CHAPTER 47

AN ACT concerning the “County Option Hospital Fee Program Act” and amending P.L.2018, c.136.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.2018, c.136 (C.30:4D-7s) is amended to read as follows:

C.30:4D-7s Definitions relative to "The County Option Hospital Fee Pilot Program Act."

2. As used in this act:

"Commissioner" means the Commissioner of Human Services.

"Department" means the Department of Human Services.

"Fee" means the local healthcare-related fee authorized pursuant to this act.

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

"Medicaid program" means the "New Jersey Medical Assistance and Health Services Program" established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.).

"Participating county" means, notwithstanding the provisions of any other law or regulation to the contrary, a county that chooses to participate in the program, has a population greater than 250,000, according to the federal decennial census immediately preceding the effective date of P.L.2018, c.136 (C.30:4D-7r et seq.), and contains a municipality which: (1) is classified, pursuant to N.J.S.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 Distress score, as last calculated by the New Jersey Department of Community Affairs prior to the effective date of P.L.2018, c.136 (C.30:4D-7r et seq.), that exceeds 55; or, based on the 2019 ACS 5 Year Survey Data, a county that chooses to participate in the program and contains a municipality with a population greater than 30,000 whose 2020 Municipal Revitalization Index Distress score is greater than or equal to 33 (1) excluding counties with a municipality with a population greater than 125,000, (2) excluding counties with a population less than 150,000, and (3) excluding counties with a median household income greater than $110,000.

"Program" means "The County Option Hospital Fee Program" established pursuant to this act.

"Proposed fee and expenditure report" means a written report by a participating county that describes how the fee will be imposed in the participating county; how the funds collected from the fee will be used by the participating county, including the amount and services the participating county plans to provide with the funds; and how the plan satisfies paragraph (1) of subsection b. of section 3 of this act.

2. Section 3 of P.L.2018, c.136 (C.30:4D-7t) is amended to read as follows:

C.30:4D-7t "County Option Hospital Fee Program."

3. a. There is established “The County Option Hospital Fee Program” in the Department of Human Services.

b. The purpose of the program is:

(1) to increase financial resources through the Medicaid program to support local hospitals and to ensure that they continue to provide necessary services to low-income citizens; and

(2) to provide participating counties with new fiscal resources.

c. Each participating county shall be authorized by the commissioner to impose a local healthcare-related fee on hospitals within its borders.

d. A participating county shall submit a proposed fee and expenditure report to the commissioner to ensure that the proposed fee and expenditure plan satisfies paragraph (1) of subsection b. of this section and subsection e. of this section, and does not create a direct or indirect guarantee to hold harmless, as those terms are used in 42 C.F.R. s.433.68(f). The commissioner shall further review the proposed fee and expenditure report to determine whether it complies with relevant rules and regulations. Each participating county shall consult with affected hospitals within its jurisdiction to prepare the proposed fee and expenditure report before the report is submitted to the commissioner. The commissioner shall make the proposed fee and expenditure report available to the affected hospitals for review and the hospitals shall be permitted to provide comments to the commissioner regarding the report for a period of 21 calendar days from the date the proposed report is made available for review. If a participating county submits a proposed fee and expenditure report that includes plans to increase Medicaid or NJ FamilyCare payments for any hospital within its jurisdiction that exceeds the calculated value of its hospital-specific disproportionate share limit, as outlined in 42 U.S.C. s.1396r-4 and calculated by the State, the proposed fee and expenditure report shall include an attestation from the chief executive officer of any such hospital confirming that the hospital is subject to a reduction in disproportionate share hospital payments, including Charity Care payments, at the commissioner's discretion and upon notice to the hospital and to the extent necessary to comply with payment limits outlined in section 1923(g) of the federal Social Security Act. The Department of Human Services shall take all appropriate action to comply with section 1923(g) of the federal Social Security Act.

e. The board of County commissioners of a participating county, following the approval of the participating county's proposed fee and expenditure plan by the commissioner, may adopt an ordinance providing for the imposition of a fee on hospitals located within its borders and for appropriate administrative provisions, including, but not limited to, provisions for the collection of interest, the collection of penalties, and the application of liens.

The fee shall be implemented in accordance with the provisions of 42 U.S.C. s.1396b(w)(3)(A), and shall be subject to the maximum aggregate amount that may be assessed pursuant to 42 C.F.R. s.433.68(f)(3), or any subsequent maximum amount as may be established by federal law, and shall be subject to review and approval by the commissioner. The fee shall not exceed the aggregate amount specified in 42 C.F.R. s.433.68(f)(3) minus one percent of total net patient revenues. The participating county may exempt a hospital within its jurisdiction from the fee, provided that the exemption complies with the requirements of 42 C.F.R. s.433.68.

The fee authorized pursuant to this act may be collected only to the extent that the commissioner determines that the revenues generated qualify as the State share of Medicaid program expenditures eligible for federal financial participation pursuant to 42 C.F.R. s.433.68.

f. Any subsequent alterations to the fee are subject to the approval of the commissioner prior to implementation. Upon approval, the commissioner shall apply for such State plan amendments or waivers as may be necessary to implement the changes and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program.

g. (1) Neither the State nor a participating county shall be liable for any amount of a local healthcare-related fee imposed on a hospital pursuant to this act that the hospital fails to pay or does not pay in a timely manner to the assessing county.

(2) With the exception of the period of time during which a participating county or Medicaid Managed Care Organization is in possession of payments prior to disbursement, neither a participating county nor Medicaid Managed Care Organization shall be liable for any

amount related to an approved expenditure plan determined to be impermissible by a federal agency. The Department of Human Services shall amend related managed care contracts to include this provision.

h. Any hospital that exceeds its hospital-specific disproportionate share limit pursuant to 42 U.S.C. s.1396r-4 as a result of payments received pursuant to the County Option Hospital Fee Program or pursuant to other State or federal funding mechanisms or pools shall be liable to the State for any funds the State may be required to reimburse the federal government for any such excess disproportionate share hospital funds attributable to the hospital.

3. This act shall take effect immediately.

Approved July 22, 2024.