

ATTACHMENT 4.18-C

Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Pharmacy			X	\$1.00 for prescription drugs costing* less than \$30.00. Copayment is based on average state payment of \$12.62 per claim (as of 06/12).
			X	\$2 00 for prescription drugs costing* \$30.00 or more but less than \$50.00.
Outpatient			X	\$3.00 for prescription drugs costing* \$50.00 or more.
			X	\$3 per day per hospital. Copayment is based on average state payment of \$243.64 per outpatient claim (as of 12/11).
Dental			X	\$3.00 per provider per date of service. Copayment is based on average state payment of \$138.29 per claim (as of 12/11)
Durable Medical Equipment (DME)/Medical Supplies			X	\$1.00 for DME/Medical Supplies costing* less than \$30.00. Copayment is based on average state payment of \$16.97 per claim (as of 06/12).
			X	\$2.00 for DME/Medical Supplies costing* \$30.00 or more but less than \$50.00.
			X	\$3.00 for DME/Medical Supplies costing* \$50.00 or more.

*Cost refers to the amount of reimbursement.

TN No. 12-009

Effective Date: 08/01/12

Supersedes

TN No. 85-22

Approval Date: 07/18/12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

- B. The method used to collect cost sharing charges for medically needy individuals:
- Providers are responsible for collecting the cost sharing charges from individuals.
 - The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

- C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

See Attachment 4.18-A, Page 1

TN No. 85-22
Supersedes
TN No. None

Approval Date: 02/28/86

Effective Date: 10/01/85

HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

- D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 1916(a)(2) and (j) of the Social Security Act and 42 CFR 447.53 (b) are described below:

The co-payment is deducted from the Medicaid payment unless the provider indicates an excluded category as contained in 42 CFR 447.53(b) on the claim form.

Vermont implements and enforces the federally required exclusions from co-payment by programming edits into the claims processing system which checks each claim for entries in date of birth, address, diagnosis, procedure code, emergency, and family planning indicator fields. Claims lacking information in any of these fields are denied. Correctly completed claims are edited against the copayment exclusion information in the system to determine whether or not a copayment is required.

American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State are exempt from co-payments.

Vermont will accept documentation from Indian Health Providers and Urban Indian Organizations, such as the IHS active or previous user letter, which indicates that the individual has received a service from an I/T/U, and the State will then provide an edit in the system exempting the individual from cost sharing.

- E. Cumulative maximums on charges:

State policy does not provide for cumulative maximums.

Cumulative maximums have been established as described below:

The Department of Vermont Health Access's (DVHA's) fiscal agent performs a calculation and produces a report, within thirty (30) days after the end of each quarter, indicating if any Medicaid beneficiaries have exceeded the 5% of the family's gross income for cost sharing. 5% of the family's gross income will not be exceeded in any quarter. The amount above the 5% cap is refunded to the beneficiary.