NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
JAY LUDLAM • Deputy Secretary, NC Medicaid

SIGNATURE REQUEST MEMORANDUM

TO: Jay Ludlam DS

FROM: Ashley Blango, SPA Coordinator

RE: State Plan Amendment

Title XIX, Social Security Act
Transmittal #2024-0037

Purpose
Attached for your review and signature is a Medicaid State Plan Amendment (Hospital Transfer Outlier) summarized below, and submitted on December 2, 2024, with a due date of December 6, 2024.

Clearance
This amendment has been reviewed for both accuracy and completeness by:

Ashley Blango,, Kathryn Horneffer, Lotta Crabtree, Adam Levinson, Melanie Bush

Background and Summary of Request
It is recommended that you sign this State Plan Amendment submission per Centers for Medicare and Medicaid Services (CMS) protocol as head of the Single State Agency administering the Medicaid program.

This SPA will revise the Hospital reimbursement policies to:

1. Add language to clarify when hospital transfers are eligible for outlier payments.
2. Add language to clarify when and how transfer codes affect reimbursement.

The proposed effective date of the SPA is December 1, 2024.

Your approval of this State Plan Amendment is requested. If you have any questions or concerns, please contact me or Ashley Blango at 919-812-6145.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(e) Reimbursement for capital expense is included in the DRG hospital rate described in Paragraph (d) of this plan.

(f) Cost outlier payments are an additional payment made at the time a claim is processed for exceptionally costly services. These payments shall be subject to retrospective review by the Division of Health Benefits, on a case-by-case basis. Cost Outlier payments will be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the costs for services that were not medically necessary or was for services not covered by the North Carolina Division of Health Benefits program.

(1) A cost outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish those relative weights. The cost threshold is the greater of twenty-five thousand dollars ($25000) or mean cost for the DRG plus 1.96 standard deviations.

(2) Charges for non-covered services and services not reimbursed under the inpatient DRG methodology (such as professional fees) shall be deducted from total billed charges. The remaining billed charges are converted to cost using a hospital specific total cost to total charge ratio not from the cost report but developed. The cost to charge ratio excludes medical education costs.

(3) If the net cost for the claim exceeds the cost outlier threshold, a cost outlier payment is made at 75% of the costs above the threshold.

(4) Refer to Attachment 4.19-A, page 24, section (c) for transfer claims subject to cost outliers.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(g) Day outlier payments are an additional payment made for exceptionally long lengths of stay on services provided to children under six at disproportionate share hospitals and children under age one at non-disproportionate share hospitals. These payments shall be subject to retrospective review by the Division of Health Benefits, on a case-by-case basis. Day outlier payments will be reduced if and to the extent that the preponderance of evidence on review supports a determination that the associated cost either exceeded the costs or was for services that were not medically necessary or for services not covered by the North Carolina Division of Health Benefits program.

(1) A day outlier threshold shall be established for each DRG at the time DRG relative weights are calculated, using the same information used to establish the relative weights. The day outlier threshold is the greater of 30 days or the arithmetical average length of stay for the DRG plus 1.50standard deviations.

(2) A day outlier per diem payment may be made for covered days in excess of the day outlier threshold at 75% of the hospital's payment rate for the DRG rate divided by the DRG average length stay.

(h) Services which qualify for both cost outlier and day outlier payments under this plan shall receive the greater of the cost outlier or day outlier payment. Refer to Attachment 4.19-A, page 24 section (c), for transfer claims subject to day outliers.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: North Carolina

Payments for Medical and Remedial Care and Services: Inpatient Hospital

SPECIAL SITUATIONS

(a) In order to be eligible for inpatient hospital reimbursement under this hospital inpatient reimbursement plan, a patient must be admitted as an inpatient and stay past midnight in an inpatient bed. The only exceptions to this requirement are those admitted inpatients who die or are transferred to another acute care hospital on the day of admission. Hospital admissions prior to 30 days after a previous inpatient hospital discharge are subject to review by the Division of Medical Health Benefits.

Services for patients admitted and discharged on the same day and who are discharged to home or to a non-acute care facility must be billed as outpatient services. In addition, patients who are admitted to observations status do not qualify as inpatients, even when they stay past midnight. Patients in observation status for more than 30 hours must either be discharged or converted to inpatient status.

(b) Outpatient services provided by a hospital to patients within the 24-hour period prior to an inpatient admission in the same hospital that are related to the inpatient admission shall be bundled with the inpatient billing.

HOSPITALS TRANSFERRING PATIENTS

(c) When a patient is transferred between hospitals, the transferring hospital shall receive a pro-rated per diem payment equal to the normal DRG payment divided by the ALOS (Average Length of Stay) for the DRG multiplied by the patient's actual length of stay at discharge. When the patient's actual length of stay equals or exceeds the average length of stay for the DRG at discharge, the transferring hospital receives the full DRG payment. Transfers are eligible for cost outliers if they meet the cost outlier criteria defined on Attachment 4.19-A, page 5, section (f). Hospitals transferring patients are eligible for day outliers if they meet the day outlier criteria defined on Attachment 4.19-A, section (g). The final discharging hospital shall receive the full DRG payment. Hospitals determined to be eligible for both cost or day outliers, will receive whichever is greater.

(d) Discharge of a hospital inpatient is considered to be a transfer under paragraph (c) above when the patient's discharge is assigned to one of the following listed below:

HOSPITALS TRANSFERRING PATIENTS

1. Patient Discharge Status = 02

   Or

2. Patient Discharge Status = 03, 05, 06, 62, 63, or 65 and TDOS before 10/1/2008 (Grouper version 24 and older) and DRG Code is 014, 113, 209, 210, 211, 236, 263, 264, 429, or 483

   Or

3. Patient Discharge Status = 03, 05, 06, 62, 63, or 65 and TDOS on or after 10/1/2008 (Grouper version 25 or later) and DRG Code is 028, 029, 030, 040, 041, 042, 219, 220, 221, 477, 478, 479, 480, 481, 482, 492, 493, 494, 500, 501, 502, 515, 516, 517, or 956

HOSPITALS RECEIVING TRANSFERS

(e) Hospitals receiving transfer patients that do not follow the criteria listed in (d)(1), (d)(2), and (d)(3) above are eligible for cost or day outliers, whichever is greater. The criteria for cost outliers is defined on Attachment 4.19-A, page 5, section (f); the criteria for day outliers is defined on Attachment 4.19-A, page 6, section (g).