Board of Commissioners

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Clerk of The Board

camden county
Making It Better, Together.

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NOTICE OF ADOPTION

The Ordinance published herewith has been finally adopted after a PUBLIC HEARING held on August 15, 2024 at 12:00 P.M., at the Camden County Courthouse, 520 Market Street, 6th Floor Meeting Room, Camden, New Jersey. A First Reading was introduced and approved on July 18, 2024, by the Camden County Board of Commissioners in the City of Camden, County of Camden, New Jersey and the 20-day period of limitation within which a suit, action or proceeding questioning the validity of such Ordinance can be commenced, as provided in the Local Bond Law, has begun to run from the date of the first publication of this statement.

ORDINANCE OF THE COUNTY OF CAMDEN AUTHORIZING AN UPDATE TO THE ADOPTION OF 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 PROVIDE NEW FISCAL RESOURCES TO THE COUNTY OF CAMDEN.

Removal Date: September 15, 2024

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WHEREAS, hospitals in Camden County (the "County") provide essential services and serve a critical role in promoting the health of the County's citizens and expanding access to care throughout the community; and

WHEREAS, each year, hospitals in the County provide millions of dollars of uncompensated health care to Medicaid and uninsured patients; and

WHEREAS, on November 1, 2018, the State of New Jersey (the "State") Legislature enacted the County Option Hospital Fee Pilot Program (the "County Option Program") to help support local hospitals in designated counties and ensure the provision of necessary services to low-income patients (P.L.2018, c. 136); and

WHEREAS, on July 5, 2022, the State of New Jersey (the "State") Legislature made the Pilot Program permanent (P.L.2022, ch.61); and

WHEREAS, pursuant to P.L.2018, c. 136, as amended by P.L. 2022, ch.61, the County is eligible to participate in the County Option Program and is thereby authorized to impose an Assessment on hospitals located within the County's borders; and

WHEREAS, the funding from the County Assessment will be transferred to the Division of Medical Assistance and Health Services within the Department of Human Services **("DHS")** to enable the State to draw down federal matching funds to support a rate increase in payments to hospitals in the County for certain services furnished to Medicaid/NJ FamilyCare beneficiaries; and

WHEREAS, the County, through its contractors, has developed a model to participate in the County Option Program, based on a comprehensive process of consulting and gathering feedback from all Assessed Hospitals, and the model may be updated and modified in each subsequent year; and

WHEREAS, the consultation process includes educating all Assessed Hospitals on the

goals and requirements of the program and any program updates, supporting hospital submission of required data forms, presenting available options to all Assessed Hospitals and hosting multiple hospital-wide discussions and follow-up discussions as requested, and soliciting written feedback from all Assessed Hospitals to inform the County's Assessment selection in each year in which the County elects to submit a new Fee & Expenditure Report; and

WHEREAS, the County has a Fee & Expenditure Report which has received approval from DHS; and

WHEREAS, the County has an interest in supporting access to health care to its low-income residents, as well as the broader community through support of necessary care provided by local hospitals; and

WHEREAS, imposing an assessment to help fund the provision of necessary care by local hospitals to low-income patients in the County is a valid public purpose that benefits the health, safety and welfare of its citizens; and

WHEREAS, ensuring the financial stability and viability of local hospitals providing such necessary health care supports important contributors to the County's economy; and

WHEREAS, the County desires to participate in the County Option Program through the model described in the most recently approved Fee and Expenditure Report including by levying and collecting an Assessment on certain services furnished by hospitals located within the County's borders more specifically described herein.

NOW, THEREFORE, BE IT ORDAINED, by the Board of Commissioners of the County of Camden, that:

Section 1. Recitals. The Recitals set forth above are hereby incorporated by reference.

Section 2. 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 calculated in the most recent Fee & Expenditure Report approved by DHS.

"Assessment Notice" means the notice distributed to each Assessed Hospital at the

beginning of each Program Year specifying the annual and quarterly Assessment amounts owed by each Assessed Hospital, and any additional elements specified herein.

"Assessed Hospitals" means the hospital facilities located within County's borders that provide inpatient hospital services.

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

“Hospital Closure” means an Assessed Hospital’s cessation of the provision of inpatient hospital services in the County.

"Implementation Date" means July 1, 2021.

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

"Managed Care Organizations" means the health plans under contract with **DHS** 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.

“New Hospital” means a hospital that begins providing inpatient hospital services within the County’s borders for the first time after the Implementation Date.

"Program Year" means each 12-month period of the County Option Program, each of which shall run concurrently with the state fiscal year.

"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 3. <u>Authority.</u> This Ordinance is adopted pursuant to P.L.2018, c. 136, as amended by P.L. 2022, ch.61 and any successor act (“The County Option Hospital Fee Program Act” or “Act”).

Section 4. <u>Assessment Scope, Basis and Use.</u>

(A) There is hereby imposed on all Assessed Hospitals an Assessment calculated as set forth in Sections 5 through 8, 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 **DHS** to be used as outlined in the Intergovernmental Agreement, described in Section 14.
   (2) The County shall retain 9% of total collected funds to be allocated as directed by the Board of County Commissioners.

(C) In the event that **DHS** returns all or a portion of the transferred Assessment funds to the County, the County shall refund to each Assessed Hospital within 15 days of receipt 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 **DHS**, or
   (2) Receipt of a refund of the overpayment or amount paid in error if the funds have been transferred to **DHS**.

(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 5. Computation of Assessment.

(A) Each Assessed Hospital shall pay an annual Assessment in accordance with the most recent Fee & Expenditure Report approved by DHS for the current Program Year.

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

(C) The Assessment shall constitute a debt due the County from the time the Assessment is due until it is paid.

(D) The Assessment may be updated annually, effective at the beginning of each Program Year, by the County filing and DHS approving a new Fee & Expenditure Report.

Section 6. **Hospital Closure.**

(A) Fees shall not be due from any Assessed Hospital for any period after the hospital's closure. An Assessed Hospital will be considered closed on the Hospital Closure date provided in the required notice in subsection (B).

(B) An Assessed Hospital shall provide the County notice of a planned Hospital Closure as soon as practicable but in no case less than 30 days before the closure.

(1) The notice shall include the date of the planned Hospital Closure.

(2) The hospital shall provide further notice to the County if the Hospital Closure date changes after the hospital has provided initial notice.

(C) The Assessed Hospital will be liable for a prorated share of the quarterly installment due for the quarter in which the Hospital Closure occurs. The share shall be equal to the share of days in that quarter prior to the date of closure.

(D) If a Hospital Closure of an Assessed Hospital occurs at the end of a quarter, no fee shall be due for the following quarter(s).

(E) An Assessed Hospital that experiences a Hospital Closure shall be liable for any outstanding Assessment amounts related to periods prior to the Hospital Closure, and such amounts shall constitute a debt due the County until they are paid.

(F) In the event that claims data collected by DHS or other available documentation indicates that an Assessed Hospital experiencing a Hospital Closure provided inpatient services after the date specified in the notice provided to the County, the closing hospital will be liable for the difference between the assessed amount based on the date of closure in the hospital's notice and an Assessment amount calculated reflecting the hospital's last date of providing inpatient services in the County, plus interest of 1.5 percent per month through the month in which the outstanding amount is paid.

(G) Revised assessment amount. The County shall submit an updated Fee & Expenditure Report for the Program Year following a Hospital Closure.

Section 7. <u>Mergers, Acquisitions, and Consolidations.</u>

(A) If two or more Assessed Hospitals merge or consolidate or one Assessed Hospital acquires another, the hospital resulting from the merger, acquisition, or consolidation is, as of the date of such transaction, considered to be an Assessed Hospital and is liable for any outstanding Assessment amounts due from any hospitals involved in the merger, acquisition, or consolidation, including outstanding amounts related to periods prior to the merger, acquisition, or consolidation.

(B) In the case of such a merger, acquisition, or consolidation, the fee paid by the resulting Assessed Hospital shall be based on the combined Assessments of the merged, acquired, or consolidated Assessed Hospitals.

(C) In the case that a merger, acquisition, or consolidation occurs between an Assessed Hospital and a hospital outside of the County, the hospital locations outside of the County shall not become Assessed Hospitals and the County shall not assess services provided outside of the County.

Section 8. <u>New Hospitals.</u>

(A) A New Hospital shall become an Assessed Hospital in the Program Year that begins at least two years following the year in which it becomes a New Hospital, unless the County determines, in consultation with DHS, that there is insufficient data to include the New Hospital in the model until the next Program Year.

(B) Beginning with the Program Year for which the new hospital becomes an Assessed Hospital, the County shall determine its Assessment as defined in Section 2.

Section 9. <u>Assessment Notice.</u>

(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 first class mail and/or electronic mail to the owner of 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 10. **<u>Assessment Invoice.</u>**

(A) At least 20 days prior to each quarterly Assessment due date, the County shall provide an Assessment Invoice by first class mail and/or electronic mail to the owner of 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 11. Untimely Payment.

(A) 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, or seek payment by any legally available means.

(B) Offset. Should the Assessed Hospital fail to remit the quarterly Assessment amount by the date specified in the Assessment Invoice, the County may, upon 10 days written notice to the Assessed Hospital, request that DHS collect the overdue Assessment and any accrued interest on behalf of the County by applying an offset to the Assessed Hospital's/Family Care payments.

Section 12. Appeals.

(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 with the County's Appeal Tribunal.

(B) Assessed Hospitals subject to interest under Section 11 may appeal the decision to impose interest and/or the amount of the interest assessed with the County's Appeal Tribunal, within 15 days after receipt of the Assessment Invoice including such interest.

(C) All appeals shall be in writing and shall indicate the specific basis for the appeal and shall include all documentation in support thereof. The appeals shall be made to the County's Appeal Tribunal which shall consist of the County Administrator, County Treasurer, and County Counsel. The Appeal Tribunal shall review the appeal submission and shall provide the appealing party with an opportunity to make an oral presentation if so desired. The Appeal Tribunal shall render a written decision within 15 days in any case where an oral presentation is made or within 15 days of receipt of the written appeal materials where no oral presentation is requested. The decision of the Appeal Tribunal shall be final, binding, and no further appeal may be taken.

Section 13. Requirement to Submit Necessary Documentation. Assessed Hospitals shall submit any data forms related to the County Option Program requested by the County by the due date specified by the County.

Section 14. Intergovernmental Agreement. The County is authorized to enter into an Intergovernmental Agreement with **DHS** governing the transfer of Assessment funds from the County to the State. The agreement shall include the following:

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

(B) A requirement that **DHS** use 90% of the Assessment amount to fund the non-federal share of Directed Payments under the County's County Option Program, except that **DHS** 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 **DHS** return to the County the non-federal share of any Directed Payment funds recouped by **DHS** from Assessed Hospitals.

(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) Assurances that funds generated by the Assessment shall not supplant or offset any current or future State funds allocated to the County.

Section 15. Termination. The Assessment shall terminate if any of the following conditions occur:

(A) The State of New Jersey Legislature repeals the Act or otherwise amends the law such that the County is no longer eligible to participate in the County Option Program;

(B) **DHS** notifies the County that the Assessment funds do not qualify as the State share of Medicaid program expenditures eligible for federal financial participation.

(C) 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; or

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

(E) The Intergovernmental Agreement described in Section 14 is terminated or no longer meets the conditions described in such section.

Section 16. Impact of Termination. In the event that the Assessment terminates pursuant to Section 15, 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 DHS or that DHS returns to the County; and

(B) Any of the portion allocated for the County's use pursuant to Section 4(B)(2) that has not already been spent or irrevocably allocated for its designated purposes.

Section 17. Public Hearing. A public hearing for the purpose of hearing persons interested in or affected by this proposed Ordinance authorizing the Assessment shall be held on August 15 at 12 noon at the Camden County Courthouse, 520 Market Street, Camden, New Jersey. The meeting will be streamed live via https://www.camdencounty.com/live where members of the public can view and participate via the live feed.

Section 18. Severability. If any section, paragraph, subdivision, clause or provision of this Ordinance shall be judged invalid such adjudication shall apply only to the section, paragraph, subdivision, clause or provision so judged, and the remainder of the Ordinance shall be deemed valid and effective.

Section 19. Effective Date. This Ordinance shall take effect 20 days following final adoption and publication in accordance with applicable law; provided, however, that in no event shall this Ordinance become effective until such date as the Local Finance Board shall render findings in connection with the matters set forth herein, in satisfaction of the provisions of N.J.S.A. 40A:5A-7.