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State/Territory Name: **NEW JERSEY**

State Plan Amendment (SPA) #: **11-05**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

JUL 11 2012

Valarie Harr
Director
Department of Human Services
Division of Medical Assistance and Health Services
State of New Jersey
P.O. Box 712
Trenton, New Jersey 08625-0712

RE: New Jersey 11-05

Dear Ms. Harr:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-05. Effective January 1, 2012 this amendment eliminates the trend factor increase for inpatient hospital rates for calendar year 2012. It also sunsets the supplemental payments to certain hospitals that performed utilization reviews, since those are now performed for the State by a third party contractor.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. This is to inform you that New Jersey 11-05 is approved effective January 1, 2012.

I have enclosed the approved State plan pages. If you have any questions, please call Tom Brady at 518-396-3810 x109 or Rob Weaver at 410-786-5914.

Sincerely,

[redacted]

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 11-05-MA	2. STATE New Jersey
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2012	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Social Security Act Section 1902(a)(13)	a. FFY 2012: ($2.8 M) b. FFY 2013: ($3.8 M)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, page I-24 Attachment 4.19-A, page I-25 Attachment 4.19-A, page I-27	Same Same Same

10. SUBJECT OF AMENDMENT:

Inpatient Hospital DRG Rates for Calendar Year 2012

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: Jennifer Velez	Valerie Harr, Director Division of Medical Assistance and Health Services P.O. Box 712, Mail Code #26 Trenton, NJ 08625-0712
14. TITLE: Commissioner, Department of Human Services	
15. DATE SUBMITTED: 07/28/11	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: JUL 11 2012
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN – 1 2012	20. [redacted] ONAL OFFICIAL:
21. TYPED NAME: Kenny Thompson	22. Deputy Director, CMCS

23. REMARKS:

6. Determination of the Statewide base rate

(a) The Division established an initial Statewide base rate, which applies to all hospitals. Those hospitals meeting the criteria for add-on amounts in accordance with Section 7 have rates higher than the Statewide base rate. The initial Statewide base rate is established as follows:

1. For the initial rate year, the Division used the actual payments made for claims paid during calendar year 2006. Total payments include all DRG and outlier payments. Payments for hospital-based physicians were removed since hospital-based physician groups will bill for these services separately beginning August 3, 2009. These historical 2006 payments were inflated to the rate year by applying the excluded hospital inflation factor, also referred to as the economic factor recognized under the Center for Medicare and Medicaid Services (CMS) Tax Equity and Fiscal Responsibility Act, Pub. L. 97-248 (TEFRA) target limitations, which is published annually in the Federal Register by CMS. These adjusted payments were used to establish the total budgeted amount for inpatient acute hospital services for the rate year.

2. The amount calculated in (a) above is reduced to account for the following DRG system payments: add-on amounts under Section 7, outlier payments, payments for alternate levels of care and the effect on payments where Medicaid is not the primary payer (that is, Medicare claims partially paid by Medicaid and third party liability

claims). A reduction in payments was also made to remove an amount for utilization review services that were previously paid for by hospitals, which will become a State obligation, effective August 3, 2009.

(b) The Statewide base rate is increased by the hospital specific add-on amounts to determine a final rate for each hospital. The final rate for new hospitals and hospitals that had no Medicaid discharges in the base year are set at the Statewide base rate.

(c) The Statewide base rate will be updated annually by the excluded hospital inflation factor, also referred to as the economic factor recognized under the CMS TEFRA target limitations, which is published in the Federal Register by CMS. The TEFRA factor will not be applied to the base rate in Calendar Year 2012.

7. Criteria to qualify for add-on amounts to the Statewide base rate

(a) Each rate year, the Division will determine if each general acute hospital participating in the New Jersey Medicaid program is eligible for add-on amounts. The Division determined hospital eligibility for add-on amounts in the initial rate year as described in (c) below and eligibility and add-ons will be calculated each rate year thereafter using the most recent year for which there is 24 months of Medicaid paid claims data. However, if the initial rate year is a partial year, add-on amounts will remain the same for the second rate year.

(b) Each hospital will receive written notification of its final rate annually, which includes any add-on amounts for which the hospital qualifies. 2006 cost report and claim data was used to set the rates and will be used to determine add-on amounts in the initial rate year. Effective August 3, 2009, the eligibility of hospitals for add-on amounts will be determined based on the methodology in (c) below.

(c) Add-on amounts were developed to provide additional payments for high volumes of inpatient services to Medicaid and other low income patients. These add-on amounts increase the Statewide base rate for qualifying hospitals as a percentage add-on to the Statewide base rate. These add-on amounts are based on high volume Medicaid inpatient services or low income access.