State of Vermont
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671-1000

Global Commitment Register

December 20, 2016

GCR 16-034
CLARIFICATION

Outpatient Prospective Payment System

Policy Summary:

The Department of Vermont Health Access (DVHA) filed Vermont Medicaid State Plan Amendment (SPA) 16-0011 to change the rates paid for hospital outpatient services. DVHA sets rates based on the Medicare national median rates without locality adjusters except when otherwise specified in the State Plan. When DVHA uses the Medicare national median rates, it makes an adjustment to the rates using an adjustment percentage. This change is made at the hospital peer group level. Effective July 1, 2016, DVHA will no longer pay separately for outpatient hospital services billed using revenue codes 510-519 (clinic services). At the same time, DVHA is making adjustments to its peer groups and the adjustment percentages that are applied to Medicare national median rates. The DVHA rates effective July 1, 2016 are the national median rate set by Medicare effective July 1, 2016 multiplied by the following percentages: for in-state hospitals that have a Medicare classification of critical access hospital (CAH): 115%; for in-state hospitals that do not have a Medicare classification of CAH: 100%; for Dartmouth-Hitchcock Medical Center: 90%; for all other out-of-state hospitals: 85%.

In an effort to mitigate the impact of this transition, DVHA is implementing a provision in the methodology for one year only whereby the peer group percentages that are multiplied by the APC medians will not be at the peer group level but at the individual hospital level for in-state hospitals. The individual hospital percentages are set in a manner so that no hospital would benefit financially due to the transition away from the clinic services billing, but no hospital would be impacted negatively by more than 7.7%. These risk corridor percentages will be in place from July 1, 2016 to June 30, 2017. After this time, DVHA will revert back to the peer group level percentages of the Medicare APC rates. The individual hospital risk corridor percentages are available here.

Effective Date:
Approved by CMS on November 21, 2016. Effective July 1, 2016.

Authority/Legal Basis:
These changes are being made pursuant to 42 CFR §430.12(c)(1)(ii) under the Medicaid State Plan, which can be found here.

Population Affected:
All Medicaid

Fiscal Impact:
These changes represent neutrality with the State Fiscal Year 2017 budget and an estimated reduction in projected outpatient reimbursement of $8,160,481.

Public Comment Period:
The public comment period was June 22, 2016 – July 15, 2016. No comments were received.

Additional Information:

The GCR final policy for 16-034: Outpatient Prospective Payment System can be viewed here.

The updated State Plan is available on the DVHA website and can be viewed here.

The following State Plan pages were amended:

- Att. 4.19-B page 2a(1a)
- Att. 4.19-B page 2a(1b)
- Att. 4.19-B page 2a(1c)