High Volume Outlier Payment Adjustment

I. General

In addition to regular claims payments and any other payment adjustments to which they are entitled, each in-state hospital may receive an additional inpatient Medicaid outlier payment adjustment, which shall not exceed the inpatient charge limitations pursuant to 42 CFR 447.271. Total payments to all hospitals will not exceed the applicable inpatient upper payment limit in accordance with 42 CFR 447.272. The outlier payment adjustment is available to in-state hospitals that have a high volume of inpatient hospital stays that qualify for outlier payments. Each hospital's percentage of the state's Medicaid fee-for-service inpatient outlier stays will be calculated annually, based on fee-for-service claims adjudicated through the MMIS to a paid status during the most recently completed state fiscal year. The outlier payment adjustment will be made annually after the office has computed the payment under this methodology. The outlier payment adjustment will be made prior to any hospital supplemental payment adjustments. The outlier payment adjustment is effective May 1, 2011 for each state fiscal year ending on or after June 30, 2011.

II. Eligibility Determination

Step One: Identify the total number of Medicaid fee-for-service claims that qualify for outlier payment that were adjudicated to a paid status during the most recently completed state fiscal year.

Step Two: For each in-state hospital, identify the number of Medicaid fee-for-service claims that qualify for outlier payment that were adjudicated to a paid status during the most recently completed state fiscal year. The current threshold amount is the greater of two times the DRG payment rate or the outlier threshold of $34,425.

Step Three: For each in-state hospital, calculate the number of claims identified in Step Two as a percentage of the total number of claims identified in Step One. This percentage is the hospital's percentage of the total number of outlier claims. To be eligible for the outlier payment adjustment, a hospital must provide more than fifteen percent (15%) of the state's Medicaid fee-for-service inpatient stays that qualify for outlier payment.

III. Payment Methodology

The outlier payment adjustment will be the difference between the hospital's total claim reimbursement for paid Medicaid fee-for-service inpatient claims qualifying for outlier payment and the costs of providing such services. For eligible hospitals, the outlier payment adjustment will be calculated using the following methodology:

Step One: For each eligible hospital, identify the Medicaid fee-for-service claims that qualify for outlier payment that were paid during the most recently completed state fiscal year.

Step Two: Calculate the total aggregate cost of the claims identified in Step One. Total cost is determined by multiplying routine units from the claim by routine per diems and by multiplying ancillary charges from the claim by ancillary cost-to-charge ratios. Routine per diems and ancillary cost-to-charge ratios will be obtained from the hospital's latest cost report on file with the office.

Step Three: Determine the total aggregate claim payments previously received for the claims identified in Step One, including Medicaid claim payments, non-Medicaid claim payments, such as third party liability (TPL) payments and Medicare payments, and spend-down.

Step Four: Subtract total aggregate claim payments in Step Three from total aggregate costs in Step Two. This difference is the outlier payment adjustment. If the payments in Step Three exceed the costs calculated in Step Two, no outlier payment adjustment will be made.

OS Notification

State/Title/Plan Number: Indiana 11-015

Type of Action: SPA Approval

Required Date for State Notification: February 7, 2012

Fiscal Impact:

FY 2011	$8,450,000
FY 2012	$20,420,000

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: No

Reduces Benefits: No

Detail: Effective for services on or after May 1, 2011, this amendment establishes an outlier payment adjustment for in-state hospitals that have a high volume of inpatient hospital stays that qualify for outlier payments. The State has satisfied public process requirements. Funding the non-Federal share of these payments will come from an already existing IGT arrangement. There are no issues with the UPL.

To be eligible for the outlier payment adjustment, a hospital must provide more than 15% of the State's Medicaid fee-for-service (FFS) inpatient stays that qualify for outlier payment. The outlier payment adjustment will be the difference between the hospital's total claim reimbursement for paid Medicaid FFS inpatient claims qualifying for outlier payment and the costs of providing such services.

Other Considerations:

This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

Recovery Act Impact:

The Regional office has reviewed this state plan amendment in conjunction with the Recovery Act and, based on the available information provided by the State regarding 1) MOE; 2) local match; 3) prompt pay; 4) rainy day funds, and 5) eligible expenditures, the Regional Office believes that the State is not in violation of the

Recovery Act requirements noted above.

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