Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

PROPOSED

PUBLIC NOTICE

Title XIX Medicaid State Plan - Reimbursement Methodology for Inpatient Hospital Outlier Services

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the **Delaware Code**) with 42 CFR §447.205, and under the authority of Title 31 of the **Delaware Code**, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is amending the Title XIX Medicaid State Plan regarding inpatient hospital services, specifically, *Medicaid Inpatient Hospital Outlier Payments*.

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to Sharon L. Summers, Planning & Policy Development Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906 or by fax to (302) 255-4454 by March 3, 2014.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

SUMMARY OF PROPOSAL

The proposed provides notice to the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Services (DMMA) intends to submit a state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) regarding Medicaid Inpatient Hospital Outlier Payments.

Statutory Authority

- 42 CFR §447.205*, Public Notice of Changes in Statewide Methods and Standards for Setting Payment Rates*
- 42 CFR §447, Subpart C - *Payment for Inpatient Hospital and Long-Term Care Facility Services*

Background

The State of Delaware reimburses enrolled providers for services provided to Medical Assistance recipients, including hospitals, under the authority of Title XIX of the Social Security Act. Federal statutes and regulations require that a state plan be developed that provides the methods and standards for reimbursement of covered services.

Medicaid Inpatient Hospital Outlier Payments

State Medicaid agencies may pay hospitals for Medicaid inpatient stays using a prospective payment system. To protect hospitals against large financial losses from extraordinarily high-cost cases, State agencies may supplement base payments with an additional payment referred to as a Medicaid inpatient hospital cost outlier payment (Medicaid outlier payment). Medicaid outlier payments are calculated using formulas that vary by State. Because hospitals cannot identify actual costs for specific patients, the formulas apply cost-to-charge ratios to current charges to convert those charges to estimated costs. The formulas include State-determined threshold amounts used to evaluate each claim for outlier status. (The threshold amount is the dollar amount by which the hospital's estimated costs for an inpatient case must exceed its prospective payments for that hospital to qualify for a Medicaid outlier payment.)

Summary of Proposed Amendment

In accordance with public notice requirements of Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205, the Division of Medicaid and Medical Assistance publishes this notice of proposed changes to the reimbursement methodology for inpatient hospital services, specifically, Medicaid Inpatient Hospital Outlier Payments.

Specifically, DMMA proposes to increase the threshold used to qualify claims. Currently, high cost outliers will be identified when the cost of the discharge exceeds the threshold of four (4) times the hospital operating rate per discharge. Effective for dates of services on and after March 1, 2014, the proposal changes the threshold to five (5) times the hospital operating rate per discharge. Outlier cases will be reimbursed at the discharge rate plus sixty-five (65) percent of the difference between the outlier threshold and the total cost of the case. Costs of the case are determined by applying the hospital-specific cost to charge ratio to the allowed charges reported on the claim for discharge.

The agency's proposal involves no change in the definition of those eligible to receive benefits under Medicaid, and the benefits available to eligible recipients remains the same.

NOTE: Previous notice to the public, published in the December 24, 2013 issue of the *News Journal* and the December 25, 2013 issue of the *Delaware State News*, originally posted the effective date as January 1, 2014. Please note that the effective date for the proposed change in reimbursement methodology is now March 1, 2014.

The payment adjustment state plan amendment is subject to the approval of the Centers for Medicare and Medicaid Services (CMS).

Fiscal Impact Statement

The estimates are based on a March 1, 2014 start date. The Federal match rates used were 55.31% for State Fiscal Year (SFY) 2014 and 53.63% for SFY 2015. SFY 2014 and SFY 2015 estimated savings for the outlier payments was $2,784,202 each of those years.

The projected fiscal impact for this SPA for Federal Fiscal Years 2014 and 2015 is as follows:

	Federal Fiscal Year 2014	Federal Fiscal Year 2015
General (State) Funds	**($725,818)**	**($1,291,034)**
Federal Funds	**($898,300)**	**($1,493,168)**

Increasing the hospital payment outlier for discharged claims will reduce the amount paid for those claims. Medicaid cost will be lowered for those claims that meet the outlier requirements.

DMMA PROPOSED REGULATION #14-03
REVISION:

ATTACHMENT 4.19-A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL CARE (Continued)

Rate Setting Methods - Development of Implementation Year Operating Rates, Updates and Rebasing (Continued)

Other Related Inpatient Reimbursement Policies

Outliers - Effective for dates of services on and after March 1, 2014, ~~High~~ high cost outliers will be identified when the cost of the discharge exceeds the threshold of ~~four~~ five (5) times the hospital operating rate per discharge. Outlier cases will be reimbursed at the discharge rate plus ~~70~~ sixty-five (65) percent of the difference between the outlier threshold and the total cost of the case. Costs of the case will be determined by applying the hospital-specific cost to charge ratio to the allowed charges reported on the claim for discharge.

Effective for dates of service on and after January 1, 2006, any provider with a high cost client case (outlier) will receive an interim payment; that is, a payment prior to the discharge of that patient when the charge amount reaches the designated level. An interim payment will be made for that inpatient stay when the client's charges have reached twenty-five (25) times the general discharge rate of that facility, or when the client's stay is greater than sixty (60) days. Additional interim payments will be made when either of the outlier conditions for an interim payment is met again. The interim payment amount is based on the current reimbursement methodology used to pay outliers. Upon the discharge of the client, the facility will receive the balance of the payment that would have been paid if the case were paid in full at the time of discharge.