students as possible who might be able to benefit to have the opportunity to do so. It is with these goals in mind that the adopted amendments were developed by the EOF Board of Directors. It is hoped that the adopted amendments will continue to allow many students from all walks of life to continue to participate in EOF.

COMMENT: Dr. Jenice Sabb, President of the Educational Opportunity Fund Professional Association, shared that she was in support of the proposed amendments as they exemplify the intent of the EOF legislation. Dr. Sabb thanked the EOF Board of Directors for their acknowledgement of the needs of this student population.

RESPONSE: The EOF Board of Directors thanks Dr. Jenice Sabb for her support.

Federal Standards Statement

The adopted amendments do not require a Federal standards analysis under Executive Order No. 27 (1994) and N.J.S.A. 52:14B-22 et seq., because the EOF was established by New Jersey legislation, is wholly supported by State appropriations, and is not subject to any Federal requirements or standards.

Full text of the adoption follows:

SUBCHAPTER 2. UNDERGRADUATE EOF ACADEMIC AND FINANCIAL ELIGIBILITY

9A:11-2.8 Duration of student eligibility

(a)-(b) (No change.)

(c) Students enrolled at senior institutions may receive a maximum of 12 semesters of Article III undergraduate grant payments to complete a baccalaureate degree, as long as they continue to meet the eligibility requirements for the program and are making satisfactory academic progress as stipulated at N.J.A.C. 9A:11-2.13. Undergraduate grant recipients may not pursue more than one baccalaureate degree within the maximum 12 semesters of Article III undergraduate grant payments.

(d) (No change.)

(e) Except for as provided in subsection (f) below, students enrolled at institutions that award associate degrees may receive a maximum of eight semesters of Article III undergraduate grant payments to complete an associate degree, as long as they continue to meet the eligibility requirements for the program and are making satisfactory academic progress as stipulated at N.J.A.C. 9A:11-2.13. Undergraduate grant recipients may not pursue more than one associate degree within the maximum eight semesters of Article III undergraduate grant payments.

(f) Undergraduate grant recipients who are enrolled in a three plus one degree program established pursuant to section 1 of P.L. 2018, c. 144 (N.J.S.A. 18A:3B-78), shall be eligible for eight semesters of Article III undergraduate grant payments to complete an associate degree and an additional two semesters of Article III undergraduate grant payments while enrolled in the third academic year of the program, as long as they continue to meet the eligibility requirements of the program and are making satisfactory academic progress as stipulated at N.J.A.C. 9A:11-2.13.

Recodify existing (f)-(i) as (g)-(j) (No change in text.)

SUBCHAPTER 5. SUMMER PROGRAM AND WINTER SESSION

9A:11-5.4 Student eligibility

(a) (No change.)

(b) Based upon the assessment of students' preparation and readiness for collegiate study, institutions may require eligible students to participate in a pre-first year summer program as a condition of their admission and/or eligibility to receive EOF grants and support services during the academic year. The EOF pre-first year summer program is intended to assist students that have been admitted to the institution as identified at N.J.A.C. 9A:11-6.1(h)2 and 3. Institutions may permit students to enroll without participating in a summer program, as long as the institution provides, during the academic year, alternative activities for such students consistent with the goals of N.J.A.C. 9A:11-5.1 and the requirements of N.J.A.C. 9A:11-5.3.

(c) EOF program applicants who have earned 24 or more college credits while in high school or earned an associate's degree as part of their high school graduation requirements are eligible for participation in the pre-first year summer program. Furthermore, these students must be considered for the EOF program based on the EOF Article III student grant funding priorities outlined at N.J.A.C. 9A:11-6.1(h), and if they meet all of the eligibility requirements set forth at N.J.A.C. 9A:11-2.2 and 2.3.

(d) (No change.)

SUBCHAPTER 6. OPERATIONAL PROCEDURES FOR ACADEMIC YEAR, WINTER SESSION, AND SUMMER ARTICLE III STUDENT GRANTS AND ARTICLE IV PROGRAM SUPPORT SERVICES FUNDS

9A:11-6.1 Renewal application process for Article III student grants and Article IV program support funds

(a)-(g) (No change.)

(h) Based on an institution's annual academic year EOF Article III allocation, student grant funds shall be awarded to eligible students in the following priority order:

1.-2. (No change.)

3. Students that have earned 24 or more college credits while in high school or who participated in a dual enrollment program and have earned an associate's degree as part of their high school graduation requirements and have no prior history of EOF funding support;

Recodify existing 3.-5. as 4.-6. (No change in text.)

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

The County Option Hospital Fee Pilot Program

Adopted New Rules: N.J.A.C. 10:52B

Proposed: October 7, 2019, at 51 N.J.R. 1493(a).

Adopted: February 20, 2020, by Carole Johnson, Commissioner, Department of Human Services.

Filed: February 24, 2020, as R.2020 d.036, **with a non-substantial change** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 30:4D-1 et seq., 30:4D-7r through 7x, and 30:4J-8 et seq.; and P.L. 2018, c. 136.

Agency Control Number: 19-A-03.

Effective Date: March 16, 2020.

Expiration Date: March 16, 2027.

Summary of Public Comments and Agency Responses:

Comments were received from:

East Orange General Hospital, East Orange, NJ;
Fair Share Hospitals Collaborative, Trenton, NJ;
Hackensack Meridian Health, Hackensack, NJ;
Hospital Alliance of New Jersey, Trenton, NJ;
New Jersey Hospital Association, Princeton, NJ;
RWJBarnabas Health, West Orange, NJ;
Saint Peter's University Hospital, New Brunswick, NJ; and
University Hospital, Newark, NJ.

1. COMMENT: The Department of Human Services (Department) received numerous comments of general support for the County Option Hospital Fee Program, including some of the following language:

> "It is imperative that New Jersey consider all avenues to maximize federal matching dollars, especially at a time when federal funding remains in jeopardy for healthcare providers…Vulnerable patients are at risk through federal changes to the Medicaid programs that can lead to patients having limited or no coverage and being forced to utilize hospital emergency rooms for primary care and certain specialty services."

"Administered at the county level, this innovative program will serve as a workable vehicle to allow participating hospitals to maximize their Medicaid funding. The program allows that the assessment selected by each county can be tailored to best fit the hospitals in that county. Allowing the counties to enter into intergovernmental transfer agreements with the State in order to maximize federal matching funds will be beneficial for New Jersey's safety net hospitals as they continue to adapt to an evolving healthcare landscape."

"… supports the program's goal of enhancing federal Medicaid resources to support our hospitals' sustained efforts to provide the highest quality services to low income and uninsured residents while also establishing a method for equitable distribution of funds amongst the hospitals."

"On behalf of our eligible hospitals, we commend the State of New Jersey and the Department of Human Services on this innovative program … that will allow local needs and differences to shape and influence the design of successful programs."

There were no comments in opposition to the proposed program.

RESPONSE: The Department appreciates the comments in support of this program, which will increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals in providing necessary services to low-income residents.

2. COMMENT: Commenters asked which hospitals can participate in the program. The commenters noted that the definition included in proposed N.J.A.C. 10:52B-1.2 for hospital includes "a hospital that is licensed pursuant to P.L.1971, c. 136 and is located within the borders of the participating county." They further noted that proposed N.J.A.C. 10:52B-3.1(c)2 requires a participating county to include in its proposed Fee and Expenditure Report a list of all hospitals within the jurisdiction and their facility type (acute care, psychiatric, rehabilitation, long-term acute care hospital, etc.). Therefore, it is unclear if this rulemaking would apply to all hospitals or just general acute care hospitals. The commenters asked that the Department clarify eligible "hospitals" and/or provide a list of the eligible "hospitals" for the seven eligible counties.

3. COMMENT: A commenter suggested that the regulations should define and provide examples as to what is meant by "classes" of hospitals.

RESPONSE TO COMMENTS 2 AND 3: The County Option Hospital Fee Pilot Program (Pilot Program) authorizes eligible counties to impose a local health care-related fee on all hospitals within its borders. The Fee and Expenditure Report must list these facilities by type to ensure compliance with Federal rules and State law that all hospital services be taken into consideration. Federal regulations at 42 CFR 433.56 define 19 classes of health care providers or services for which a health care-related tax as discussed at 42 CFR 433.68 may be imposed, of which only two of those classes, inpatient hospital services and outpatient hospital services, are authorized to be assessed under the County Option Fee Pilot Program pursuant to P.L. 2018, c. 136. Inpatient and outpatient hospital services are further defined in Federal regulations at 42 CFR 440.10 and 440.20, respectively. The Federal rules do not distinguish between acute, psychiatric, rehabilitation, or other types of hospitals.

4. COMMENT: Proposed N.J.A.C. 10:52B-3.1(c)6, states that the county can request to exclude facilities from the fee. The commenters asked the Department to define an allowable rationale for exclusion to assist the counties in developing their Fee and Expenditure Reports. The commenters note that "classes" of hospitals are permitted within the confines of 42 CFR 433.68 and that proposed N.J.A.C. 10:52B-3.1(d)2 states that exemptions must comply with 42 CFR 433.68 and that "classes" of hospitals may need to be considered to maximize funds, encourage participation, and/or account for different facility types within the confines of 42 CFR 433.68. The commenters additionally suggest that the regulations should provide clarity as to what hospitals can participate and/or be excluded, providing a list of the eligible "hospitals" for the seven eligible counties. The industry should be given the opportunity to comment on the definition developed through the regulation.

RESPONSE: Although N.J.A.C. 10:52B-3.1(d)2 does not use the term "class," as noted in the Response to Comment 3, for health care-related tax purposes, "classes" are the types of health care services for which a health care-related tax may be imposed. The participating county may choose to exclude certain hospital facility types. However, if a county chooses to exclude certain hospital facility types from the county assessment, the Federal Centers for Medicare and Medicaid Services (CMS) must approve of the exclusion in the form of a waiver of the broad-based requirements in Federal regulations. The State does not intend to define which hospitals, if any, to exclude from any proposed county assessment. Any decision to exclude certain hospital facility types would be part of the consultation and discussion with local hospitals in the jurisdiction as required at N.J.A.C. 10:52B-3.1(b). However, if hospitals are excluded from the county assessment, the Department must assure that the resultant assessment complies with the requirements of 42 CFR 433.68(c) and that approval of a waiver of the broad-based requirements is received from CMS. In addition, if a county were to propose assessing hospitals included in the county fee program at different levels, a waiver of the Federal uniformity requirement at 42 CFR 433.68(d) must also be submitted and approved by CMS before the county program could be implemented.

5. COMMENT: Several commenters suggested that due to the delay in program initiation the Department should petition the Legislature to extend the pilot program to a full five years of operation subject to hospital willingness to participate.

RESPONSE: The legislation creating the County Option Hospital Fee Pilot Program (P.L. 2018, c. 136) specifies the end date of the program to be April 30, 2024. The Department believes everyone's efforts are best focused on launching the pilot.

6. COMMENT: Commenters noted that at N.J.A.C. 10:52B-3.3(b)1 and 2, the proposal indicates the distribution of funds to hospitals is at the discretion of the Department: "The Department may: (1) Increase Medicaid/NJ FamilyCare fee-for-service (FFS) payments to hospitals located in the participating county; (2) Make payments to Medicaid/NJ FamilyCare managed care organizations (MCOs) operating in participating counties for increased hospital or hospital-related payments"; or (3) Use a combination of the two mechanisms.

The commenters state that preferably, distributions to the hospitals should be an aggregate flow-thru payment, not an add-on to Medicaid FFS or MCO rates and paid on a quarterly basis in conjunction with the county fee assessment to mitigate hospital cash flow issues. The commenters also state that the distribution of funds to the hospitals must be timely, minimizing the time between a hospital's assessed payment and return of funds through the MCOs, FFS, or both.

7. COMMENT: A commenter stated that for MCOs, payments should be calculated using actual encounter data from the prior quarter and should not be combined with regular payments from MCOs. The commenter maintains that quarterly payments will allow for easier tracking of the payments funded by the assessment and could also reduce cash flow uncertainty caused by the time separation of the tax payments from receipt of the supplemental payments.

RESPONSE TO COMMENTS 6 AND 7: As the single state agency for the Medicaid/NJ FamilyCare Program, the role of the Department of Human Services is to review the proposed program to assure that the assessment design and proposed payment methodology, if provided, are in compliance with Federal regulation governing such programs. The most appropriate method of distribution is dependent upon, among other things, the aggregate value of the proposed plans submitted by the counties and, therefore, the Commissioner of the Department of Human Services will distribute the funds in the most cost effective and efficient manner as allowable by Federal statute, regulation, and guidance. The counties, in consultation with the hospitals, have the option of recommending to the Commissioner the manner of distribution of the Medicaid/NJ FamilyCare payments in their proposed Fee and Expenditure Report. Such recommendations may include the methods suggested by the commenters.

8. COMMENT: Several commenters noted that at N.J.A.C. 10:52B-3.3, the rule does not indicate or impose a cap on the amount the Medicaid MCOs can charge for an administrative fee. The commenters suggested that the Department should establish sufficient oversight and cap MCO fees at an amount to cover actual administrative fees and costs. The commenters stated that doing so will ensure that the legislative intent of supporting hospitals' efforts in providing care to the most vulnerable residents will be maximized.

RESPONSE: The statute creating the County Option Hospital Fee Pilot Program expressly forbids any MCO from retaining funds generated by the fee other than to offset increased administrative costs incurred as a result of the pilot program. In the event the payments under the pilot program are distributed through an MCO, the Department will review and approve the MCOs' administrative costs through the existing rate setting process to ensure compliance with this provision.

9. COMMENT: Several commenters noted that at N.J.A.C. 10:52B-3.3(a)3, if the State's administrative costs exceed the total value of funding, the State's costs will be subtracted from the hospitals' payments (from the non-Federal share of dollars). The commenters state that there should be a limit to the amount of remaining administrative costs that the Department can subtract from the non-Federal share.

RESPONSE: The Department will operationalize the Pilot Program as efficiently as possible, so that the maximum amount of the fee proceeds are used to provide necessary services to residents with low-incomes. However, as the Department does not have separate resources appropriated for this purpose, all administrative costs must be provided from fee proceeds.

10. COMMENT: A commenter noted that at N.J.A.C. 10:52B-3.3(d), all hospitals shall be required to maintain records regarding the expenditure of funds and make such records available to the Department or any authorized agent of the Department upon request. For the purpose of clarification, can the Department further articulate what is meant by "expenditure of funds." It is assumed these are the funds paid by the hospital to the county for the local health care-related fees.

RESPONSE: The expenditures addressed in this section refer to the additional Medicaid/NJ FamilyCare funds received by the hospital. Providing records regarding the expenditure of such funds upon the Department's request will help to ensure that the legislative intent of the Pilot Program has been satisfied and expenditures are consistent with the description provided within the Fee and Expenditure Report.

11. COMMENT: Several commenters noted that at N.J.A.C. 10:52B-3.3(d), all hospitals shall maintain records regarding expenditure of funds and make such records available upon request to the Department or any authorized agent of the Department. Commenters asked what the required retention date is and if there are penalties for failure to retain records.

RESPONSE: Records must be kept and available, in line with Federal and State guidelines, to maintain compliance with any Federal and State audit that may be conducted. Please refer to N.J.A.C. 15:3 for State guidelines and the CMS Record Schedule at www.cms.gov for Federal guidelines. Records must be kept in accordance with prudent business practice to ensure that records are available for any and all audits to which hospitals are routinely subject. Such audits may include penalties depending on their findings and the authority and scope of the audit. Counties should maintain all records in accordance with N.J.A.C. 15:3 and the County Agency General Records Retention Schedule (See https://www.nj.gov/treasury/revenue/rms/retention.shtml).

12. COMMENT: The commenters stated that the Department plans to provide an example of the required Fee and Expenditure Report as indicated at N.J.A.C. 10:52B notice of proposal Summary, at paragraph 7; however, no timeline is provided. The commenters state that the example Fee and Expenditure Report should be distributed to the hospitals and county to review and provide comments before they are finalized.

RESPONSE: The description of the Fee and Expenditure Report is provided at N.J.A.C. 10:52B-3.1 and the opportunity to comment on the elements of the Fee and Expenditure Report was available during the comment period of the proposed rules. The template of the Fee and Expenditure Report will be made accessible to the hospitals and counties through the New Jersey Department of Human Services/Division of Medical Assistance and Health Services website for completion.

13. COMMENT: The commenters indicated that at N.J.A.C. 10:52B-2.1(h)1, a participating county may amend its approved Fee and Expenditure Report annually with the approval of the Commissioner and with any required Federal approvals before any changes are implemented. The commenters stated that hospitals should be included in the review and approval process of a participating county's request to amend its approved Fee and Expenditure Report.

RESPONSE: If a county chooses to amend its approved Fee and Expenditure Report, the proposed amended report must go through the complete review and approval process, which includes the requirement that the affected hospitals and interested parties be provided a 21-day period during which to review and comment on the Fee and Expenditure Report.

14. COMMENT: The commenters noted that at N.J.A.C. 10:52B-3.1(b), participating counties shall consult with affected hospitals to develop their proposed Fee and Expenditure Report prior to submission to the Department. The commenters stated that there is nothing to specify the degree, or amount, of consulting required between the county and the hospital.

RESPONSE: N.J.A.C. 10:52B-2.2(a)1 requires that the county ordinance or resolution include a description of the process for communicating with the affected hospitals and collecting feedback and comments on the county proposal. As this communication will vary based on the complexity of the proposed report and the positions of the involved parties, the Department does not believe a change to the rule is necessitated.

15. COMMENT: A commenter noted that N.J.A.C. 10:52B-2.1(a)2 requires the Department to make a participating county's proposed Fee and Expenditure Report available for review and comment by affected hospitals and other interested parties for a period of 21 days and to consider comments received in its review of the proposed report. The commenter stated that the rulemaking does not describe the method whereby the Department will make the proposed Fee and Expenditure Report available for review. The commenter suggested the Department include an explicit process for doing so in the final adopted regulations. In line with this, the commenter strongly recommended the Department include as part of the proposed Fee and Expenditure Report available for comment, its own validated modeling so affected hospitals can compare the data and respond accordingly.

RESPONSE: The Department will make the Fee and Expenditure Report available electronically to all impacted hospitals and interested parties and include a mechanism that allows submission of comments on these reports to the Department. The Department will include a description of the payment distribution model. The Department intends to review and analyze each Fee and Expenditure Report with the data and assessment modeling submitted by the county for compliance with Federal regulations.

Because the electronic means may change with technology, the Department declines to specify a particular platform or method in the rule.

16. COMMENT: A commenter noted that while the proposed regulations require the Department to consider comments received, the process by which this would occur is not expressly stated. The commenter believes that the Department should respond in writing to comments submitted on the proposed Fee and Expenditure Report. This would resemble the currently existing process required by the Administrative Procedures Act for regulatory proposals.

RESPONSE: The Department will consider all comments received as part of the plan approval process but will not issue written responses to such comments. In the event the comments point to over-arching confusion or implementation issues, the Department may determine to release written clarification or consider further rulemaking.

17. COMMENT: Commenters noted that N.J.A.C. 10:52B-3.1(d)3 states that fees will be assessed consistent with Federal rules on the basis of any of the following: net or gross revenues, discharges, encounters, days, beds, visits, and may exclude revenue or utilization of Medicaid/NJ Family Care, Medicare, or both. The commenters state that the County Fee Assessment data must be based on audited data to ensure accuracy of assessment. The latest common year audited cost report should be used and we urge that audits are completed timely. Hospitals must be permitted to review and appeal any Medicaid MCO day discrepancies.

18. COMMENT: A commenter stated that additional items should be required for submission to produce an accurate, verifiable, and transparent Fee and Expenditure Report: (1) Methodology Description—The Fee and Expenditure Report must include a detailed description of the methodology used to levy assessments on all affected hospitals and the methodology concerning the distribution of funds generated by the program. An "overview of the fee and expenditure plan" is insufficient; (2) Modeling—The report must include a detailed model that demonstrates the flows of funds to and from all affected hospitals;

(3) Data Sources—The county must cite and provide references to all data sources used to produce the model, including, but not limited to, the following: new or gross revenues; discharges; encounters; days; beds; visits; and excluded revenue or utilization of Medicaid/NJ FamilyCare and/or Medicare; (4) Validation—The Department should review the model as presented by the county to verify the accuracy of the data used to produce the Fee and Expenditure Report, including reproducing the county's model and results; and (5) Accessibility—The Department must provide access to the data used to produce and verify the model to affected hospitals so they have sufficient time to review and potentially appeal any determination.

RESPONSE TO COMMENTS 17 AND 18: The hospitals will provide their own audited and verifiable data (including the source documents) as attested by the hospital's chief executive officer to the county.

The county will use this information to develop the Fee and Expenditure Report in consultation with the hospitals. How the county chooses to design the fee is within its discretion, subject to the Department's review and CMS approval. The Fee and Expenditure Report detailing the assessment, along with accompanying source data and attestations, shall be submitted to the Department.

The Department would, therefore, have the required source documents from the hospitals to verify the data and the assessment plan (modeling) submitted by the county. Following an initial review by the Department, the Fee and Expenditure Reports will be made available to affected hospitals and interested parties for a period of 21 days for review and comment.

19. COMMENT: A commenter stated that the distribution base and methodology should be based on the latest audited Medicare or Medicaid cost report to ensure fair distribution of funds. Other sources as listed will not provide for the level of dependability and comparability that will be needed. On the Medicaid Submitted Cost Report, there are reporting inconsistencies among hospitals. For example, one hospital may be using estimated days while another may be using actual matched days or even including appeal days, thus creating potential economic advantages for one hospital versus another. Regarding the State's 24-month Medicaid Fee-for-Service and Managed Care Encounter Reports, this commenter maintained that often times MCO encounter reports are not complete and could be riddled with errors.

20. COMMENT: A commenter suggested that the Department impose standards governing the distribution of funds to the participating hospitals in participating counties. The commenter suggested that the standards include the distribution base and the requirement that methodologies use audited data, such as the State's 24-month Medicaid FFS and Managed Care Encounter Reports, when feasible and allowable under Federal rules. The commenter stated that, additionally, the Department should develop a mechanism to allow hospitals to review and appeal any data discrepancies, including variances between hospital FFS and Medicaid MCO data, and that hospitals must be permitted to review and appeal any Medicaid MCO day discrepancies.

RESPONSE TO COMMENTS 19 AND 20: As codified at N.J.A.C. 10:52B-3.1(c)5, the Fee and Expenditure Report must, at the minimum, include source documentation of the data used to create the Fee and Expenditure Report (for example, Medicare or Medicaid/NJ Family Care cost report, survey data, etc.). The comments submitted reflect varying experience related to the reliability and accuracy with 24-month Medicaid FFS and Managed Care Encounter Reports. For this reason, data submitted by the hospitals will need to be certified by the hospital's chief executive officer and will serve as the basis for supporting the fee assessment. Acceptable sources of data submitted by the hospital must be supported through Medicare cost reports and other audited documents and/or their source materials. The Department will request additional documentation as needed should a discrepancy be noted during the review and approval process. Please also see the Response to Comments 17 and 18.

21. COMMENT: Commenters noted that in accordance with 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. The commenter suggests that the hospitals should be provided a 10-day grace period beyond the due date, before any penalties or interest are imposed.

22. COMMENT: The commenters noted that at N.J.A.C. 10:52B-3.6(a), a participating county must specify a process for an appeal of the fee amount. The appeal shall be filed with the county within 15 days after the participating hospital receives notice of the fee amount due. The commenters suggested that the hospitals should be provided 15 or 30 working days to prepare and file an appeal with the county.

23. COMMENT: A commenter stated that to ensure a transparent process and that hospitals have an adequate amount of time to receive, review, and process payments to the counties, it is recommended the regulations be revised to require the due date to be included in the ordinance or resolution. The county should be required to provide written notice of the fee amount at least 30 days in advance of the due date.

24. COMMENT: A commenter stated that the hospitals should be provided 15 business days to file an appeal with the county regarding both the assessed fee amount and any decision related to imposition of penalties.

25. COMMENT: A commenter stated that the counties should also be required to respond in writing to a hospital's appeal.

26. COMMENT: Several commenters asked what happens once an appeal is filed with the county and the recourse the hospitals have.

RESPONSE TO COMMENTS 21 THROUGH 26: Required elements of the county ordinance and resolution are cited in N.J.A.C. 10:52B-2.2. Hospitals may address these issues with their respective counties as the ordinances are developed. The rules set baseline parameters for counties regarding these issues as the contents of the ordinance is not the responsibility of the Department and should be the result of the collaboration between the counties and the hospitals.

27. COMMENT: A commenter stated that the proposed regulations do not detail what would constitute adequate consultation between the counties and the impacted providers. The commenter recommended that the Department require that counties actively consult with all impacted providers and allow all impacted providers to comment to the county in writing on proposed Fee and Expenditure Reports. The process should include a requirement for counties to respond in writing to all comments, similar to the requirements for State agencies pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. Subsequently, a participating county should be required to submit all comments and responses it received during the consultation process to the Department. This would allow the Department to ensure any consultation undertaken at the county level is not cursory. If the Department is not satisfied with county responses to impacted provider comments, the Department should require further county consultations prior to approving or denying a proposed Fee and Expenditure Report.

RESPONSE: The rules set baseline parameters for counties. Hospitals and counties may coordinate additional local processes. Affected hospitals will have the opportunity to provide comments to the Department during the 21-day Fee and Expenditure Report review and comment period.

28. COMMENT: The commenters noted that the county's proposed Fee and Expenditure Report must include the financial calculation for the Department to determine whether payments under the proposed plan, when combined with other Medicaid and disproportionate share (DSH) payments, are expected to exceed the hospital specific DSH limit. At N.J.A.C. 10:52B-3.1(c)8, hospitals must provide the supporting documentation for the DSH limit calculation. If a hospital's Medicaid and DSH payment are expected to exceed the hospital specific DSH limit, the hospital's CEO must provide attestation agreeing to authorize a payment reduction to DSH payments including Charity Care payments to mitigate the risk of non-compliance with Federal DSH Limits.

The commenter asked about the process and timing for the reduction in DSH payments using the example that if a hospital utilized the State fiscal year (SFY) 2016 Medicaid DSH Audit as the basis to determine whether the payment under the proposed plan, when combined with other Medicaid and disproportionate share (DSH) payment, is expected to exceed the hospital specific DSH limit in 2020, the actual SFY 2020 Medicaid DSH Audit would not be available until sometime in 2023.

29. COMMENT: The commenters stated that the assessment must be a direct offset on the Medicaid DSH Audit. For hospitals to minimize the

potential of exceeding their Medicaid DSH Limit, the hospital assessment must be a direct offset against the funds distributed back to the hospital for Medicaid DSH Audit reporting.

RESPONSE TO COMMENTS 28 AND 29: Section 1923(g)(1) of the Social Security Act imposes a limit on the amount a hospital may receive in DSH payments. Any increased Medicaid payments created from an assessment program will count towards a hospital's DSH limit. If payments from an assessment program accrue to a point that the hospital's DSH payments (that is, charity care) would exceed that limit, the Department is required to reduce the hospital's DSH payments to avoid loss of Federal funds.

Under P.L. 2018, c. 136, the stated purpose of the County Option Hospital Fee Pilot Program is "to increase financial resources through the Medicaid program to support local hospitals …" Since the purpose of the program is to provide additional Medicaid funding to hospitals to serve residents, the funding must be in compliance with all applicable rules and regulations related to the Medicaid program. As the single state agency administering the Medicaid program, the Department is obligated to comply with these Federal rules, including the Federal limits imposed on DSH payments.

In regard to the timing of the DSH limit projections, please also see the Response to Comment 30. There will be a multiple year gap from the implementation of the program to the most recent DSH audit. Hospitals will provide projections of their DSH limit. In calculating the DSH limit, the Department will accept a hospital's use of the Inpatient Prospective Payment System (IPPS) Hospital Market Basket as published by CMS to trend costs to the current fiscal year, unless hospital documentation verifies a different cost inflation for the hospital, as referenced at N.J.A.C. 10:52B-3.1(c)8i(3).

30. COMMENT: The commenters asked if there is a reconciliation process in the event the hospital's actual DSH payments do not exceed the Federal DSH Limits.

RESPONSE: The Department does not intend to create a separate reconciliation process for DSH payments and, therefore, is not including such a process in this rulemaking.

CMS requires the DSH limits to be audited once the actual data for the fiscal year is available. This is required regardless of whether the hospitals do projections. The audit is typically two to three years after the year for which the projected DSH limit was calculated. If CMS finds through these audits that a hospital received DSH payments in excess of the audited DSH limit, the State will recoup the excess payment from the hospital and refund the Federal share to CMS. While a projected DSH limit is unlikely to match the audited calculation with precision, the accuracy of the preliminary DSH limit is critical to avoid potential overpayments or underpayments, as the hospitals will bear the risk, not the State.

31. COMMENT: A commenter suggested that when hospitals exceed the allowable Federal DSH limit, the incremental funding that becomes available as a result should be redirected first to those hospitals currently not considered safety net providers under current legislation providing the highest level of documented charity care.

RESPONSE: The proposed new rules do not alter the provisions for DSH payments or the formula for Charity Care. The comment is beyond the scope of the rulemaking.

32. COMMENT: Several commenters asked if the hospital is entitled to recoup the forfeited DSH payments and what happens to the forfeited DSH Funds, are they held in reserve or they distributed to other hospitals. Additionally, it was stated that when the pilot program ends on April 30, 2024, the regulations should indicate that hospitals that forfeited DSH payments will be able to resume their full DSH payments.

RESPONSE: The new rules do not alter the provisions for DSH payments, the formula for Charity Care, or outline the disposition of DSH payment reduction. There is no mechanism for a recoupment of reduced DSH funds.

The comments regarding the forfeited DSH funds are outside the scope of this rulemaking. When the authorization period of the County Option Hospital Fee Pilot Program, pursuant to P.L. 2018, c. 136, sunsets (April 2024), then the authority for the program parameter to forfeit DSH payments for the Medicaid payments associated with the County Option Hospital Fee Pilot Program will no longer exist.

33. COMMENT: The commenters asked if the hospital authorized reduction in the DSH payments is an annual authorization or for the entire program period.

RESPONSE: The county's proposed Fee and Expenditure Report must include an attestation from the specific hospital's chief executive officer confirming that the hospital is agreeing to a potential reduction to the hospital's Medicaid DSH payments, including Charity Care payments, to the extent necessary to comply with payment limits outlined at Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4). This attestation will cover the entire program period unless the county proposes "to amend its approved Fee and Expenditure Report … by submitting a proposed amendment to its Fee and Expenditure Report to the Commissioner for review and approval," which it may choose to do annually. Each subsequent submission of the Fee and Expenditure Report must contain all necessary documents, including updated attestations.

34. COMMENT: A commenter stated that the anticipated flexibility provided to counties to develop their own county-specific proposed Fee and Expenditure Report is supported. For the purpose of clarification, can the Department confirm that the use of the phrase "at the Department's discretion" within the 3rd paragraph of the notice of proposal Summary (complete sentence for reference: "Funds generated under the pilot program and transferred to the Department will be combined with matching Federal Medicaid dollars and distributed to hospitals in participating counties through the existing Medicaid/NJ FamilyCare managed care organization (MCO) or directly to hospitals using fee-for-service payments, or a combination of the two mechanisms, at the Department's discretion.") indicates that the Department will be reviewing and approving the county's proposed allocation (between FFS and MCO) and hospital payment methodology and does not mean the Department will set the allocation nor develop the hospital payment methodology?

35. COMMENT: A commenter asked for clarification and confirmation that the Department will not determine the allocation between Medicaid fee-for-service and/or Medicaid managed care, nor develop the payment methodology in either delivery system. But rather, the Department will implement the county-designed allocation and hospital payment methodology as developed by the county, described within the Fee and Expenditure Report and approved by the Department and CMS.

RESPONSE TO COMMENTS 34 AND 35: The Department is not planning to proactively set allocations or methodologies. 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. The Department will notify counties of non-compliance with Federal rules as part of its review of the proposed Fee and Expenditure Report and may seek to amend the proposed Fee and Expenditure Report, as necessary.

36. COMMENT: A commenter noted that proposed N.J.A.C. 10:52B-2.1(c) through (g) outlines the State's approval determination process and specifies a fee may only be collected from an assessed hospital to the extent, and for the period, that the Department has determined the fee proceeds qualify as the non-Federal share of Medicaid expenditures. For the purpose of clarification, can the Department confirm what documents CMS needs to review and approve prior to county assessment and program implementation?

RESPONSE: The documents submitted to CMS depend on how the assessment program and the Medicaid payments are designed. For fee-for-service payments created under a pilot program, a State Plan Amendment must be submitted to CMS for approval. If payments are to be made through an MCO under the pilot program, a pre-print describing the payment and its rationale, in detail, must be submitted to CMS for approval. If the design of the fee is either non-broad based or non-uniform, a waiver must be submitted to CMS for approval.

37. COMMENT: A commenter noted that proposed N.J.A.C. 10:52B-3.3(b) lists the purposes for which the Department will use the proceeds transferred from the county and any Federal funding generated. For the purpose of clarification, can the Department confirm that the list of the three items are not exclusive of each other and that the use of "or" at the

end of paragraph (b)2, could be replaced with "and/or" as is articulated in the notice of proposal Summary.

RESPONSE: The commenter is correct and the rule will be changed upon adoption to replace "or" with "and/or" to be consistent with, and for the reasons stated in, the notice of proposal Summary.

38. COMMENT: A commenter noted that proposed N.J.A.C. 10:52B-3.3(c) regulates the statute language of P.L. 2018, c. 136, specifically prohibiting the Department from using the proceeds to supplant or offset current or future State funds allocated to a participating county. For the purpose of clarification, can the Department provide the citation and language that is included in the proposed regulation that implements the similar statutory language of P.L. 2018, c. 136, as it pertains to hospital funding, specifically "Payments distributed to hospitals pursuant to this act shall not supplant or offset any current or future funds paid to hospitals through other State or federal funding mechanisms or pools."

RESPONSE: P.L. 2018, c. 136, provides that payments through a pilot program shall not supplant or offset other hospital payments. However, under Federal law hospitals are not permitted to receive DSH payments in excess of their hospital specific DSH limits. Under P.L. 2018, c. 136, the stated purpose of the County Option Hospital Fee Pilot Program is "to increase financial resources through the Medicaid program to support local hospitals …" Since the purpose of the program is to provide additional Medicaid funding to hospitals to serve residents, the funding must comply with all applicable rules and regulations related to the Medicaid program. As the single state agency administering the Medicaid program, the Department is obligated to comply with these Federal rules, including the Federal limits imposed on DSH payments.

39. COMMENT: A commenter noted that CMS recently proposed a fiscal accountability rule designed to increase oversight and transparency in Medicaid supplemental payment programs and states' financing of these programs including intergovernmental transfer (IGT) programs. 84 Fed. Reg. 63722 (Nov. 18, 2019). Considering the rule's potential impact on the County Option Hospital Fee Pilot Program, most specifically on New Jersey's use of provider assessments and an intergovernmental tax to draw down enhanced Federal dollars, the Department should consider the potential impact of the rule and create a mechanism to reevaluate the State's program and its appropriateness when the rule is adopted.

RESPONSE: Because the Department always monitors legislation, rules, and guidance to ensure Medicaid-related programs meet the requirements of both State and Federal law, there is no need currently to alter the rule, but will do so in the future if needed.

40. COMMENT: A commenter suggested that all acute care hospitals should be held to the same formula when calculating assessments and allowed payment distributions, giving no one hospital an economic advantage based on a defined exception, such as a Level One Trauma Center, a school of medicine located in a defined county, etc.

RESPONSE: Under the County Option Hospital Fee Pilot Program, the assessment is designed by the county. The county may choose to treat distinct types of hospitals differently, as well as to include or exclude hospitals from its assessment program, so long as the overall design is in compliance with the Federal rules related to health care-related taxes and a waiver of the broad-based requirements is secured from CMS.

The county may also propose the basis and formula for the distribution of payments created under its assessment program. However, these payments are also subject to Federal Medicaid rules and payment limitations such as the Medicare upper payment limit under fee-for-service and actuarial soundness under managed care.

41. COMMENT: A commenter stated that the rules and regulations should continue to be developed in conjunction with the hospitals. Hospitals should continue to be included and work with the Department of Human Services Division of Medical Assistance and Health Services (DMAHS) on design and implementation of the program.

RESPONSE: The Department will maintain communication regarding this program with the counties and the hospitals and if the need for additional guidance is identified, the agency will work to provide it in a timely manner.

Federal Standards Statement

42 U.S.C. § 1396b allows governmental jurisdictions to apply an assessment on health care services and Federal regulations at 42 CFR 433.68 define permissible health care related taxes.

42 U.S.C. § 1396d(a) requires a state Title XIX program to provide inpatient and outpatient hospital services to most eligibility groups. Inpatient and outpatient hospital services are optional services for the medically needy population; however, New Jersey has elected to provide these services to medically needy beneficiaries. Federal regulations at 42 CFR 440.2, 440.10, and 440.20, provide definitions of inpatient and outpatient hospital services.

Title XXI of the Social Security Act (SS Act) allows states to establish a children's health insurance program for targeted low-income children. New Jersey elected this option through implementation of the NJ FamilyCare Children's Program. Section 2103, 42 U.S.C. § 1397cc, provides broad coverage guidelines for the program. Section 2110 of the SS Act, 42 U.S.C. § 1397jj, defines hospital services for the children's health insurance program.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the adopted rules falls within Federal standards. Moreover, the county fee and expenditure reports, and the Pilot Program more broadly, will require approval by the Federal government before implementation. Therefore, a Federal standards analysis is not required.

Full text of the adopted new rules follows (addition to proposal indicated in boldface with asterisks ***thus***; deletion from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 52B
THE COUNTY OPTION HOSPITAL FEE PILOT PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

10:52B-1.1 Scope and purpose

(a) This chapter sets forth the policies and procedures for eligible counties to participate in The County Option Hospital Fee Pilot Program.

(b) The County Option Hospital Fee Pilot Program will raise funds to increase financial resources through the New Jersey Medicaid/NJ FamilyCare program to support local hospitals and to ensure that they continue to provide the necessary services to residents with low incomes.

10:52B-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Act" means The County Option Hospital Fee Pilot Program Act, N.J.S.A. 30:4D-7r et seq.

"Affected hospital" means a hospital that is assessed a fee imposed by a participating county.

"Centers for Medicare and Medicaid Services (CMS)" means the agency of the Federal Department of Health and Human Services that is responsible for the administration of the Title XIX Medicaid program and the Title XXI Children's Health Insurance Program (CHIP), known in New Jersey as the Medicaid/NJ FamilyCare program.

"Commissioner" means the Commissioner of the New Jersey Department of Human Services.

"Days" mean calendar days.

"Department" means the New Jersey Department of Human Services.

"Eligible county" means a county with a population greater than 250,000, according to the 2010 Federal decennial census, that contains a municipality that:

1. Is classified, pursuant to N.J.S.A. 40A:6-4, as a First or Second Class municipality, or a Fourth Class municipality whose population exceeds 20,000; and

2. Has a Municipal Revitalization Index score, as last calculated by the New Jersey Department of Community Affairs prior to April 27, 2019, that exceeds 60.

"Fee" means the local health care-related fee authorized by the Act.

"Hospital" means a hospital that is licensed pursuant to P.L. 1971, c. 136 (N.J.S.A. 26:2H-1 et seq.) and is located within the borders of the participating county.

"Intergovernmental agreement (IGA)" means the agreement between a participating county and the Department through which a transfer of funds is made by the participating county to the Department.

"Intergovernmental transfer (IGT)" means the transfer of funds meeting the requirements of 42 U.S.C. §1396b(w) to the Department by a participating county pursuant to an intergovernmental transfer agreement.

"Medicaid/NJ FamilyCare program" means the New Jersey Medical Assistance and Health Services Program established pursuant to P.L. 1968, c. 413 (N.J.S.A. 30:4D-1 et seq.) and P.L. 1997, c. 2 (N.J.S.A. 30:4J-8 et seq.).

"Non-Federal share" means the portion of a Medicaid/NJ FamilyCare expenditure that is financed by State or local funds.

"Participating county" means an eligible county that chooses to participate in the pilot program.

"Pilot program" means The County Option Hospital Fee Pilot Program established by a participating county.

"Proposed fee and expenditure report" means a written report by a participating county that describes how the local health care-related fee authorized pursuant to the Act will be imposed in the participating county; how the funds collected from the fee will be used by the participating county; and how the plan described in the fee and expenditure report satisfies the purposes of the pilot program specified at N.J.A.C. 10:52B-1.1(b).

SUBCHAPTER 2. PARTICIPATION REQUIREMENTS

10:52B-2.1 Authorization and implementation of a county option hospital fee

(a) The Department of Human Services may authorize a county to become a participating county by approving its implementation of a pilot program imposing a fee on hospitals located within the county. Approval is subject to the following procedures:

1. The county shall submit a proposed fee and expenditure report to the Department for review and approval as specified in N.J.A.C. 10:52B-3.1;

2. The Department will make a participating county's proposed fee and expenditure report available for review and comment by affected hospitals and other interested parties for a period of 21 days and will consider the comments received in its review of the proposed report; and

3. The Department may request that a participating county amend its proposed fee and expenditure report if the Department determines that the county's proposal does not meet Federal or State requirements or address comments received during the comment period.

(b) As part of the Department's process to decide whether to approve the proposed fee and expenditure report, the Department shall determine whether the report meets the following requirements, whether:

1. The county's proposed fee and expenditure report will increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals and to ensure that they continue to provide the necessary services to residents with low-income;

2. The county's proposed fee complies with 42 U.S.C. § 1396b(w)(3)(A);

3. The county's proposed fee and expenditure plan described in the fee and expenditure report will not create a direct or indirect guarantee to hold affected hospitals harmless, consistent with 42 CFR 433.68(f);

4. The county's proposed fee will not exceed the aggregate amount specified in 42 CFR 433.68(f)(3) minus three and one-half percent of total net patient revenues, as defined therein;

5. The revenues collected from the fee will qualify as the non-Federal share of Medicaid/NJ FamilyCare program expenditures;

6. The financial impact of the county's proposed fee and expenditure report will reduce access to Medicaid/NJ FamilyCare services, reduce services to the uninsured, or otherwise threaten critical health care services at any hospital within the county, as determined by the Commissioner; and

7. The county's proposed plan described in the fee and expenditure report demonstrates that all good faith efforts will be made by the county to ensure that payments to be made under its proposal will not result in any hospital in the county exceeding its hospital-specific disproportionate share (DSH) limit as outlined in 42 U.S.C. § 1396r-4.

(c) After review of each county's proposed fee and expenditure report and consideration of any comments received during the 21-day public review period, the Department shall make a determination regarding approval for each county's proposed fee and expenditure report.

(d) Once a county's fee and expenditure report is approved, the board of chosen freeholders of the participating county may enact an ordinance or resolution, as appropriate to the county's form of government, imposing the fee and containing the elements specified at N.J.A.C. 10:52B-2.2.

(e) If a waiver is required pursuant to 42 CFR 433.68(e) to implement the county's approved fee and expenditure report, the Department will notify the county when the approval of such waiver is received from CMS.

(f) If revenue collected from the fee will be used as the non-Federal share of expenditures for new Medicaid/NJ FamilyCare provider payments, the Department will notify the county that it has received CMS approval for new Medicaid/NJ FamilyCare provider payments.

(g) A fee may only be collected from assessed hospitals to the extent, and for the period that, the Department determines that the fee proceeds qualify as the non-Federal share of Medicaid/NJ FamilyCare program expenditures pursuant to 42 CFR 433.68.

(h) A fee shall be collected and the proceeds from the fee shall be used in accordance with a participating county's approved fee and expenditure report.

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.

2. Any amendment to a participating county's approved fee and expenditure report shall be subject to the requirements and process specified in this chapter.

3. Revenues from the imposition of a fee must be used as specified at N.J.A.C. 10:52B-3.3.

10:52B-2.2 Required elements of county ordinance or resolution

(a) In order for an eligible county to participate in the pilot program, the county may enact a county ordinance or resolution, as appropriate to the county's form of government, that clearly defines the following:

1. The process for communicating with affected hospitals and collecting feedback and comments on the county proposal;

2. Which hospitals are subject to the fee;

3. The revenue or other metric that will be used as the basis for the fee and the rate that will be used to assess the hospital fee;

4. The notice and collection process;

5. Penalties that may be imposed for nonpayment or late payment;

6. The appeals process;

7. Use of fees for administrative costs, transfers for State administrative costs, and transfers to finance Medicaid/NJ FamilyCare payments to county providers;

8. A statement that there will be no impact on patients or payers; and

9. Affirmation that payments made under the pilot program will not supplant or otherwise offset payments made to hospitals from other sources, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share (DSH) limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

SUBCHAPTER 3. FINANCIAL REQUIREMENTS

10:52B-3.1 Fee and expenditure report; appropriate fee methodology

(a) A participating county must submit a proposed fee and expenditure report to the Department for review in accordance with instructions specified by the Department. The fee and expenditure report shall describe the county's plan for imposing fees and making expenditures from those fees and include such information as may be required by the Department to determine whether the county's report satisfies the requirements at N.J.A.C. 10:52B-2.2.

(b) A participating county shall consult with affected hospitals located in the county to develop its proposed fee and expenditure report prior to submission to the Department.

(c) A participating county's proposed fee and expenditure report must include, at a minimum, the following:

1. An overview of the fee and expenditure plan described in the fee and expenditure report;

2. A list of all the hospitals within the jurisdiction and their facility type (acute care, psychiatric, rehabilitation, long-term acute care hospital, etc.);

3. The proposed fee methodology;

4. The proposed expenditure methodology;

5. Source documentation for the data used to create the fee and expenditure report (for example, Medicare or Medicaid/NJ FamilyCare cost report, survey data, etc.);

6. Any and all facilities the county requests to exclude from the fee with the rationale for those exclusions;

7. A delineation of the percentage of the fee proceeds that the county proposes to:

i. Transfer to the Department to cover State administrative costs; and

ii. Transfer to the Department to be used as non-Federal share of Medicaid/NJ FamilyCare payments to hospitals in the participating county; and

8. A submission of the county's prospective hospital specific disproportionate share payment limit (DSH limit) calculation with supporting documentation for each hospital subject to the hospital fee. The DSH limit is the difference between a hospital's costs for treating Medicaid and uninsured individuals minus Medicaid payments and minus any payments received on behalf of the uninsured.

i. The DSH limit must:

(1) Be calculated in a form and in accordance with instructions specified by the Department;

(2) Be based on the data from the most recent Federal DSH audit;

(3) Use the Inpatient Prospective Payment System (IPPS) Hospital Market Basket as published by CMS to trend costs to the current fiscal year, unless hospital documentation verifies a different cost inflation for the hospital;

(4) Exclude any proposed payments to be made under the pilot program;

(5) Adjust for any changes in Federally matched State subsidy payments since the time of the finalized DSH audit used in the calculation (that is, Charity Care, Graduate Medical Education); and

(6) Be approved by the Department. The Department reserves the right to discount any values included in the calculation that are not supported by appropriate documentation.

ii. Should the county's fee and expenditure report include provisions that would result in increased Medicaid/NJ FamilyCare payments for any hospital that exceed the calculated value of the hospital's DSH limit, the county's proposed fee and expenditure report must include an attestation from the specific hospital's chief executive officer confirming that the hospital is agreeing to a reduction to the hospital's Medicaid DSH payments, including Charity Care payments, to the extent necessary to comply with payment limits outlined in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4). The Department reserves the right to take all appropriate action to comply with Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(d) A participating county's proposed fee and expenditure report must describe the fee methodology that the county is proposing to adopt. An appropriate fee methodology is any methodology that is permitted under applicable Federal regulations and that meets the following criteria:

1. The county must determine how to apply the fee; the fee may be applied to inpatient hospital services, outpatient hospital services, or both;

2. The fee must be applied to all hospitals uniformly, except that the participating county may exempt hospitals within the county that provide the assessed service from the fee, provided that the exemption complies with the requirements of 42 CFR 433.68(c) and (d), and the Department requests and receives approval of the waiver of the broad-based and/or uniform requirements from CMS; and

3. The fee shall be assessed consistent with Federal rules, with the basis of the assessment being: net or gross revenues, discharges, encounters, days, beds, or visits, and may exclude revenue or utilization attributable to Medicaid/NJ FamilyCare, Medicare, or both.

10:52B-3.2 No impact on patients or payers

The chief executive officer of each hospital subject to the fee shall certify 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.

10:52B-3.3 Permissible use of funds

(a) A participating county shall use funds collected from the imposition of a fee as follows:

1. The participating county shall use at least 90 percent of the fee proceeds for the benefit of hospitals located in the county, as follows:

i. The participating county shall make an intergovernmental transfer (IGT) of the funds under an intergovernmental agreement (IGA) with the Department authorizing the Department's use of the funds as the non-Federal share of Medicaid/NJ FamilyCare payments to the local hospitals; or

ii. The participating county may retain the funds and use the funds to make payments to local hospitals as authorized in its approved fee and expenditure report. However, the Commissioner shall only approve a participating county's proposal to retain funds collected from the imposition of a fee provided that the participating county demonstrates, to the satisfaction of the Commissioner, that the county has sufficient funds to make payments to local hospitals in the amount of the fee proceeds that would otherwise have been transferred to the Department, plus an amount equal to the Federal matching funds that would have been paid to the Department had the fee proceeds been used as the non-Federal share Medicaid/NJ FamilyCare payments;

2. A participating county may retain no more than nine percent of the proceeds for its own use;

3. The county shall transfer at least one percent of assessment proceeds to the Department for the cost of administering the program. Should the State's administrative costs for the program exceed the total value of funding transferred by the participating counties for this purpose, remaining costs shall be subtracted from amounts otherwise available as the non-Federal share of payments to hospitals in the participating counties; and

4. Unless the county has received approval to retain funds pursuant to (a)1ii above, the county shall transfer all funds to the State on a quarterly basis, not later than 15 days after the close of each quarter of the State fiscal year. Failure to transfer the funds within this timeframe shall result in penalties imposed by the Department that may include interest penalties of up to 1.5 percent of the outstanding transfer amount per month and/or removal from the pilot program.

(b) The Department shall use the fee proceeds transferred from a participating county, and any Federal matching funds or other Federal funds generated therefrom, for the following purposes, the Department may:

1. Increase Medicaid/NJ FamilyCare payments to hospitals located in the participating county;

2. Make payments to Medicaid/NJ FamilyCare managed care organizations operating in the participating county for increased hospital or hospital-related payments; *[or]* ***and/or***

3. Use the funds for costs directly related to the administration of the pilot program.

(c) The Department shall not use the transferred fee proceeds to supplant or offset any current or future State funds allocated to a participating county, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share (DSH) limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C § 1394r-4).

(d) All hospitals shall maintain records regarding expenditure of funds and make such records available to the Department, the Department's designated representative, or other authorized agent, upon request.

10:52B-3.4 Notice, collection, and return of fee proceeds

(a) Each participating county must develop a process to calculate the amount of the fee to be applied to each participating hospital in compliance with this chapter and Federal rules. The county may require submission of necessary financial data by the participating hospitals, or the county can choose to use other publicly available data sources.

(b) A participating county must specify in its ordinance or resolution, the frequency of collection of the fee (for example, quarterly, monthly, biannually, etc.).

(c) The participating county must provide written notice of the fee amount to each participating hospital postmarked at least 20 days in advance of the due date or define the due date in its ordinance or resolution.

(d) Each participating hospital will pay the fee amount indicated by the county on the specified due date.

(e) Each participating county will provide for refunding of overpayments, or amounts otherwise in error, to the participating hospitals within 15 days of identifying the overpayment or error. The participating county shall specify in its ordinance or resolution the maximum time limit by which a hospital must identify overpayments or amounts otherwise in error.

(f) In the event the Department returns to the participating county any of the transferred funds, the participating county will refund the full amount returned by the Department to the participating hospitals based on the pro rata share of the total fees paid, within 15 days after receipt by the county of the funds from the Department.

10:52B-3.5 Penalties

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.

10:52B-3.6 Appeal of assessment or enforcement action

(a) A participating county must specify a process for an appeal of the fee amount. The appeal shall be filed with the county within 15 days after the participating hospital receives notice of the fee amount due.

(b) A participating county must specify a process for an appeal of the decision to impose penalties and/or the amount of the penalties assessed pursuant to N.J.A.C. 10:52B-3.5.

(c) A hospital filing an appeal of either the amount of the fee or the penalty imposed by the county, or both, must provide any additional information requested by the county as part of the appeal process.

10:52B-3.7 Reports and access

(a) Participating counties, affected hospitals, and managed care organizations are required to retain supporting documents and shall provide access to and shall furnish such reports to the Department, without charge, as the Department may specify, in order for the Department to:

1. Determine the amount of increased funding required to be paid by the managed care organizations to the hospitals;

2. Verify that the managed care organization has calculated and paid the correct amount due; or

3. Respond to inquiries from governmental entities with oversight of the pilot program, including CMS.

(b) Information and records submitted to the Department under this section shall be used only for the purposes specified in this section.

(a)

OFFICE OF PROGRAM INTEGRITY AND ACCOUNTABILITY

Notice of Readoption

Manual of Standards for Community Care Residences

Readoption: N.J.A.C. 10:44B

Authority: N.J.S.A. 30:11B-1 et seq., specifically 30:11B-4.4.

Authorized By: Carole Johnson, Commissioner, Department of Human Services.

Effective Date: February 19, 2020.

New Expiration Date: February 19, 2027.

Take notice that this chapter, which was scheduled to expire on March 19, 2020, pursuant to N.J.S.A. 52:14B-5.1.c, is being readopted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. This chapter contains the rules to establish minimum requirements for the provision of residential services to individuals with developmental disabilities residing in Community Care Residences.

The Department of Human Services (Department) recognizes that further rulemaking is necessary to update this chapter to be consistent with best practices and to include the provisions of the Fee for Services Initiative; the Centers for Medicare and Medicaid Services guidelines for funding; the Central Registry of Offenders Against Individuals with Developmental Disabilities (N.J.S.A. 30:4D-77); P.L. 2017 c. 328 (an act concerning background checks and licensing of certain entities); Stephen Komninos' Law (P.L. 2017 c. 238); and updated organizational changes. To that end, the Department is preparing a rulemaking with substantive amendments to be published in a future issue of the New Jersey Register.

The Department has reviewed the rules and has determined them to be necessary, reasonable, and proper for the purposes for which they were originally promulgated. The rules set minimum requirements that are necessary to implement the Department's statutory mandate to license Community Care Residences for individuals with developmental disabilities. In accordance with N.J.S.A. 52:14B-5.1.c(1), these rules should be readopted and continue in effect for a seven-year period (and as anticipated to be revised).

The following are summaries of the subchapters of N.J.A.C. 10:44B:

Subchapter 1, General Provisions, provides the purpose and scope of the chapter which is to protect the health, safety, welfare, and rights of individuals with developmental disabilities when living in community care residences. Terms used throughout the chapter are defined. The subchapter also includes rules for licensing, including inspection, as well as negative licensing actions, such as: denial, suspension, or revocation due to non-compliance with State and/or Federal laws that govern community care residences.

Subchapter 2, Management of the Residence, includes rules that detail the requirements for licensees, the process and boundaries for the placement and departure of a community care resident, the requirements regarding an alternate who will assume the role and responsibility of a community care residence when the licensee is absent, as well as the licensee's reporting/disclosure requirements including, but not limited to: mistreatment, hospitalization, death, police activity in the residence, changes to the contact information of the residence, and/or whether the licensee has plans to voluntarily discontinue operation of a community care residence.

Subchapter 2A, Records, includes rules setting forth the requirements for maintaining licensee records that must be kept at the residence, as well as the documentation, maintenance, and confidentiality requirements for the records of the community care residents.

Subchapter 3, Care of the Individual, provides rules to ensure individuals in community residences are not prohibited from exercising their human, legal, and civil rights and that they are provided information about their rights. This subchapter also includes rules governing the community care resident's personal funds, health, and hygiene, as well as the provision of food and clothing.

Subchapter 4, Habilitation, includes rules that provide the requirements for service plans developed for each community care individual by the interdisciplinary team, as well as guidance for daily activities, such as education, employment, rehabilitation, and/or chores in the home.

Subchapter 5, Health Services, sets forth requirements for medical and health care including requirements that individuals in the community care residences have appropriate medical providers (that is, doctors, advance practice nurses, dentists, etc.), have had the appropriate medical screening exams and keep up with necessary follow ups, as well as the compliance with the requirement for the residence to have a first aid kit available on-site. This subsection also provides requirements for medication including administration when the IDT and service plan state that the individual cannot take their medication on their own, storage, and documentation and recordkeeping.