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METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE

2. a. Outpatient Hospital Services

2. Effective with dates of service on or after May 1, 2008, the Department of Vermont Health Access (DVHA) will reimburse qualified providers for outpatient hospital services under a prospective fee schedule as set forth in this plan. The majority of services will be paid using the Medicare Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) fee schedule as its basis. Covered services that are delivered in an outpatient setting that are not payable in Medicare's OPPS will be paid using a fee that has been set on DVHA's professional fee schedule. The majority of the services on DVHA's professional fee schedule are derived from Medicare's Resource Based Relative Value Scale (RBRVS) relative value units (RVUs).

i. Participating Hospitals

All in-state and out-of-state hospitals will be included in this payment methodology, regardless of any designation provided by Medicare.

ii. Discussion of Pricing Methodology

A. APC Rates

The DVHA will follow the Medicare OPPS pricing methodology with respect to how each CPT/HCPCS will be treated in the Medicare OPPS, with the exception that the DVHA will not utilize Medicare OPPS composite pricing logic. The DVHA will use the status indicator that the Medicare OPPS assigns to each CPT/HCPCS to set pricing methodology. Additionally, the DVHA will follow Medicare's methodology with respect to packaging items into the payment with the primary service.

Effective with dates of service on or after January 1, 2012, the rate paid for each service payable in DVHA's OPPS will be set as follows:

- For in-state hospitals that have a Medicare classification of either sole community hospital (SCH) or critical access hospital (CAH): 110.58% of the Medicare 2012 OPPS national median rate without local adjustment.
- For in-state hospitals that do not have a Medicare classification of either SCH or CAH: 103.25% of the Medicare 2012 OPPS national median rate without local adjustment.
- For Dartmouth-Hitchcock Medical Center: 89.75% of the Medicare 2012 OPPS national median rate without local adjustment.
- For out-of-state hospitals other than Dartmouth-Hitchcock Medical Center: 83.80% of the Medicare 2012 OPPS national median rate without local adjustment.

The DVHA will not pay any transitional outpatient payments (TOPs) made by Medicare to SCHs or to rural hospitals with 100 or fewer beds that are not SCHs as defined by Section 1886(d)(5)(D)(iii) of the Social Security Act.

The DVHA will update the APC rates, the status indicators, the packaging methodology, and the outlier payment methodology annually based upon the Medicare OPPS Final Rule set each year.

B. Outlier Payments

The DVHA will follow the Medicare OPPS pricing methodology with respect to identifying claims eligible as high-cost outliers and for the outlier payment calculation for these claims.

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METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE  
(Continued)

2. a. 2. Outpatient Hospital Services (Continued)

iii. Special Payment Provisions

A. Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services performed for outpatients and nonhospital patients are reimbursed at the lesser of the submitted charges or the Medicare maximum allowable rate for the date of service.

B. Outpatient Hospital Services Paid at Cost

If the participating hospital is an in-state hospital, the Cost to Charge Ratio is applied to determine the payment, which is derived from the hospital's most recent filed Medicare Cost Report. If the participating hospital is an out-of-state hospital, the Cost to Charge Ratio is applied to determine the payment, which is the average in-state hospital Cost to Charge Ratio. The Cost to Charge Ratio is the total hospital cost to charge ratio, which includes inpatient and outpatient. The Cost to Charge Ratio is applied only to detailed lines on a claim in which: (1) the service is a covered service by DVHA and (2) it is not a packaged service in Medicare's OPPS and (3) it does not have a rate on the Medicare OPPS, the Medicare Lab Fee Schedule, or DVHA's professional fee schedule.

C. Covered Outpatient Services Not Paid Under the Medicare OPPS Payment Methodology

In addition to clinical diagnostic laboratory services, other services that DVHA covers in an outpatient hospital setting do not have a set fee under the Medicare OPPS Fee Schedule. These include, but are not limited to, physical, occupational, and speech therapy; routine dialysis services; screening and diagnostic mammography services; vaccines; non-implantable prosthetic and orthotic devices; some rehabilitative therapies; and non-implantable durable medical equipment. The full list of covered outpatient services paid outside of DVHA's OPPS payment methodology can be found at <http://dvha.vermont.gov/for-providers/claims-processing-1>. The agency's rates were set as of January 1, 2012 and are effective for services on or after that date. These services will be paid either on a prospective fee schedule or using a Cost to Charge Ratio methodology not to exceed cost as defined by the Medicare Cost Report. For items paid by fee schedule, the fee applied will be defined by the DVHA but fees for specific services will not exceed the fee established by Medicare.

D. Observation Services

The DVHA will follow the Medicare OPPS payment methodology for observation services when it is accompanied by a primary procedure. Additionally, if a provider bills for observation in the absence of a primary procedure, the DVHA will pay the lesser of allowed charges times the hospital-specific Cost to Charge Ratio or \$1,500.

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