Cost Outlier Payment

Reimbursement Policy ID: RPC.0043.72AC

Recent review date: 12/2025

Next review date: 12/2027

AmeriHealth Caritas Pennsylvania Community HealthChoices reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Pennsylvania Community HealthChoices may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes payment of cost outliers for inpatient and outpatient services by providers contracted with AmeriHealth Caritas Pennsylvania Community HealthChoices and/or participating with Medicaid.

AmeriHealth Caritas Pennsylvania Community HealthChoices will align with the Department of Medicaid by utilizing the state's guidelines to calculate inpatient cost outlier reimbursement for covered services.

When the agreed-upon inpatient contract between AmeriHealth Caritas Pennsylvania Community HealthChoices and hospitals specifies a percent above 100% of the Medicaid rate, the diagnosis-related group

(DRG) base rate will be increased by this percentage. Any outlier reimbursement will be calculated at 100% of the Medicaid rate using the enhanced base rate.

When the agreed-upon outpatient contract between AmeriHealth Caritas Pennsylvania Community HealthChoices and hospitals specifies a percent above 100% of the Medicaid rate, the base rate will be increased by this percentage. Any outlier reimbursement will be calculated at 100% of the Medicaid rate using the enhanced base rate.

Exceptions

N/A

Reimbursement Guidelines

Medicaid inpatient admissions are reimbursed under a prospective payment system that includes pre-established, fixed amounts for each admission based on diagnosis-related groups (DRGs) or all patient refined diagnosis-related groups (APR-DRGs).

Medicaid outpatient services may be reimbursed under a prospective payment system (OPPS) for a variety of outpatient settings, including hospital emergency rooms, outpatient clinics, and same day surgery.

Medicaid makes outlier payments to hospitals or ambulatory surgery center (ASC) facilities to help cover significantly higher costs for certain inpatient admissions and outpatient services. Cost outlier reimbursement is based on the percent of charges above and beyond the APR-DRG rates. A hospital inpatient admission qualifies as an outlier if it exceeds certain cost or charge thresholds. For example, if a discharge is eligible for an outlier payment, the payment will be equal to a specified percentage of the value of eligible outlier costs by the plan. Outpatient services exceeding certain cost or charge thresholds will be reimbursed similarly.

The premium payment (percent above Medicaid) would apply only to the base rate of the DRG/APR-DRGs that is on the state fee schedule. The AmeriHealth Caritas Pennsylvania Community HealthChoices payment is based on this rate. Outlier payment is calculated separately, as opposed to the DRG/APR-DRG payment, which would be based on the enhanced contracted base rate.

Definitions

Base rate
Hospital specific values used to determine the DRG outlier costs.

Cost outlier
Inpatient services provided during a single visit that have an extraordinarily high cost as established by Medicaid are therefore eligible for additional payments above and beyond the base rates of DRG or APR-DRG.

Edit Sources

I. Current Procedural Terminology (CPT)
II. Healthcare Common Procedure Coding System (HCPCS)
III. International Classification, 10th revision, Clinical Modification (ICD-10-CM), and associated publications and services.
IV. Centers for Medicare and Medicaid Services (CMS), https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

12/2025	Reimbursement Policy Committee Approval
11/2025	Annual review • No revisions
04/2025	Revised preamble
04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas Community HealthChoices from policy history section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added