Outlier Factors effective July 1, 2014

To qualify as a DRG high outlier claim, the estimated costs must be greater than the DRG allowed amount plus $40,000.

The estimated costs equal the total submitted charges minus any noncovered and nonallowed charges multiplied by the hospital's ratio of costs-to-charges (RCC). The DRG allowed amount equals the hospital's DRG rate multiplied by the relative weight.

These criteria are also used to determine if a transfer claim qualifies for high outlier payment for claims with admission dates before July 1, 2014. For transfer claims submitted on or after July 1, 2014, the agency uses the prorated DRG amount to determine if the transfer claim qualifies for high outlier payment. The prorated DRG amount is the lesser of:

- The per diem DRG allowed amount (hospital's rate times relative weight for the DRG code assigned to the claim by the agency) divided by the average length of stay (for the DRG code assigned by the agency for the claim) multiplied by the client's length of stay plus 1 day.
- The total DRG payment allowed amount calculation for the claim.

Calculating Medicaid high outlier payment

The high outlier payment is the difference between the agency's estimated cost of services associated with the claim and the high outlier threshold multiplied by a percentage. The percentage varies according to the severity of illness (SOI) for the DRG assigned to the claim:

- SOI 1 or 2 get 80%
- SOI 3 or 4 get 95%

High outlier examples by SOI are in the table below. They assume the following:

- DRG Allowed Amount = $10,000
- $10,000 = DRG Medicaid rate of $5,000 multiplied by a relative weight of 2.0
- Billed covered allowed charges = $250,000
- Hospital specific RCC = 0.40

DRG SOI	Base DRG Allowed Amount	Billed Charges	RCC	Cost	Threshold	Cost Above Threshold	Outlier Percent	Outlier	Total Claim Payment
A	B	C	D	F	E	G	H	I	J
			(1)	*C * D (2)*	*$40,000 + B*	*F - E*		*G * H*	*B + I*
1,2	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.80	$40,000	$50,000
3,4	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.95	$47,500	$57,500

Calculating state-only-funded program high outlier for state administered program (SAP) claims

These high outlier payment rules are the same as for Medicaid claims except for the following differences:

- The agency uses the SAP DRG rate instead of the Medicaid DRG rate to calculate the DRG allowed amount.
- The agency multiplies the high outlier payment by the hospital's ratable.

The examples in the table below assume the following:

- DRG Allowed Amount = $10,000
- $10,000 = DRG SAP rate of $1,000 multiplied by a relative weight of 10
- Billed covered allowed charges = $250,000
- Hospital specific RCC = 0.40
- Hospital ratable = 0.5

DRG SOI	Base DRG Allowed Amount	Billed Charges	RCC	Cost	Threshold	Cost Above Threshold	Outlier Percent	Ratable	Outlier	Total Claim Payment
A	B	C	D	F	E	G	H		I	J
			(1)	*C * D (2)*	*$40,000 +*	*F - E*			*G * H*	*B + I*
1,2	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.80	0.50	$20,000	$30,000
3,4	$10,000	$250,000	0.40	$100,000	$50,000	$50,000	0.95	0.50	$23,750	$33,750