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

NEWSLETTER

Volume 22 No. 16 **September 2012**

TO: **Out of State Acute Care Hospital Providers**

SUBJECT: **Regulation change regarding reimbursement for inpatient and outpatient services provided to New Jersey Medicaid/NJ FamilyCare**

EFFECTIVE: **Dates of service July 1, 2012 and beyond**

PURPOSE: The purpose of this Newsletter is to inform out-of-state hospital providers of changes to N.J.A.C. 10:52-4.5 regarding the reimbursement methodology that will be applied to all inpatient and outpatient claims with dates of service on or after July 1, 2012.

BACKGROUND: Historically, in accordance with N.J.A.C 10:52-4.5, reimbursement for out-of-state acute care hospitals shall be at one hundred percent of the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located.

With the passage of the State Fiscal Year 2013 Appropriation Act, the out of state policies contained in N.J.A.C 10:52-4.5 are being amended and the reimbursement methodology that will be applied to out of state hospital pricing will be as follows for claims with dates of service on or after July 1, 2012.

ACTION: Reimbursement for inpatient hospital services for an out-of-state acute care hospital, participating in the New Jersey Medicaid/NJ FamilyCare program shall be based on the following criteria.

All rates in effect at the time the service is rendered shall be considered final rates by the State. Reimbursement shall be at the lesser of the established DRG payment rate for New Jersey acute care hospitals, as described in 10:52-14, (excluding add-ons), one hundred percent of the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located, or the total charges reflected on the claim. The Division of Medical Assistance and Health Services (DMAHS) shall not reimburse out-of-State hospitals for disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located.

An out-of-state acute care hospital must provide official documentation of the Medicaid rate that has been established by the State Medicaid agency in the state in which the hospital is located. If official documentation is not provided upon request by DMAHS, the claim will be denied.

An example of acceptable documentation is a copy of the letter sent by the State Medicaid Agency to the hospital specifying the Medicaid rate.

In the event an out-of-state acute care hospital does not participate in the Medicaid program in the state where the hospital is located, or has not established a rate with the State Medicaid agency, reimbursement for inpatient services shall be at the lesser of the established DRG payment rate for New Jersey acute care hospitals (excluded add-ons), as described in 10:52-14 or the total charges reflected on the claim.

Reimbursement for outpatient hospital services for an out-of-state acute care hospital, participating in the New Jersey Medicaid/NJ FamilyCare program shall be based on the following criteria:

All rates in effect at the time the service is rendered shall be considered final rates by the State. Reimbursement shall be at the lesser of the New Jersey State wide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care hospitals, as described in 10:52-4.3, one hundred percent of the claim-specific reimbursement methodology approved by the State Medicaid agency in the state in which the hospital is located, or the total charges reflected on the claim.

The New Jersey state wide average cost-to-charge ratio is the average cost-to-charge ratio of all New Jersey acute care hospitals based on the prior calendar year's hospital specific cost-to-charge ratio. This information is updated annually and published on the fiscal agent's web site.

An out-of-state acute care hospital must provide official documentation of the Medicaid rate that has been established by the State Medicaid agency in the state in which the hospital is located. If official documentation is not provided upon request by DMAHS, the claim will be denied.

An example of acceptable documentation is a copy of the letter sent by the State Medicaid Agency to the hospital specifying the Medicaid rate.

In the event an out-of-state hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with the State Medicaid agency, reimbursement for outpatient services shall be at the lesser of the New Jersey State wide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care hospitals, as described in 10:52-4.3 or the total charges reflected on the claim.

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