Table of Contents

State/Territory Name: New Jersey

State Plan Amendment (SPA) #: NJ 18-0007

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, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

January 16, 2019

Meghan Davey
State Medicaid 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: State Plan Amendment (SPA) 18-0007

Dear Ms. Davey:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State Plan submitted under transmittal number (TN) 18-0007. Effective October 1, 2018 this amendment will update the All Patient Refined Diagnosis Related Groups to 3M Corporation version 34 for inpatient hospital services.

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 implementing Federal regulations at 42 CFR Part 447. This letter is to inform you SPA 18-0007 is approved effective October 1, 2018. We are enclosing the CMS-179 and the approved plan pages.

If you have any questions, please contact Charlene Holzbaur at 609-882-4103 Ext. 104.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18-0007 MA

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2018

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:

Social Security Act Section 1902(a)(13)

7. FEDERAL BUDGET IMPACT:

a. FFY 2019 $0
b. FFY 2020 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A Pages I-1, I-2, I-3	Same
Attachment 4.19A Page I-5, I-6, I-7	Same
Attachment 4.19A Page I-8	Same
Attachment 4.19A Page I-9	Attachment 4.19A Page I-9 through I-22
Attachment 4.19A Page I-26	Same
Attachment 4.19A Page I-28, I-29, I-30	Same
Attachment 4.19A Page I-34	Same

10. SUBJECT OF AMENDMENT:

Inpatient Reimbursement General Acute Care Hospitals

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]

13. TYPED NAME: Carole Johnson

14. TITLE: Commissioner,
Department of Human Services

15. DATE SUBMITTED: 12/18/18

16. RETURN TO:

Meghan Davey, Director
Division of Medical Assistance and Health Services
P.O. Box 712, Mail Code #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JAN 16 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM CMS-179 (07-92) ***Instructions on Back***

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Of New Jersey

Inpatient Reimbursement for General Acute Care Hospital Based on DRG Weights And a Statewide Base Rate

1. Effective date

(a) Effective for inpatient services with discharge dates effective on and after October 1, 2018 general acute care hospitals will be paid in accordance with New Jersey Medicaid Diagnosis Related Groups (DRG) Reimbursement System described in this subchapter.

(b) If the initial rate year is a partial year, all rate setting components used to calculate inpatient reimbursement delineated below will remain the same for the second rate year, except that the final rates will be increased by the economic factor applicable to that rate year as described in Section 6(c).

Section 2. Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Add-on amount" means an amount, calculated as a percentage of the Statewide base rate, which is added to the Statewide base rate, and which is determined on a hospital-specific basis using criteria established by the Division that recognizes the additional costs associated with treating a high volume of Medicaid and other low income patients.

"Calibration" means the adjustment factor effective on and after October 1, 2018, multiplied by All Patient Refined Diagnosis Related Groups (APR-DRG) national weights to reflect New Jersey-specific weights. Calibration assures SFY 2016 Dates of Discharge Fee-For-Service claim volume will be budget neutral with the previous DRG based system.

"Calibration factor" means the factor by which all national weights are multiplied to determine New Jersey specific weights. The factor is 1.604.

"Delegated" means Quality Improvement Organization's process by which hospitals are authorized to have in-house medical staff conduct utilization review. A delegated hospital would be subject to oversight by the QIO for compliance and continued authority.

"Diagnosis Related Groups (DRGs)" means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, procedures, age, sex and discharge status. DRG's are a four digit code where the first three digits are the diagnosis / disorder grouping and the fourth digit is severity of illness (SOI).

"DRG weight" means the New Jersey specific DRG weight that equals the national APR-DRG weight developed by 3M Health Information Systems, Inc., version 34, multiplied by the calibration factor. Calibrated DRG weights, and the version number of the 3M weights in use, will be accessible on the New Jersey Medicaid Management Information System website at:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

"Final rate" means a hospital's inpatient rate per case, which includes the Statewide base rate and the hospital's add-on amounts, if applicable, trended for inflation to a given rate year.

"Geometric mean length of stay" is the value derived by multiplying all of the lengths of stay for a DRG and then taking the n^{th} root of that number, where "n" equals the number of discharges. For the purposes of calculating the "DRG daily rate" this calculation is done using trimmed 3M values(rounded to a whole number); for the purposes of calculating the "day outlier payment for alternative level of care days" this calculation is done using untrimmed (non-rounded) 3M values. Geometric mean lengths of stay by DRG can be found on the New Jersey Medicaid Management Information System website:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

"Non-delegated" means the Quality Improvement Organization retains responsibility to perform all of the utilization review activities in a hospital.

"Quality Improvement Organization" or "QIO" means an organization, which is composed of or governed by active physician, and other professionals where appropriate, who are representative of the active physicians in the area in which the review mechanism operates and which is organized in a manner that insures professional competence in the review of services; formerly known as a peer review organization or a utilization review organization.

"Rebasing" means setting the Statewide base rate using a more current year's claim payment data.

3. Calculation of the DRG payments

For discharges on or after October 1, 2018 the following methodology is used:

(a) The DRG weight is:

the national DRG weight developed by 3M Health Information Systems, Inc., multiplied by a calibration factor.

Current calibrated weights can be found at the Division's website:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

Historical calibrated weights can be found at the Division's website:

https://www.njmmis.com/documentDownload.aspx?document=Final_DRG_Weights_V27.pdf

(b) The calibrated DRG weight is multiplied by the hospital's final rate, as described in Section 6 in order to determine DRG reimbursement.

This page is intentionally left blank.

This page is intentionally left blank.

4. List of DRG Weights

Final current DRG weights are accessible on the New Jersey Medicaid Management Information System website:

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf effective on and after October 1, 2018.

Historical DRG weights can be found at the Division's website:

https://www.njmmis.com/documentDownload.aspx?document=Final_DRG_Weights_V27.pdf

Pages I-9 through I-22 are left intentionally blank.

(d) The initial Statewide base rate calculated in this section is $4,479. The Statewide base rate will not be changed, except for annual inflation as noted in (c) above.

1. High volume Medicaid inpatient services, referred to as critical services, are comprised of two categories; the first category is maternity and neonates, and the second category is mental health and substance abuse. The data used to determine eligibility as a critical service provider is patient days from the Medicaid fee-for-services claims for all DRGs in Major Diagnostic Categories (MDCs) 14, 15 (maternity and neonates), 19 and 20 (mental health and substance abuse), as specified in the Diagnosis Related Groups Patient Classification System Definitions Manual published by 3M Health Systems. The methodology determines eligibility for add-on amounts separately for each of the two categories, ranks patient day volume from high to low, and deems eligible those hospitals with patient days in the top 25 percent (referred to as the first quartile) of the total number of hospitals. Hospitals ranked in the first quartile for either category qualify for a 10 percent add-on to the Statewide base rate, and those hospitals that ranked in the first quartile of both categories qualify for a 15 percent add-on to the Statewide base rate.

2. High volume low income utilization, referred to as critical access, is expressed as a percentage and is defined as the sum of Medicaid fee-for-service days, Medicaid managed care days and charity care days, divided by total patient days. The data sources are Medicaid fee-for-service and charity care claims adjudicated by the New Jersey Medicaid fiscal agent and Medicaid HMO and total patient days as reported on the Medicare cost reports. Each hospital's low income utilization percentage is ranked from high to low, and hospitals in the first quartile are classified as access critical access hospitals. Critical access hospitals qualify for a 10 percent add-on to the Statewide base rate. However, those hospitals with the highest low income utilization

percentages for the top 10 percent of the total number of hospitals qualify for an additional five percent, which equals 15 percent add-on to the Statewide base rate.

3. The Medicaid claims data used to calculate the add-on amounts as defined in (c)1 and 2 above, will be the most recent data available for which the Division has 24 months of Medicaid paid claims data as of July 1 of the year prior to the rate year. For each year the add-on amounts are calculated, the Medicaid claims will have DRGs assigned using the version of the DRGs Grouper that was used to pay the claims in that year.

4. The total number of hospitals reference in the (c)1 and 2 above is all hospitals that are open at the beginning of the rate year. The total number of hospitals is used in the hospital counts in the calculation of add-on amounts under (c)1 above, regardless of whether or not the hospitals have data in the relevant MDCs. The number of hospitals as calculated in (c)1 and 2 above are rounded to the nearest whole number.

(d) Regarding the treatment of closed hospitals, the calculation of add-on amounts will be determined as follows:

1. Hospitals expected to be closed by December 31 of the year prior to the rate year will be excluded from the add-on calculations. Only those hospitals with a Certificate of Need for closure approved by the Department of Health and a closure date set by Department of Health of December 31 or earlier will be excluded from the add-on calculations. The Division will only use hospital closure information available up to October 1 of the year prior to the rate year for add-on calculations; and

2. The add-on amounts will be calculated only once prior to the beginning of each rate year. If hospital closures occur before the December 31 prior to the rate year without prior notification as described in (d)1 above, the Division will not recalculate the add-on amounts. Hospital closures during the rate year will not result in a recalculation of the add-on amounts.

10. Standard DRG payment calculation

The standard DRG payment is the hospital's final rate multiplied by the DRG weight.

11. Cost outlier payment calculation

(a) A cost outlier is defined as an inpatient stay with an estimated cost, which exceeds the greater of the State designated cost outlier threshold or the cost outlier statistical limit for a certain DRG. The cost outlier calculation is set forth in (e) below.

(b) The cost outlier statistical limit is the statistical limit for each DRG, defined as the sum of the Statewide average cost per stay for that DRG plus 1.96 times the standard deviation of the Statewide average cost per stay for that DRG posted on njmmis.com website effective on and after October 1, 2018.

https://www.njmmis.com/documentDownload.aspx?document=APR-DRGDescriptionAndWeights34.pdf

(c) The cost outlier threshold is the fixed dollar amount cost outlier limit established by the Division which applies to all DRGs. Applying this threshold in the cost outlier calculation assures that no cost outlier payments will be made for any DRG with a cost outlier statistical limit less than the threshold amount. The dollar amount of the cost outlier threshold can never fall below $25,000.

(d) The marginal cost percentage is the State-designated percentage used to determine the proportion of estimated cost that will be reimbursed as a cost outlier payment as