



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 19 No. 43

August 2009

TO: New Jersey General Acute Care Hospitals
Chief Executive Officer

ROUTE TO: Chief Financial Officer, Finance and Accounting

EFFECTIVE: August 3, 2009

SUBJECT: **New Medicaid Fee-for-Service Reimbursement Methodology for New Jersey General Acute Care Hospital Inpatient Services**

PURPOSE: The purpose of this newsletter is to notify all New Jersey general acute care hospitals that the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) will be implementing a new Medicaid fee-for-service reimbursement methodology for inpatient services.

ACTION: New Jersey general acute care hospitals will continue to be reimbursed based on diagnosis related groups (DRGs), but the new DRG reimbursement system is based upon a Statewide base rate and DRG weights, instead of the current system which sets a rate for each DRG for each acute care hospital based on 1988 costs.

DMAHS used the All Payer (AP) DRG Classification System (referred to as the "Grouper") developed by 3M Health Information Systems to assign the appropriate DRG based on clinical data on the claims. The current system uses Version 8.1 of the Grouper, and the new system will use Version 24.

DRG weights were developed using 2003 Medicaid inpatient claims and 2003 Medicare cost report data. A DRG weight was calculated for each DRG based on costs derived from the charges and days on the claims data. Routine costs were calculated by multiplying the routine per diem costs from the Medicare cost report times the number of days on the claims, and using ancillary cost to charge ratios from the Medicare cost report multiplied by the ancillary charges on the claims. Total costs were aggregated by each DRG, and the DRG weight calculation uses the following formula: statewide average cost per case for a specific DRG divided by the statewide average cost per case for all DRGs.

The Statewide base rate is based upon DRG payments from 2006 claims data, with reductions to exclude outlier payments, payments for alternative levels of care days, payments where Medicaid is the secondary payer, hospital based physician payments and utilization review payments. These net 2006 Medicaid inpatient payments were adjusted for inflation for the period 2006 to 2009 by using the Center for Medicare and Medicaid Services (CMS) operating market basket index factor for hospitals excluded from the CMS Inpatient Prospective Payment System (IPPS) which is published annually in the Federal Register by CMS. This CMS inflation factor is referred to in the rules for the current system as "the factor recognized under the TEFRA target limitations".

Utilization review payments will continue to be paid directly to hospitals until DMAHS has a contractor in place to perform utilization review services. Hospitals will receive separate payments equal to the aggregate amount of utilization review removed before establishing the statewide base rate. Each hospital will receive a utilization review payment based on its proportional number of Medicaid fee-for-service discharges from the 2007 Medicaid paid claims data.

The new Medicaid hospital payments will not include the costs of physicians who render inpatient services at New Jersey general acute care hospitals. Physicians must bill for Medicaid inpatient services, under their own Medicaid provider number or under the Physicians Group Medicaid number if they are a member of a physicians group. If a physician or physicians group is not a Medicaid provider, they must enroll in the New Jersey Medicaid program. Claims must be submitted on CMS-1500 claim forms and reimbursement will be made using the Medicaid fee schedule for physicians.

The Statewide base rate also excludes direct and indirect medical education payments which will continue to be paid separately to eligible hospitals as allowed by federal regulations. The new DRG methodology provides add-on amounts to the Statewide base rate for those qualifying hospitals that provide high volumes of services to Medicaid and other low income patients

The DRG payment for an inpatient claim will be calculated by multiplying the Statewide base rate, plus add-on amounts if applicable, times the DRG weight. Two categories of outlier payments will provide an additional payment above the DRG payment.

Cost outliers are those cases that qualify for an additional payment for those cases exceeding certain cost limits. Cost is calculated using charges from the claim and applying a hospital specific cost to charge ratio. Cases with costs exceeding the applicable cost limit will be reimbursed a cost outlier payment equal to 75 percent of the costs exceeding the cost limit.

Day outliers are cases in which there are alternate level of care (ALC) days, defined as skilled or intermediate care facility days, with payment made for ALC days that exceed the statistical DRG day limit. Day outlier reimbursement is based on qualifying ALC days times the annual nursing facility rate per day set by the Department of Health and Senior Services. Hospitals may qualify for both day and cost outlier payments simultaneously.

Daily rates were set for each DRG and are used to reimburse same day discharges to apportion payments for cases in which a patient's Medicaid eligibility began or ended during an inpatient stay, and for some transfer cases.

The statewide base rate and other new system components including the DRG weights will be effective August 3, 2009. Complete details of the proposed regulatory changes were published in the New Jersey Register on Monday, April 6, 2009. Final adoption of the rules was published on Monday, August 3, 2009.

If you have questions concerning this Newsletter, please contact the Division's Office of Reimbursement at (609) 588-2668.

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