are funded under the county pilot programs. This legislation follows parameters established by federal authorities as outlined in Section 1903(w) of the Social Security Act,[2] 42 CFR 433.68,[3] and 42 CFR 433.51.[4]

In the initial year of the program (SFY 2022), each eligible county did choose to participate by submitting a fee and expenditure report describing their proposed hospital fee program to the Department of Human Services ("The Department"). The Department conducted a review to determine whether the proposed programs met State and Federal regulatory requirements and that the data and methodologies contained within were accurate. These plans were subsequently made available for comment during a 21-day public review period, followed by a careful review by the Department of all submitted plans. Finding no cause to alter any county plan, the Department submitted the initial documents authorizing the program payments for State Fiscal Year 2022 (SFY22) to CMS for approval. Approval of all plans as submitted was granted by CMS on July 16, 2021, retroactive to an effective date of July 1, 2021.

Program Operations

County Process of Submitting Fee & Expenditure Report and Other Materials

Per N.J.A.C. 10:52B-3.1, "a participating county must submit a proposed fee and expenditure report to the Department for review in accordance with instructions specified by the Department." Subsequently, each eligible county submitted a proposed fee and expenditure report (F&E Reports, Appendix A) that included all provisions outlined in N.J.A.C. 10:52B-3.1 and supporting documents, including the Hospital

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

[3] 42 CFR 433.68 defines permissible health care-related taxes

[4] 42 CFR 433.51 authorizes the use of public funds transferred from local governments as the State share of Medicaid expenditures.

Attestations (Appendix B), Data Forms (Appendix C), and Preliminary DSH Calculation Templates (Appendix D) from each hospital.

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." For SFY23, counties seeking an amendment will be required to submit amended F&E Reports by December 10, 2021. Amended/updated F&E Reports will include a 21-day review and comment period. Participating counties may submit amendments to their F&E reports to the Dmahs.hospcountyfee@dhs.nj.gov email address. If a county plans to continue their program unchanged into a subsequent program year, a resubmission of the F&E report is not required.

Participating hospitals will be asked to submit analysis of provider payments as a percentage of commercial utilization data and of Medicare utilization data to the State or its technical contractor by early December of each program year, as this data will be utilized in the annual submission to CMS (see Appendix E for template to be completed for this analysis). In addition, participating hospitals will be required to submit a list of NPIs and their correlated Medicare ID number(s) for participation in the program (see Appendix F for template).

Regardless of whether any changes to the county program are proposed, counties must work with hospitals within their borders to ensure that the hospitals update and submit DSH projections and the Hospital Attestation form to the State every program year via the Dmahs.hospcountyfee@dhs.nj.gov email address. Counties and county representatives are not responsible for updating the DSH form or hospital attestation forms for each of their hospitals. 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 will be 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 Pilot Programs, these annual DSH projections are needed to identify and limit DSH payments (i.e., Charity Care) that, when combined with other Medicaid payments provided to hospitals, are likely to exceed federal maximum limits and trigger a recoupment of federal DSH funding upon subsequent audit.

Submission of backup materials is **not required**. Backup materials will be accepted if participating counties want to submit documents that may be useful during review of the DSH template. The State or its technical contractor will ask participating hospitals to return an updated DSH Calculation Template (See Appendix D for SFY23 version) and any backup materials by early December prior to every program year. The State or its technical contractor may request further detail based on the hospitals' initial submission. For SFY23 (July 1, 2022 - June 30, 2023), participating hospitals must return an updated, completed DSH Calculation Template, analysis of provider payments as a percentage of commercial utilization data and of Medicare utilization data, list of NPIs/Medicare CCN and Medicaid provider ID numbers (s), and Hospital Attestation by December 10, 2021 to the Dmahs.hospcountyfee@dhs.nj.gov email address.

County Ordinances/Resolutions and Intergovernmental Transfer Agreements (IGAs)

As outlined in N.J.A.C. 10:52B-2.2, each eligible county enacted 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 also entered into an Intergovernmental Agreement (IGA) with the Department of Human Services authorizing and outlining various details of the transfer of fees collected under the county's program to the Department to fund the non-federal share of the County Option hospital payments and Departmental administrative costs. Table 1 lists the dates on which the participating counties enacted Ordinances or Resolutions (see Appendix G for the full text of each Ordinance/Resolution) and approved their IGAs (see Appendix H for the full text of each IGA).

Ordinances/Resolutions remain in effect and do not need to be updated annually, unless or until:

- The NJ County Option Hospital Fee Pilot Program's authority sunsets, or
- A participating county introduces an amendment to their previously approved Program.

IGAs will require revision based on the above reasons or if there are programmatic changes required by NJ State Legislature or CMS.

Table 1: County Ordinances/Resolutions and IGA Approvals

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

Use of Local Fee Proceeds

Subject to CMS approval, the Division of Medical Assistance and Health Services (DMAHS) will use the local hospital fees to fund Medicaid State Directed Payments (SDPs) through the State's Medicaid managed care organizations to hospitals in the participating counties. DMAHS will prepare the annual application (via preprints) for the SDPs for CMS approval, which will include a prior review by DMAHS's actuary. DMAHS will share a draft of the preprint at least 14 days prior to submission to CMS (March 17 for the SFY23 preprints), with a due date for any comments from counties due no later than 7 days before submission to CMS (March 24 for the SFY23 preprints). DMAHS will submit the preprints to CMS no later than March 31 each year.

The CMS approval documents for SFY22 are located in Appendix I.

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 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.

NJ 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 Pilot Program. The remaining fee amount (after the county (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 Pilot 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 2021:

> "...participating facilities projected to received total Medicaid payments that exceed the federal maximum hospital-specific DSH limit in 42 U.S.C. s.1396r-4 may be subject to Charity Care reductions, including the possible return of funding to the Department. This is required to ensure compliance with federal regulations and is consistent with attestations signed by facilities and submitted to DHS as part of the County Option program. The attestations signed by the facilities are designated as the form notifying the Commissioner of Health as required pursuant to the FY 2022 Appropriations Act. Any Charity Care funding reconciled with the Department during the fiscal year will be redistributed to other hospitals pursuant to language in the FY 2022 Appropriations Act."

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 SFY22 Appropriation's Act language below:

> "Notwithstanding the provisions of any law or regulation to the contrary, the amounts hereinabove appropriated from the Health Care Subsidy Fund for Charity Care payments are subject to the following condition: A disproportionate share hospital eligible for funding through the Charity Care program may decline Charity Care payments for the fiscal year by notifying the Commissioner of Health on a form designated by the Department of Health on or before the fifteenth day following enactment. If a disproportionate share hospital declines Charity Care payments for the fiscal year the amount declined will be redistributed in accordance with the provisions of section 3 of P.L.2004, c.113 (C.26:2H--18.59i), as amended by this act."

As part of the NJ County Option Hospital Fee Pilot Program's approved F&E Report and reiterated in DOH's guidance above, all participating hospitals attested that they would forgo Charity Care payments if the

receipt of County Fee Pilot Program payments is projected to generate total payments that exceed their DSH limit.

Non-Compliant Hospitals

To meet the federal standards of no hold harmless,[5] all local hospital fees must be paid. If a hospital does not meet its payment obligations, the counties may institute a penalty 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 counties have included language in their IGAs[6] (Appendix G) and Ordinances/Resolutions[7] (Appendix F) authorizing the same interest or penalties as noted above.

If necessary, the State's technical contractor will track the financial obligations owed by the delinquent hospitals, as well as the penalties (see "Tracking Transfers and Payments" section below). These penalties and payment obligations will be imposed quarterly until they are fulfilled.

Underpayment of IGT

If an IGT amount is 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. [8] As specified in each participating county's IGA, any shortfalls in the amount transferred in a given year will be subtracted from to the amounts otherwise available to fund the non-federal share of enhanced payments for the particular county in the subsequent program year. These details are available in each county's IGA.[9]

Overpayment of IGT

If a transferred amount is greater than what was expected from a specific county, the state or their

[5] 42 CFR 433.68(f) defines the conditions under which a taxpayer will be considered to be held harmless under a tax program

[6] 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

[7] 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

[8] N.J. Stat. § 30:4D-7tg

[9] 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

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 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. CMS requires that these estimates be reconciled to actual Medicaid utilization for the year in which payments are made once the actual utilization data is available. These required settlements will occur annually for all County Option participants and will generate revised payments amounts based on the following: actual hospital utilization (actual inpatient utilization reflected in Encounter data for SFY22 [June 2021-July 2022], with a claims run out period through October 1), the 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 true 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 payment in Q2 of each program year.

See Appendix J for Reconciliation/Payment Visual

Tracking Transfers and Payments

Once fee proceeds that act as the non-federal share of payments have been transferred to DMAHS and after the State provides payment charts to each MCO (which identify hospital-specific payment amounts), the State will provide funding equal to the combined federal and non-federal share of funds to the MCOs (see Appendix K for full schedule) to make the SDPs to the hospitals.

MCOs are required to make the hospital payments within 15 calendar days of receipt of the funds from DMAHS. DMAHS will provide the MCOs with a quarterly payment breakout chart 15 calendar days prior to receipt of the funds from DMAHS. MCOs are required to make the payment to the specific NPI 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. The State's technical contractor is responsible for confirming each hospitals' payments from each MCO (40 hospitals and five MCOs - 200 total payments each quarter) and reporting these confirmations to the State.

MCO Briefing

The State briefed the five participating MCOs operating in the participating counties on the Program in August 2021 – the State shared background information, contract requirements (Appendix L), IGT and payment schedule, and a draft payment chart. DMAHS's technical contractor has also shared all confirmed NPIs, points of contact, and physical addresses for each of the hospitals as backups, as all County Pilot Program payments are expected to be processed by EFT (see Appendix M for more information).

Other Annual Processes

Measuring Impact

Representatives from DMAHS and its technical contractor met with CMS to review quality metrics for the Program. County consultants worked with the counties and selected two measures that were mutually agreeable to all stakeholders; these measures will first be reported with the SFY24 preprint submissions to capture a full program year of measures (Appendix N).

Evaluation Plan

CMS requires all directed payments to demonstrate that the payments are intended to advance at least one of the goals in the State quality strategy.[10] Program participants have chosen the goal of "Improving quality of care and services," with the objective of "access to care and services will be equitable." These outcomes must be reported to CMS within the preprint in the subsequent full program year. The State or its technical contractor will request the quality reporting from the hospitals be submitted by January 1, 2023; the counties may choose to collect this information and submit it on behalf of the hospitals. Additional details will be provided to the hospitals in the Fall of 2022. DMAHS or its technical contractors can provide assistance to the hospitals in order to fulfill their requirements to CMS. Participating hospitals (or counties on their behalf) may submit their quality reports to the Dmahs.hospcountyfee@dhs.nj.gov email address. In consultation with CMS and the counties, the state has chosen two measures to evaluate annually to assess the success of the program:

Table 2: Evaluation Measures

Measure Name	Baseline Year	Baseline Statistic	Performance Target
Average (median) time patients spent in the ED before leaving from the visit	CY 2019	Acute: 142 minutes (national average)	For the acute hospitals with number of minutes above the national average, reduce the gap between hospital actual and national average by 1% per year.
Clostridium difficile (C.diff.) intestinal infections	Long Term: FFY 2019 Rehab: FFY 2019	Long Term: 0.537 Rehab: 0.557 (National Average)	For the LTACH and Rehab hospitals with a CDI ratio above the national average, reduce the gap between hospital actual and national average by 1% per year.

[10] 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

Use and dissemination of historical encounter data

The State will continue to provide MCO encounter data to the counties/hospitals, as needed, to develop estimated payment models (CY19 MCO Encounter data criteria detailed in Appendix O). Any updates to the encounter data provided by the State will reflect a prior 12-month calendar year period, allow for claims runout, and use transparent criteria to ensure the encounter data provided is as accurate and timely as possible.

For SFY22, the State provided CY19 MCO Encounter data for the counties to create their estimated models. For SFY23, DHS plans to continue to utilize CY19 MCO Encounter data to make interim payments.

Contacts

State Contacts

If you have questions about the NJ County Option Hospital Fee Pilot Program, please direct your questions to the County Option email inbox 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 Pilot Program:

Aetna	Christina Taggart	TaggartC@aetna.com	(609) 282-8204
Amerigroup	Jennifer Ciaglia	Jennifer.ciaglia@amerigroup.com	(732) 439-4360
Horizon	Steven Kaminski	Steven_Kaminski@horizonblue.com	(609) 434-4538
United Healthcare	Monique Brown	monique_k_brown@uhc.com	(732) 623-1125
WellCare	Sean McBride	Sean.McBride@wellcare.com	(973) 848-3078

County Administrators

Each county has designated a contact for any questions related to the NJ County Option Hospital Fee Pilot Program. The following contacts signed their counties' respective Fee and Expenditure Reports:

Atlantic County	Jerry DelRosso	Dewees_jacqueline@aclink.org Delrosso_jerry@aclink.org
Camden County	Ross Angilella	rossa@camdencounty.com
Essex County	Joseph Divincenzo	JoeDi@admin.essexcountynj.org

Hudson County	Abraham Antun	aantun@hcnj.us
Mercer County	Lillian Nazzaro	lnazzaro@mercercounty.org
Middlesex County	John Pulomena	John.pulomena@co.middlesex.nj.us
Passaic County	Richard Cahill	rcahill@passaiccountynj.org

Appendices

A. Fee and Expenditure Report template

B. Attestation template

C. Data Form template

D. Preliminary DSH Calculation template (SFY23 version)

E. Table 2; Impact of State Directed Payment of Payment Levels

F. List of NPIs and their correlated Medicare ID number(s)

G. Approved Ordinances/Resolutions

H. Approved SFY22 IGAs

I. SFY22 Approved Preprints

J. SFY22 Reconciliation/Payment Visual

K. List of Key Dates for SFY22

L. MCO Contract Language

M. MCO Briefing Slides with Sample MCO Payment Schedule

N. NJ County Option Quality Evaluation Plan

O. CY19 MCO Encounter Data Criteria

P. Adopted Rules and Summary of Public Comments

Q. SFY22 List of Counties and Hospitals