45 NJR 2(2)
February 19, 2013
Filed January 17, 2013

HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Hospital Services Manual

Basis of Payment and Appeal Procedure; Out-of-State Hospital Services

Proposed Amendment: N.J.A.C. 10:52-4.5

Authorized By: Jennifer Velez, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Agency Control Number: 11-P-18.

Proposal Number: PRN 2013-028.

Submit comments by April 22, 2013 to:

James M. Murphy Attn: 11-P-18

Division of Medical Assistance and Health Services

Mail Code #26

P.O. Box 712

Trenton, NJ 08625-0712

Fax: (609) 588-7343

Email: James.M.Murphy@dhs.state.nj.us

Delivery: 6 Quakerbridge Plaza

Mercerville, NJ 08619

The agency proposal follows:

Summary

The Department is proposing amendments to the Hospital Services Manual, at N.J.A.C. 10:52-4.5, to implement a new payment methodology for out-of-State acute care general hospitals for inpatient and outpatient services for New Jersey Medicaid and NJ FamilyCare recipients as provided in New Jersey's State Fiscal Year 2013 (SFY 13) Appropriations Act, P.L. 2012, c. 18. Specifically, reimbursement for inpatient services for an out-of-State acute care general hospital participating in the New Jersey Medicaid or NJ FamilyCare program and participating in the Medicaid program in its own state shall be the lesser of: (1) the established Diagnosis Related Group (DRG) payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-14 (excluding add-ons); (2) 100 percent of the claim specific reimbursement methodology approved by the state Medicaid agency in the state in which the hospital is located except as specified in N.J.A.C. 10:52-4.5(b)2 and (c); or (3) the total charges reflected on the claim. If an out-of-State acute care general hospital does not participate in the Medicaid program in the state in which 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 general hospitals (excluding add-ons), as described in N.J.A.C. 10:52-14, a rate negotiated with the Division of Medical Assistance and Health Services (Division) at

the time of enrollment for inpatient hospital services, or the total charges reflected on the claim.

Reimbursement for outpatient services for an out-of-State acute care general hospital participating in the New Jersey Medicaid or NJ FamilyCare program and participating in the Medicaid program in its own state shall be the lesser of: (1) the New Jersey Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care general hospitals, as described in N.J.A.C.10:52-4.3; (2) 100 percent of the claim-specific reimbursement methodology approved by the state Medicaid agency in the state in which the hospital is located except as specified in N.J.A.C. 10:52-4.5(d)2 and (e); or (3) the total charges reflected on the claim. Where an out-of-State acute care general hospital does not participate in the Medicaid program in the state where the hospital is located or has not established a rate with that state's Medicaid agency, reimbursement for outpatient services shall be the lesser of the New Jersey Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-4.3 or the total charges reflected on the claim. Specifically, the following amendments are proposed:

Throughout the text of N.J.A.C. 10:52-4.5, "acute care general" is added between "out-of-State" and "hospital."

At subsection (a), proposed amendments add a reference to proposed new subsection (e), regarding reimbursement for outpatient services and the existing cross-reference to subsection (e) in the final sentence of subsection (a) is recodified as subsection (f).

Subsection (b) is proposed for amendment to add the distinction of "and participating in the Medicaid program" in its own state. At paragraph (b)1, proposed amendments describe the methodology for reimbursement of inpatient hospital services for an out-of-State acute care general hospital participating in the NJ Medicaid or NJ FamilyCare program. Specifically, two methods of reimbursement are added, (1) "the lesser of the DRG payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-14 (excluding add-ons)"; and (2) "the total charges reflected on the claim." At paragraph (b)2, a proposed amendment adds the requirement that without official documentation requested by the Division, the claim will denied. The proposed amendment to subparagraph (b)2i deletes the last sentence, stating that the purpose of this information is to facilitate claims processing.

Existing subsection (c) is proposed for amendment to delete the methodology whereby a rate was negotiated. Proposed new paragraph (c)1 describes the reimbursement methodology for out-of-State acute care general hospitals that do not participate in the Medicaid program in the state where the hospital is located or that have not established a rate with that state's Medicaid agency.

Existing subsection (d), the methodology for outpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid or NJ FamilyCare program is proposed for deletion. Proposed new subsection (d) sets forth the new methodology. New paragraph (d)1 provides that all rates in effect at the time a service is rendered are considered final rates by the State. It also provides that reimbursement shall be at the lesser of the New Jersey Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care

general hospitals, as described in N.J.A.C. 10:52-4.3, 100 percent of the claim-specific reimbursement methodology approved by the state Medicaid agency in the state in which the hospital is located, except as specified in N.J.A.C. 10:52-4.5(d)2 and (e), or the total charges reflected on the claim. New subparagraph (d)1i sets forth the New Jersey Statewide average cost-to-charge ratio formula. Proposed new paragraph (d)2 sets forth the policy that if an out-of-State acute care general hospital does not provide official documentation of the Medicaid rate that has been established by the Medicaid agency in the state where the hospital is located as requested by the Division, the claim will be denied and gives an example of acceptable documentation.

Proposed new subsection (e) sets forth the outpatient reimbursement methodology where an out-of-State acute care general 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.

Recodified subsection (f) is proposed with only a technical amendment.

The Department has determined that the comment period for this notice of proposal will be at least 60 days; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is excepted from the rulemaking calendar requirement.

Social Impact

During State Fiscal Year 2011, an estimated 3,692 Medicaid/NJ FamilyCare fee-for-service beneficiaries received out-of-State acute care general hospital services under the Medicaid fee-for-service program and there were 251 participating out-of-State acute care general hospital providers who rendered hospital services. The

proposed amendments are designed to provide equity in payments to in-State and out-of-State acute care general hospitals.

The proposed amendments should have no social impact on Medicaid and NJ FamilyCare beneficiaries. The amendments likewise are not expected to have any social impact on providers.

Economic Impact

During State Fiscal Year 2011, the Division spent approximately $166.9 million (Federal and State shares combined) for out-of-State acute care general hospital services. The proposed amendments are expected to save the State approximately $2.5 million annually, which will have a positive economic impact on the State. The proposed amendments will have a net negative economic impact of the same amount on out-of-State acute care general hospitals that provide services to New Jersey Medicaid beneficiaries because reimbursement to them will now be lower as a result of making their reimbursement more comparable to that paid to in-State providers. The proposed amendments should have no economic impact on Medicaid and NJ FamilyCare beneficiaries.

Federal Standards Statement

Federal regulations require a state Medicaid program (Title XIX) to cover hospital inpatient services (42 CFR 440.10). Section 1923(a) of the Social Security Act (42 U.S.C. § 1396r-4) gives a state the freedom to establish hospitals' payment rates within certain upper and lower payment limits. The Federal regulations at 42 CFR 447.253

state that the state must assure that Medicaid has an appeal or exception procedure regarding payment rates.

Section 1902(a)(13) of the Social Security Act, 42 U.S.C. § 1396a(a)(13), describes the public process that a state Medicaid program must use when establishing or amending inpatient hospital rates. Under Federal regulations at 42 CFR 447.272, a state must also ensure that the aggregate payments to each group of hospitals do not exceed the amount that can reasonably be estimated would have been paid under Medicare principles of reimbursement. In establishing payment rates for hospital services, a state Medicaid program must also take into account the costs of a hospital that treats a disproportionate share of low-income individuals, consistent with Section 1923 of the Social Security Act, 42 U.S.C. § 1396r-4. This section also describes the minimum amount, as well as the maximum amount, that must be paid for treatment of a disproportionate share number of low-income individuals. Federal regulations at 42 CFR 447.321 require that the total amounts paid by Medicaid programs, Medicare, and the beneficiary cannot exceed what the total payments would be from Medicare for comparable outpatient services under comparable circumstances.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the proposed amendments do not exceed Federal standards and, therefore, a Federal Standards analysis is not required.

Jobs Impact

The Department does not anticipate that the proposed amendments will result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

No impact on the agriculture industry in the State of New Jersey is expected to occur as a result of the proposed amendments.

Regulatory Flexibility Statement

The providers affected by the proposed amendments are all hospitals that have more than 100 full-time employees. Therefore, they are not considered small businesses, as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and a regulatory flexibility analysis is not required.

Housing Affordability Impact Analysis

Since the proposed amendments concern the reimbursement of out-of-State acute care general hospital services provided to Medicaid and NJ FamilyCare beneficiaries, the Department anticipates that the proposed amendments will have no impact on the development of affordable housing or the average cost of housing in the State.

Smart Growth Development Impact Analysis

Since the proposed amendments concern the reimbursement of out-of-State acute care general hospital services provided to Medicaid and NJ FamilyCare beneficiaries, the proposed amendments will have no impact on smart growth

development or on the construction within Planning Areas 1 and 2, or within designated centers, under the State Development and Redevelopment Plan.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 4. BASIS OF PAYMENT FOR HOSPITAL SERVICES

10:52-4.5 Basis of payment and appeal procedure; out-of-State **acute care general** hospital services

(a) The Division shall reimburse an out-of-State approved **acute care general** hospital (see N.J.A.C. 10:52-1.2, Definitions) for providing inpatient and outpatient hospital services to New Jersey Medicaid or NJ FamilyCare beneficiaries if the hospital meets the requirements of the Division and the services are prior authorized pursuant to N.J.A.C. 10:52-1.10. Reimbursement of inpatient hospital services is outlined in (b) [through] **and** (c) below, and for outpatient services is outlined in (d) **and (e)** below. See [(e)] **(f)** below for the procedure for rate appeals for out-of-State **acute care general** hospitals.

(b) Reimbursement for inpatient hospital services for an out-of-State **acute care general** hospital participating in the New Jersey Medicaid or NJ FamilyCare program **and participating in the Medicaid program in the state in which the hospital is located,** shall be based on the following criteria:

1. 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 general hospitals, as described in**

N.J.A.C. 10:52-14 (excluding add-ons), 100 percent of the claim-specific reimbursement methodology approved by the [State] **state** Medicaid agency in the state in which the hospital is located**,** except as specified in (b)2 and (c) below**, or the total charges reflected on the claim**. The Division shall not reimburse out-of-State **acute care general** hospitals for disproportionate share hospital (DSH) payments even if the DSH payments are included in the claim-specific reimbursement methodology approved by the [State] **state** Medicaid agency in the state in which the hospital is located.

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

i. An example of acceptable documentation is a copy of the letter sent by the [State] **state** Medicaid [Agency] **agency** to the hospital specifying the Medicaid rate. [The purpose of this information is to facilitate claims processing.]

(c) In the event an out-of-State **acute care general** 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] **state** Medicaid agency[, the hospital must enter into a negotiated rate with the Division at the time of enrollment for inpatient hospital services. The rate that is established between the hospital and the Division may be reviewed periodically thereafter.]**:**

1. Reimbursement for inpatient services shall be at the lesser of the established DRG payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-14 (excluding add-ons), a rate negotiated with the

Division at the time of enrollment for inpatient hospital services, or the total charges reflected on the claim.

Recodify existing 1. and 2. as **2**. **and 3.** (No change in text.)

[(d) Reimbursement for outpatient hospital services in an out-of-State approved hospital is based on the rate of reasonable covered charges (subject to a percentage reduction based upon the cost-to-charge ratio) approved by the State Medicaid Agency in the state in which the hospital is located if the hospital participates in the State‘s Medicaid program, or if the hospital does not participate in the State‘s Medicaid program, the rate negotiated by the Division with the hospital.]

(d) Reimbursement for outpatient hospital services for an out-of-State acute care general hospital participating in the New Jersey Medicaid or NJ FamilyCare program and participating in the Medicaid program in the state in which the hospital is located shall be based on the following criteria:

1. 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 Statewide average cost-to-charge ratio or established fee schedule payment rate for New Jersey acute care general hospitals, as described in N.J.A.C. 10:52-4.3; 100 percent of the claim-specific reimbursement methodology approved by the state Medicaid agency in the state in which the hospital is located, except as specified in (d)2 and (e) below; or the total charges reflected on the claim.

i. The New Jersey Statewide average cost-to-charge ratio is the average cost-to-charge ratio of all New Jersey acute care general 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 website.

2. An out-of-State acute care general hospital should 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 the Division, the claim will be denied.

i. An example of acceptable documentation is a copy of the letter sent by the state Medicaid agency to the hospital specifying the Medicaid rate.

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

[(e)] **(f)** In addition to the provisions of N.J.A.C. 10:52-9.1(c) and (d), the following rate appeal procedure shall be followed for a rate appeal filed by an out-of-State hospital:

1. (No change.)

2. The following limitations shall apply to the rate appeal procedure in [(e)1] **(f)1** above.

i. The hospital shall submit with its rate appeal to the Division all appropriate documentation demonstrating that an appeal was filed with the [State] **state**

Medicaid agency in the state in which the hospital is located and the date that the appeal was filed.

ii. (No change.)