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) began reimbursing qualified providers for outpatient hospital services under a prospective fee schedule as set forth in this plan. The majority of services are 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 or are not packaged in the price for another service in Medicare's OPPS are paid using either a fee that has been set on DVHA's professional fee schedule or by using a cost-to-charge ratio multiplied by covered charges. 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). Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 1, 201~~98~~ and are effective for services provided on or after that date. All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1.

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 although may deviate in rare circumstances from this methodology for specific operational and/or policy reasons. For example, effective January 1, 2015, DVHA adopted some, but not all, of the Medicare OPPS composite and comprehensive pricing logic. In most cases, 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 July 1, 2018, the DVHA has defined peer groups to set rates for groups of hospitals in its OPPS. The rate paid for each service payable in DVHA's OPPS using APC rates will be set as follows:

- For in-state hospitals that have a Medicare classification of critical access hospital (CAH): the peer group base rate is 11~~30~~.00% of the Medicare 201~~98~~ OPPS national APC payment rate without local adjustment.
- For in-state hospitals that do not have a Medicare classification of CAH and who are not considered an academic medical center, the peer group base rate is 8~~98~~.00% of the Medicare 201~~98~~ OPPS national APC payment rate without local adjustment.
- For two academic medical centers, the University of Vermont Medical Center (UVMMC) and Dartmouth-Hitchcock Medical Center, the peer group base rate is 8~~76~~.00% of the Medicare 201~~98~~ OPPS national APC payment rate without local adjustment.
- For all other out-of-state hospitals, the peer group base rate is 8~~21~~.00% of the Medicare 201~~98~~ OPPS national APC payment rate without local adjustment.

The percentages listed above are considered the base rates for DVHA's OPPS. The DVHA maintains a global policy of reimbursing the lesser of total claim billed charges and total estimated APC payments.

Effective with dates of service on or after July 1, 2016, the DVHA will no longer pay separately for outpatient hospital services billed using revenue codes 510-519 (clinic services).

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