COUNTY OF MERCER, NEW JERSEY

ORDINANCE NO. 2023- 5

1st Reading.....April 27, 2023.....

2nd Reading.....May 11, 2023.....

Public Hearing. May 11, 2023...

Date Adopted:

May 11, 2023

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May 30, 2023

Effective Date

Date to County Executive. May 12, 2023.

Date Returned. May 15, 2023.....

Date Resubmitted to Board.....

Approved as to ~~Form and Legality~~

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County Counsel

AN ORDINANCE OF THE COUNTY OF MERCER AMENDING THE ADMINISTRATIVE CODE OF MERCER COUNTY, NEW JERSEY, AND AUTHORIZING AN ASSESSMENT ON CERTAIN SERVICES FURNISHED BY HOSPITALS LOCATED WITHIN THE COUNTY'S BORDERS FOR THE PURPOSE OF INCREASING FUNDING TO SUPPORT THE PROVISION OF NECESSARY SERVICES BY SUCH HOSPITALS TO LOW-INCOME CITIZENS, AND TO PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF MERCER. N.J.S.A. 30:4D-7r, et seq. (AMENDMENT NO. 25)

RECORD OF VOTE

First Reading							Second Reading						
COMMISSIONERS	Aye	Nay	N.V.	Abs.	Res.	Sec.	COMMISSIONERS	Aye	Nay	N.V.	Abs.	Res.	Sec.
Cimino				X			Cimino				X		
Frisby	X				✓		Frisby	X				✓	
Lewis	X					✓	Lewis	X					
McLaughlin	X						McLaughlin				X		
Melker				X			Melker	X					✓
Stokes	X						Stokes	X					
Walter	X						Walter	X					

X—Indicates Vote Abs.—Absent N.V.—Not Voting
Res.—Resolution Moved Sec.—Resolution Seconded

Rejected [ ] By.....

Approved [X]

Reconsidered

By Board.....

County Executive

Override [ ] [ ]

Vote Aye Nay

Lucille R. Walter

Chair of the Board

Darlene N. Worthy

Clerk to the Board

WHEREAS, on November 1, 2018, the State of New Jersey (the "State") enacted the County Option Hospital Fee Pilot Program (the "County Option Program") a 5-year pilot program designed to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients (P.L.2018, c. 136), N.J.S.A. 30:4D-7r, et seq; and,

WHEREAS, on July 5, 2022, the State Legislature passed legislation to remove the pilot program characterization, and establish the County Option Program as permanent (P. L. 2022, ch. 61); and,

WHEREAS, under the County Option Program, the County is authorized to impose an Assessment on certain services furnished by local hospitals; and,

WHEREAS, pursuant to Ordinance No. 2021-1, as adopted by the Mercer County Board of Commissioners on April 22, 2021, the County Option Program was codified and set forth in the Administrative Code of Mercer County, Chapter 4.08, *Hospital Fee Program*; and,

WHEREAS, due to certain developments affecting the program, including the merger of two (2) area hospitals covered by same, it is necessary to amend the County's Administrative Code accordingly;

NOW, THEREFORE, BE IT ORDAINED, by the Mercer County Board of Commissioners that the Mercer County Administrative Code shall be amended to provide as follows:

1. Chapter 4.08, County Hospital Fee Program

Section 4.08.01. Recitals. The Recitals set forth above are hereby incorporated by reference.

Section 4.08.02. Definitions. As used in this Ordinance, the following capitalized terms, not otherwise defined herein, shall have the following meanings, unless the context hereof otherwise requires.

"Assessment" means the assessment imposed and levied upon the Assessed Hospitals as defined herein.

"Assessment Notice" means the notice distributed to each Assessed Hospital at the beginning of each Program Year specifying the annual Assessment owed and the quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

"Assessed Revenues" means, with respect to each Assessed Hospital, the total amount of net inpatient hospital service revenues, other than Medicare revenues, reported on the most recent "Data Form for County Option Hospital Fee [Pilot] Program" prepared by the Assessed Hospital and submitted to the State prior to the effective date of this Ordinance. Such non-Medicare net inpatient hospital service revenues are determined by subtracting Lines 2, 3, 5 and 7 of Column A from the total net inpatient revenues reported in Line 1 of Column A of such data form. A blank data form is included herein for informational purposes.

"Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services, including: Capital Health Regional Medical Center; Capital Health Medical Center – Hopewell; St. Francis Medical Center; Robert Wood Johnson University Hospital – Hamilton; St. Lawrence Rehabilitation Center; and Princeton House Behavioral Health, **subject to Section 4.08.06**.

"Directed Payments" means the Medicaid managed care rate increase payments distributed by DMAHS through the Managed Care Organizations to hospitals as authorized under the County Option Program.

"Implementation Date" means July 1, 2021 provided that the County Option Program has received all necessary federal approvals, but in no case shall the Assessment be implemented if the County has not entered into an Intergovernmental Agreement consistent with Section 4.08.11.

"Intergovernmental Agreement" means the agreement between the County and DMAHS governing the transfer of the Assessment funds collected from the Assessed Hospitals

"Managed Care Organizations" means the health plans under contract with DMAHS to provide covered services to Medicaid beneficiaries through the Medicaid/NJ FamilyCare program and that will be directed to distribute Medicaid managed care rate increase payments to hospitals under the County Option Program.

"Program Year" means each 12-month period of the County Option Program, beginning with July 1, 2021 through June 30, 2022.

"Quarterly Assessment Invoice" means the notice distributed to each Assessed Hospital prior to each quarterly Assessment due date specifying the quarterly Assessment amount due, any interest incurred, and any additional elements specified herein.

Section 4.08.03. Authority. This Ordinance is adopted pursuant to P.L.2018, c. 136, **as amended by P. L. 2022, ch. 61** and N.JS.A. 30:4D-7r, et seq., as same may be amended and supplemented from time to time.

Section 4.08.04. Assessment Scope, Basis and Use.

(A) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Section 4.08.05, to take effect on the Implementation Date.

(B) The County shall use the amounts collected from the Assessment only as follows:
  (1) The County shall transfer 91% of total collected funds to DMAHS to be used as outlined in the Intergovernmental Agreement, described in Section 4.08.11.
  (2) The County shall retain 9% of total collected funds to be allocated at the County's discretion.

(C) In the event that DMAHS returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital the pro rata portion of such funds.

(D) In the event that an individual Assessed Hospital is determined to have overpaid their Assessment or otherwise paid in error, the County shall refund the overpayment or the amount paid in error to the Assessed Hospital within 15 days of the later of:
  (1) Discovering the overpayment or error, if the funds have not been transferred to DMAHS, or
  (2) Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to DMAHS.

(E) Assessed Hospitals shall not pass on the cost of the fee to any patient, insurer, self-insured employer program, or other responsible party, nor list it separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

Section 4.08.05. Computation of Assessment.

(A) The annual Assessment for each Assessed Hospital shall equal 6.76% of Assessed Revenues.

(B) The annual Assessment amounts for each Assessed Hospital, calculated pursuant to (A), above, shall equal the following:
(1) Capital Health Regional Medical Center: $8,661,359
(2) Capital Health Medical Center – Hopewell: $10,691,108
(3) St. Francis Medical Center: $1,911,437
(4) Robert Wood Johnson University Hospital – Hamilton: $2,942,842
(5) St. Lawrence Rehabilitation Center: $214,149
(6) Princeton House Behavioral Health: $1,816,610

(C) The annual Assessment shall be payable in four quarterly installments, each to equal 25% of the annual Assessment amount.

Section 4.08.06. Mergers and Consolidations.
(A) If two (2) or more assessed hospitals merge or consolidate, the hospital resulting from the merger or consolidation is considered to be an Assessed Hospital and is liable for any outstanding Assessment amounts due from any hospitals involved in the merger or consolidation, including outstanding amounts related to periods prior to the merger or consolidation.

(B) In the case of such a merger or consolidation, the fee paid by the resulting Assessed Hospital shall be based on the combined Assessed Revenues of the merged or consolidated Assessed Hospitals. The annual Assessment amount shall be equal to the sum of the amounts for each hospital prior to merger or consolidation as listed in Section 4.08.05

(C)In the case that such a merger or consolidation occurs between an Assessed Hospital and a hospital outside of the County, the hospital located outside of the County shall not become an Assessed Hospital and the County shall not access services provided outside of the County

Section 4.08.07. Assessment Notice.

(A) At least 30 days prior to the due date of the first Assessment of each Program Year, the County shall provide an Assessment Notice by certified mail/RRR and first class mail to the each Assessed Hospital.

(B) The Assessment Notice shall include (1) a brief explanation of the Assessment, (2) a description of the methodology used to determine the Assessment amount, (3) the annual Assessment amount owed by the Assessed Hospital for the upcoming Program Year, (4) the quarterly Assessment amounts owed by the Assessed Hospital for the Program Year; (5) the acceptable methods of payment, (6) the dates on which each quarterly Assessment is due, (7) the interest rate that will be charged for late payments; and (8) a statement of the Assessed Hospital's appeal right and the timing and requirements of such appeal.

Section 4.08.08. Assessment Invoice.

(A) At least 20 days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by certified mail/RRR and first class mail to each Assessed Hospital.

(B) The Assessment Invoice shall include (1) the Assessment amount due for the relevant quarter, including any accrued interest from prior quarters, (2) the acceptable methods of payment, and (3) the due date of such payment.

Section 4.08.09. Interest. Should an Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may require the Assessed Hospital to pay interest in the amount of 1.5% of the outstanding payment amount per month, to be added to the following quarter's Assessment Invoice.

Section 4.08.10. Appeals/appeal panel.

(A) Upon receipt of the County's Assessment Notice at the beginning of each Program Year, Assessed Hospitals shall have 15 days to file an appeal of the Assessment amount stated in the Assessment Notice.

(B) Any appeal shall be in writing and shall indicate the specific basis for the appeal, and shall include all documentation in support thereof. The appeal shall be made to the County's appeal panel which shall consist of the County Administrator, County Treasurer, and a designee from the County's Department of Health & Human Services. The appeal panel shall review the submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The appeal panel shall render a written decision within fifteen (15) days of receipt of the appeal materials where no oral presentation is requested; a written decision shall be provided within fifteen (15) days of the conclusion of any oral presentation. The decision of the appeal panel shall be final and binding upon the parties.

Section 4.08.11. Requirement to Submit Necessary Documentation. Assessed Hospitals shall submit any data forms reasonably related to the County Option Program requested by the County by the due date specified by the County.

Section 4.08.12. Intergovernmental Agreement. The County is authorized to enter into an Intergovernmental Agreement with DMAHS governing the transfer of Assessment funds from the County to the State, including the following general terms:

(A) Timing requirements for the transfer of Assessment funds from the County to DMAHS, from DMAHS to the Managed Care Organizations, and from the Managed Care Organizations to the hospitals.

(B) A requirement that DMAHS use 90% of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that DMAHS may permit the Managed Care Organizations that make the Directed Payments to retain up to 5% of the total amount paid to them exclusively to cover their incremental cost of any state insurance premium tax.

(C) Assurances that the County will not be liable for any unpaid Assessment amounts and will only be responsible for transferring Assessed funds to the extent received by the Assessed Hospitals.

(D) A requirement that DMAHS return to the County the non-federal share of any Medicaid Directed Payment funds received by the assessed hospitals but subsequently recouped by DMAHS.

(E) A statement that any resulting Medicaid/NJ Family Care payments distributed under the County Option Program shall not supplant or otherwise offset payments made to hospitals from other State or federal funding mechanisms or pools, except that payments may be otherwise limited to the hospital's hospital-specific disproportionate share limit as provided in Section 1923(g) of the Social Security Act (42 U.S.C. § 1394r-4).

(F) A statement describing DMAHS's use of the Assessment funds as the non—federal share of payments to draw down federal matching funds.

Section 4.08.13. Termination. The Assessment shall terminate upon expiration of the County Option Program under State law, unless any of the following conditions occur earlier:

(A) DMAHS notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation;

(B) The Assessment is otherwise finally determined to be unlawful under County, State, or Federal law by an agency or Court competent to make such a final determination;

(C) The County Option Program is terminated by the State, or fails to obtain required approval or reapproval by the federal Centers for Medicare and Medicaid Services; or

(D) The Intergovernmental Agreement described in Section 4.08.11 is terminated by its terms or no longer meets the conditions described in such section.

Section 4.08.14. Impact of Termination. In the event that the Assessment terminates early pursuant to Section 4.08.12 (A)-(D), the County shall refund to each Assessed Hospital within 15 days of the effective date of such termination the pro rata portion of:

(A) Any funds that have not been transferred to DMAHS or that DMAHS returns to the County; and,

(B) Any of the portion allocated for the County's use pursuant to Section 4.08.04(B)(2) that has not already been spent or irrevocably allocated for its designated purposes.

2. The Clerk to the Board is hereby directed to comply with the publication of the Ordinance with the provisions of law.

3. This Ordinance shall take effect immediately upon passage and publication, subject to all necessary State and federal approvals.

4. Upon adoption, the Clerk shall forward a certified copy of this Ordinance to the County's Chief Financial Officer, County Counsel and the County Administrator.