Volume 2 No. 68 December 1992

TO: Chief Executive Officer - Hospitals

SUBJECT: Inpatient Hospital Reimbursement

EFFECTIVE: January 1, 1993

BACKGROUND: Prior to the enactment of P.L. 1992, Chapter 160, rates for Assistance and Health Services through the New Jersey Department of Health and the Hospital Rate Setting Commission as part of a hospital all payer system. As the result of Chapter 160, Medicaid must now implement a new rate setting methodology for inpatient hospital services. The purpose of this Newsletter is to inform acute general and special (Classification A) hospitals of the rate setting methodology for reimbursement by the New Jersey Medicaid program for inpatient hospital services provided on and after January 1, 1993.

APPLICABILITY:

This Newsletter does not apply to those special hospitals (Classification A or B) or distinct (excluded) units of acute general hospitals reimbursed according to Medicare principles of reimbursement or special hospitals (Classification C) reimbursed under the CARE (Cost Accounting and Rate and Evaluation) system.

ACTION: On and after January 1, 1993, reimbursement by the New Jersey Medi Commission in 1992. In addition, a hospital-specific Medicaid payer factor will be calculated by the New Jersey Department of Health and adjusted using a statistical methodology developed by the New Jersey Medicaid program as outlined in the proposed regulations to be added at N.J.A.C. 10:52-1.23.

Under the methodology, the Medicaid payer factor will vary according to the Medicaid program's findings as to the relative efficiency of the hospital(s). The methodology will adjust for the differences between DRG rates that had been established under Chapter 83 for 1992 and the rates that are necessary to assure that Medicaid payments in the aggregate do not exceed the amount that would be paid under Medicare principles of reimbursement. In addition, the rates will be adequate to meet necessary costs that must be incurred by economical and efficient facilities.

Between January 1, 1993 and June 30, 1993, the Medicaid payer factors will be adjusted to a level that accounts for differences between the amounts paid during calendar year 1992 and the Medicare upper payment limit for that year and to a level which results in payments that are reasonable and adequate to meet necessary costs at an economical and efficient facility.

BILLING INSTRUCTIONS:
For inpatient hospital services provided to Medicaid recipients, there is no change in the billing methodology. Hospitals should continue to bill using the DRG designation on the UB-82 claim form.

For further information or questions regarding this Newsletter, please contact Ann Kohler, Institutional and Provider Reimbursement, Division of Medical Assistance and Health Services, at (609) 588-2668.

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