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

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

~~ii. Discussion of Pricing Methodology (Continued)~~

~~If it was determined that an individual hospital's payments under the new peer group base rates would yield an amount that was greater than payments under the payment policies prior to July 1, 2016, then the individual hospital's base rate was lowered below their peer group base rate to the level that the hospital's net impact was equal to current payments.~~
~~If it was determined that an individual hospital's payments under the new peer group base rates would yield an amount that was no greater than payments under the payment policies prior to July 1, 2016 but not less than 7.7% below payments under the payment policies prior to July 1, 2016, then the hospital receives its peer group base rate.~~
~~If it was determined that an individual hospital's payments under the new peer group base rate would yield an amount that was more than 7.7% less than payments under the payment policies prior to July 1, 2016, then the individual hospital's base rate was raised above their peer group base rate to the level that the hospital's net impact was equal to 7.7% less than current payments.~~

~~The hospital-specific percentages based on the above risk corridor methodology are available here: http://dvha.vermont.gov/global-commitment-to-health/fy2017-opps-hospital-specific-percentages.pdf.~~

Since the DVHA uses peer groups that distinguish in-state critical access hospitals (CAHs) from other hospitals, ~~T~~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~~ endeavors to update the APC rates, the packaging methodology, and the outlier payment methodology annually based upon the Medicare OPPS Final Rule set each year. The DVHA will also update the status indicators quarterly based upon the Medicare quarterly OPPS Addendum B updates.

B. Outlier Payments

The DVHA will follow ~~the~~ a modified Medicare OPPS pricing methodology with respect to identifying claims eligible as high-cost outliers and for the outlier payment calculation for these claims; the modification relates to apportionment of packaged charges to a specific APC; for operational simplicity, DVHA uses all packaged charges and costs on a claim to determine whether the two-tiered test used by Medicare is met.~~.~~

iii. Special Payment Provisions

A. Clinical Diagnostic Laboratory Services

When not packaged into another service payment in DVHA's OPPS, 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.

(Continued)

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