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

2. a. Outpatient Hospital Services

1. For all Vermont hospitals and the following New Hampshire hospitals (Dartmouth-Hitchcock, Cheshire, Valley Regional, Alice Peck Day, Cottage, Upper Connecticut Valley, Weeks Memorial, and Littleton Regional), payment is made on an interim basis at a hospital specific interim percentage of charge subject to year-end audit and cost-adjustment in accordance with the Title XVIII principles of Reasonable Cost Reimbursement (42 CFR Part 413). For dates of service beginning October 1, 2005, the final settlement will be made at 82.5% of cost. For dates of service beginning July 1, 2006, and ending April 30, 2008 that percent of cost will be made at 81.0%. Interim payment rates will be reduced accordingly. The following exceptions also apply:
 - i. Services normally furnished in a physician's office are paid using the physician fee schedule. No payment is made for the hospital "facility fee" or overhead, and hospital costs attributable to these services are not allowed for outpatient hospital cost settlement.
 - ii. Psychiatric partial hospitalization services are paid at per diem rates with no year-end cost settlement.
 - iii. Laboratory services are paid at the lesser of the actual charge, the RVU (the RVU price is the price on file based on a relative value scale for lab services) price or the Medicare maximum allowable amount with no year-end cost settlement.
 - iv. Radiology services as defined in 42 CFR §413.122 are paid at the lesser of actual charge, the Medicaid price on file or the Medicare maximum allowable amount with no year-end cost settlement.
 - v. Observation care services are paid at the lesser of the hospital's percentage of the charge for not more than 24 hours of outpatient care with a year-end cost settlement or the hospital's per diem rate for a medical/surgical day without a year-end cost settlement.
 - vi. Methadone treatment services are paid at the lesser of the hospital's charge or the Medicaid rate on file with no year-end cost settlement.

All other hospitals will be reimbursed at the mean percentage of the interim rates for Vermont and the New Hampshire hospitals listed above for services rendered with no year-end cost settlement.

(Continued)

TN# 07-013B
Supersedes
TN# 05-06b

Effective Date: 05/01/08
Approval Date: 08/19/08

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

2. a. Outpatient Hospital Services (Continued)

2. Effective with dates of service on or after May 1, 2008, the Office of Vermont Health Access (OVHA) 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.

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 OVHA will follow the Medicare OPPS pricing methodology with respect to how each CPT/HCPCS will be treated in the Medicare OPPS. The OVHA will use the status indicator that the Medicare OPPS assigns to each CPT/HCPCS to set pricing methodology. Additionally, the OVHA will follow Medicare's methodology with respect to packaging items into the payment with the primary service. The APC rates that will be applied are the national median rates with no local wage adjustment applied.

The OVHA will update the APC rates, the status indicators, and packaging methodology annually based upon the Medicare OPPS Final Rule set each year.
Outlier Payments

B. Outlier Payments

The OVHA 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.

(Continued)

TN# 07-013B

Supersedes

TN# None

Effective Date: 05/01/08

Approval Date: 08/19/08

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. Services Paid Under the Medicare OPPS Using Cost-Based Pass-through Payment

If the participating hospital is an in-state hospital, the Cost to Charge Ratio applied to determine the cost-based pass-through payment is derived from the hospital's most recent Medicare Cost Report. If the participating hospital is an out-of-state hospital, the Cost to Charge Ratio applied to determine the cost-based pass-through payment is the average in-state hospital Cost to Charge Ratio.

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

In addition to clinical diagnostic laboratory services, other services that OVHA 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; and non-implantable durable medical equipment. 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 OVHA but fees for specific services will not exceed the fee established by Medicare.

D. Observation Services

The OVHA 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 OVHA will pay the lesser of allowed charges times the hospital-specific Cost to Charge Ratio or \$1,500.

(Continued)

TN# 07-013B
Supersedes
TN# None

Effective Date: 05/01/08
Approval Date: 08/19/08

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

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

iii. Special Payment Provisions (Continued)

E. Medicare Crossover Claims

Effective with dates of service on or after May 1, 2008, the OVHA will limit payment on outpatient Medicare crossover claims to the allowable deductible and coinsurance amount.

F. Hospital-based Physician Services

Hospital-based physician services will not be reimbursed if billed by the hospital on the UB-04 claim form. These services must be billed to the physician program in order to be reimbursed by the OVHA.

G. New Facilities

New facilities under the APC system will receive payments using the same payment methodology as stated in 2.ii.A and 2.ii.B. The Cost to Charge Ratio that will be used in the initial year for the purposes of calculating outlier payments will be the average in-state Cost to Charge Ratio. If the new provider is an in-state hospital, the Cost to Charge Ratio that will be used for calculating outlier payments after the first year will be the hospital's Cost to Charge Ratio calculated from its Medicare Cost Report. If the new provider is an out-of-state hospital, the Cost to Charge Ratio after the first year will continue to be the average in-state Cost to Charge Ratio.

(Continued)

TN# 07-013B

Supersedes

TN# None

Effective Date: 05/01/08

Approval Date: 08/19/08

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

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

iii. Special Payment Provisions (Continued)

H. New Medicaid Providers

New Medicaid providers will receive payments using the same payment methodology as stated in 2.ii.A and 2.ii.B. The Cost to Charge Ratio that will be used in the initial year for the purposes of calculating outlier payments will be the average in-state Cost to Charge Ratio. If the new provider is an in-state hospital, the Cost to Charge Ratio that will be used for calculating outlier payments after the first year will be the hospital's Cost to Charge Ratio calculated from its Medicare Cost Report. If the new provider is an out-of-state hospital, the Cost to Charge Ratio after the first year will continue to be the average in-state Cost to Charge Ratio.

I. Other Rate Adjustments

There may be some situations where a fee has not been established by the Medicare OPSS or by the OVHA for a covered outpatient service. Payment for these services will be allowed charges multiplied by the Cost to Charge Ratio assigned to the hospital as defined in 2.iii.c.

iv. Ongoing Maintenance

As a part of ongoing maintenance of the payment system, the OVHA may change the following on a periodic basis either separately or in combination:

- A. The Medicare Cost Report values used to establish outlier payment status
- B. The inflation factor used to best represent current costs
- C. The Medicare OPSS APC fee schedule
- D. The Fixed Outlier Value
- E. The Outlier Percentage

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

2. b. Rural Health Clinic Services/Federally Qualified Health Centers

- The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.
- The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements Prospective Payment System (PPS).
- The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:
 1. is agreed to by the State and the center or clinic; and
 2. results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

Effective in the center's fiscal year beginning January 1, 2002, or later, payment to RHC's and FQHC's will be made at the greater of the federal PPS payment level with any adjustment for changes in scope, or allowable costs up to the Medicaid upper limit. For RHC's subject to the Medicare upper limit, the Medicaid upper limit shall be calculated at 100 percent of the Medicare amount. For FQHC's, the Medicaid upper limit shall be calculated at 125 percent of the Medicare upper limit for that year. For RHC's not subject to the Medicare upper limit, the Medicaid upper limit shall be 125 percent of the non-urban FQHC Medicare upper limit. The Director may waive the application of the upper limit, in part or in whole, for good cause shown.

Thirty days prior to a fiscal year the OVHA shall set the interim payment for the next year at the greater of the PPS rate or the rate derived from the most recent adjudicated cost report up to the Medicaid upper limit. If the entity submits a timely cost report, the OVHA will settle on the basis of reasonable costs up to the limit. If the entity does not file a timely cost report and the interim payment was based on the costs, the OVHA will settle the interim payments at the PPS levels.

If a facility elects to be paid by the PPS system, it need not file a Medicaid cost report for that year. If a center elects to be paid by the cost-based system, it must include a declaration of agreement to use the cost-based alternative with its cost report.

3. Other Laboratory and X-Ray Services

Payment is limited to laboratories and laboratory services certified by Medicare.

Reimbursement is made at the lower of the provider's charge or the Medicaid rate on file.

TN# 02-02

Effective Date: 01/01/02

Supersedes

TN# 01-02

Approval Date: 05/16/02

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

4. a. Nursing Facility Services

The Division of Rate Setting of the Agency of Human Services, pursuant to 33 VSA §193, certifies to the Commissioner of Social Welfare prospective per diem rates to be utilized in reimbursing for care in each participating nursing facility.

Payment for authorized care furnished to a Vermont Medicaid recipient by a certified out-of-state nursing facility will be made at the per diem rate established by the state's single state agency for Medicaid. No retroactive adjustments are made in payments to an out-of-state facility.

A prospective per diem rate for the purpose of reimbursing for nursing facility care furnished in Vermont general hospitals will be established by the Division of Rate Setting at the beginning of each fiscal year.

See ATTACHMENT 4.19-C for additional methods and standards governing payment during temporary absences from the facility.

Payment for Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled such as head injured or ventilator dependent people will be made at the lowest of:

- 1) the amount charged; or
- 2) a negotiated rate; or
- 3) the Medicaid rate as paid by at least one other state Medicaid agency in the Boston region.

Payment for rehabilitation center services which have not been authorized by the Medicaid Director or a designee will be made at the nursing facility (non rehabilitation center) rate established by Medicaid in the state in which the center is located.

b. Early and Periodic Screening, Diagnosis and Treatment

All providers are reimbursed in accordance with the methods and standards described within this state plan for each specific service.

Personal care services, home visiting, and health education are paid at the lower of the actual charge or the Medicaid rate on file.

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

4. c. Family Planning Services

Family planning services are reimbursed in accordance with the methods and standards described within this State Plan for each specific service. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

5. Physician's Services

Payment for a service rendered by a physician (M.D or D.O.) is made at the lower of the actual charge for the service or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

6. a. Podiatrist's Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

b. Optometrist's Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

c. Chiropractors

Payment is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

TN# 08-007

Supersedes

TN# 08-005

Effective Date: 10/12/08

Approval Date: 06/08/08

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

6. d. Other Practitioners Services

1. Behavior Health Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

2. Opticians' Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

3. High-Tech Nursing Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

4. Licensed Lay Midwife Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

5. Naturopathic Physician Services

Payment is made at the lower of actual charge for the service or the Medicaid rate on file. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

7. Home Health Services

Payment is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

8. Private Duty Nursing

Payment is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

TN# 08-007

Effective Date: 10/12/08

Supersedes

TN# 08-005

Approval Date: 06/08/08

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

9. Clinic Services

- a. Payment for clinic services other than a mental health clinic, comprehensive service clinics and Free Standing Dialysis Centers is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.
- b. Payment for mental health clinic services is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.
- c. Payment for comprehensive service clinics is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.
- d. Free Standing Dialysis Centers Payment is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

10. Dental Services

Payment is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

11. Physical Therapy and Related Services

Payment is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

12 a. Prescribed Drugs

- "Multiple Source" drugs are paid at the lowest of the amount charged, the average wholesale price plus a dispensing fee or the upper limit determined by the state (Estimated Acquisition Cost) derived from the upper limit established by HCFA plus a dispensing fee, or the Vermont Maximum Acquisition fee established by the state plus a dispensing fee.
- "Other Drugs" are paid at the lower of the amount charged or the average wholesale price less 11.9 percent plus a dispensing fee.
- "Physician Certified as Brand Necessary" are paid at the lower of the amount charged or the average wholesale price less 11.9 percent plus a dispensing fee.
- Payment for compounded prescriptions is made at the lower of the amount charged at the average wholesale price on file plus a compounding fee plus a dispensing fee.

Effective July 1, 2005, the dispensing fee for all fills and refills will be:

- a. \$4.75 for Vermont pharmacies, and
- b. \$3.65 for out-of-state pharmacies

TN# 08-007

Effective Date: 10/12/08

Supersedes

TN# 08-005

Approval Date: 06/08/08

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

12. b. Dentures

Reimbursement is made at the lower of the actual charge or the Medicaid rate on file.

c. Prosthetic Devises

Reimbursement is made at the lower of the actual charge or the Medicaid rate on file.

d. Eyeglasses

Payment is made at the negotiated contract price for lenses and frames. With prior approval, payment may be made to local dispensers at actual costs of lenses and frames.

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services

Reimbursement is made at the lower of the actual charge or the Medicaid rate on file or as specified below:

Substance Abuse Services: payment is made at the lower of the usual and customary rate charged to the general public or the Medicaid rate on file. Assurance is made that no reimbursement is made for residential (room and board) charges.

Community Mental Health Center Services: payment is made at the lower of the usual and customary rate charged to the general public or the Medicaid rate on file.

Private Non Medical Institutions (PNMI) for Child Care Services: payment is made via capitation rates as described in the PNMI section of the Medicaid Division Practices and Procedures Manual. Assurance is made that no reimbursement is made for residential (room and board) charges.

School Health Services: services provided for the development of an initial IEP/IFSP will not be reimbursed. Reimbursement for services ordered by an IFSP are paid fee-for-service. Services ordered by an IEP are reimbursed via a case rate system, with the exception of the following services that will be paid fee-for-service; assessment and evaluation, medical consultation, durable medical equipment, vision care services and nutrition services.

TN# 98-6

Supersedes

TN# 94-19

Effective Date: 02/22/98

Approval Date: 05/18/98

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

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services (Continued)

Intensive Family Based Services: Payment is made at per diem rates, paid weekly, which are based on the average costs of services delivered within the program.

Developmental Therapy: Payment is made at the lower of the actual charge or the Medicaid reimbursement rate on file.

Day Health Rehabilitation Services: Payment is made per hourly rates rounded to the nearest quarter hour, paid weekly.

Assistive Community Care Services: Payment is made at a uniform per diem rate, paid monthly. No reimbursement will be made for room and board.

Therapeutic Substance Abuse Treatment Services (TSATS): Payment is made at a uniform per diem rate paid monthly. No reimbursement will be made for room, board, transportation to non-medical appointments, vocational activities, and services and therapies not eligible for traditional Medicaid reimbursement.

14. Services for Individuals 65 or Older in Institutions for Mental Disease

- a. See Inpatient Psychiatric Hospital Services – 4.19-A
- b. Skilled nursing facility services – not covered.
- c. Intermediate care facility services – see 4.19-C and 4.19-D.

TN# 01-05

Supersedes

TN# 99-7

Effective Date: 07/01/01

Approval Date: 09/14/01

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

15. a. Intermediate Care Facility Services (Nursing Facilities)
See Attachments 4.1 9-C and 4.1 9-D.
- b. Intermediate Care Facilities for the Mentally Retarded
See Attachment 4.1 9-D.
16. Inpatient Psychiatric Facility Services for Individuals Under Age 22
See Attachment 4.19-A.
17. Nurse-Midwife Services
Covered nurse-midwife services are reimbursed at the lower of the actual charge or the Medicaid rate on file for a physician providing the same service.
18. Hospice Care
Payment is made in accordance with Medicare Title XVIII principles. During the period of October 21, 1990 through December 31, 1990 payment of 5.2 percent in excess of the Medicare rate will be maintained after which payments will be made in conformity with Medicare principles.

TN# 94-25

Supersedes

TN# 93-14

Effective Date: 07/01/94

Approval Date: 12/28/94

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

19. Case Management Services

Payment for Targeted Case Management Services provided to a child pursuant to an IFSP is made at a rate established on the basis of periodic time studies furnished by the service provider.*

Payment for Targeted Case Management Services provided to a child pursuant to an IEP is included in payment made under the case rate system.*

Payment for Targeted Case Management services provided by the Department of Social and Rehabilitation Services is developed from direct staff salaries, benefits and operating expenses (including indirect costs) which will be rebased periodically.

Payment for Targeted Case Management services furnished as part of the Healthy Babies Program is made at the lesser of the provider's charge or the Medicaid rate on file.

Payment for Targeted Case Management services provided to At-Risk Children Ages 1 to 5 years is made at the lesser of the provider's charge or the Medicaid Rate on file.

*Per approved state plan amendment 98-6 (School Health Services) effective 2/22/98.

TN# 08-013
Supersedes
TN# 08-011

Effective Date: 06/28/08
Approval Date: 01/12/09

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

Payment for Target Case Management services provided to pregnant and postpartum women and infants through twelve months of age enrolled in the Vermont Department of Children and Families, Healthy Babies, Kids, and Families Program is based on a market-based rate.

The agency established payment rates based on an analysis of the provider cost structure and has periodically been updated to assure access to high quality care while maintaining economy and efficiency. Rates are established at levels necessary to assure access to the service for the target population.

Payment rates are based on the skill level of the provider. Separate rates have been established for each of three skill levels: Registered Nurse, Master's Degree and Bachelor's Degree. Separate rates enable the agency to recognize differences in salary costs.

The established rates are paid based on a unit of service defined as a visit. While the duration of visits can vary depending on the needs of the individual, a visit typically represents one hour of service.

Reimbursement is made at the lesser of the provider's charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

The agency's rates were set as of June 28, 2008 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers.

TN#: 08-015

Effective Date: 06/28/08

Supersedes:

TN#: None

Approval Date: 03/03/09

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

Payment for Targeted Case Management services provided to children, ages one to five years, who have been identified by a health professional or community program who are at risk of inappropriate health care service utilization, medical complications, neglect, and or abuse and who do not have another case management provider whose responsibility is to provide or coordinate the interventions included in this service is made at the lesser of the provider's charge or the Medicaid rate on file.

The agency established payment rates based on an analysis of the provider cost structure and has periodically been updated to assure access to high quality care while maintaining economy and efficiency. Rates are established at levels necessary to assure access to the service for the target population.

The established rates are paid based on a unit of service defined as a visit. While the duration of visits can vary depending on the needs of the individual, a visit typically represents one hour of service.

Reimbursement is made at the lesser of the provider's charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

The agency's rates were set as of June 28, 2008 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers .

TN#: 08-017

Supersedes:

TN#: None

Effective Date: 06/28/08

Approval Date: 03/03/09

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

20. Extended Services to Pregnant Women

Payment is made at the lower of the usual and customary charge to the general public or the Medicaid rate on file for the particular service.

21. Ambulatory Prenatal Care For Pregnant Women During a Presumptive Eligibility Period
Not provided.

22. Respiratory Care

Payment is made at the lower of the actual charge or the Medicaid rate on file.

23. Certified Pediatric and Family Nurse Practitioners

Covered pediatric or family nurse practitioner services are reimbursed at the lower of the actual charge or the Medicaid rate on file for a physician providing the same service.

24. Any Other Medical Care And Any Other Type Of Remedial Care Recognized Under State Law, Specified By The Secretary

a. Transportation

Ambulance: Payment for ambulance services is made at the lower of the actual charge or the Medicaid rate on file.

Mental Health Center: Payment for transportation services to and from a mental health agency is made at the lower of the actual charge or the Medicaid rate on file.

Medical Services: Payment for transportation other than that covered in the Ambulance and Mental Health Center paragraphs above is made at negotiated rates under the terms of a provider agreement.

School Health Services Providers: Payment is made at the lower of the actual charge or the Medicaid rate on file.

TN# 92-21

Effective Date: 03/25/93

Supersedes

TN# 92-14

Approval Date: 07/16/93

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

24. Any Other Medical Care And Any Other Type Of Remedial Care Recognized Under State Law, Specified By The Secretary (Continued)

- b. Christian Science Nurses:
Not available in Vermont.
- c. Christian Science Sanatoria:
Not available in Vermont.
- d. Skilled Nursing Facility for Persons Under 21
Payment for skilled nursing facility services for persons under age 21 is made as outlined in Attachment 4.19-B, item 4.a.
- e. Emergency Hospital Services (In Hospitals Not Participating in Title XVIII)
The Department will apply the same standards, cost reporting period, cost reimbursement principles and methods of cost apportionment as currently used in computing reimbursement for emergency hospital services in non-participating hospitals under Title XVIII of the Social Security Act.
- f. Personal Services:
Payment is made at the lower of the actual charge or the Medicaid rate on file.
- g. Services to Aliens:
The method and standard employed is that each type of service as contained in Section 4.19-B of the Vermont State Plan.

TN# 92-14

Supersedes

TN# 91-12

Effective Date: 07/01/92

Approval Date: 11/05/92

ADEQUACY OF ACCESS - OBSTETRICAL AND PEDIATRIC STANDARDS

Standard: c. Other

The Department of Social Welfare through the twelve district offices around the State of Vermont operates an action referral program to assure that Medicaid recipients have access to all covered health care, including obstetrical and pediatric care.

This program provides immediate and direct responses to recipients reporting difficulty in securing access to a Medicaid-covered service. Recipients may also call the toll free "hotline" maintained at the DSW State Office in Waterbury.

Under the direct supervision at the State Medicaid Director, a Medicaid staff member is designated to handle access problems which have not been resolved at the local or district office level.

The State practice outlined above and the almost negligible record of non-participation among pediatric and obstetrical providers assures the State of Vermont that the Medicaid fee-for-service rates are adequate to assure access.

There are currently approximately 215 family practitioners, 101 obstetricians, 112 pediatricians, and 16 certified nurse midwives enrolled in Vermont Medicaid, representing nearly 100 percent participation.

HMO Obstetrical and Pediatric Services

There are two Medicaid enrolled HMO's currently operating in Vermont, Community Health Plan (CHP) and Blue Cross Blue Shield. CHP began serving Title XIX recipients on 10/1/96 and BC/BS began serving recipients on 1/1/97.

Counseling regarding enrolled providers and services is available to all recipients required to enroll in managed care. As of 3/21/97, 6865 traditional Medicaid recipients are enrolled in managed care plans.

TN# 97-2

Effective Date: 07/01/97

Supersedes

TN# 96-4

Approval Date: 04/07/97

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

PAYMENT TO PACE PROVIDERS

Rates and Payments

- A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.
1. Rates are set at a percent of fee-for-service costs
 2. Experience-based (contractors/State's cost experience or encounter date)(please describe)
 3. Adjusted Community Rate (please describe)
 4. Other (please describe)
- B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.
- C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

Vermont calculates the Upper Payment Limit and Payment Rates for PACE as follows:

Data Source

- Paid claims data and historical eligibility for SFY 2000, 2001 and 2002 (July 1, 1999-June 30, 2002)
 - Analysis does not include transactions outside of claims system
 - Nursing Facility expenditures adjusted for wage supplements
 - Excludes Qualified Medicare Beneficiaries (QMBs)

TN# 03-17

Supersedes

TN# None

Effective Date: 12/01/04

Approval Date: 02/10/04

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

PAYMENT TO PACE PROVIDERS (Continued)

Methodology

- Identify potential participants for PACE (requirements of long term care services)
 - Categories of Service 05-01 and 05-02 (NF) and 27-01 (HCBS)
 - Excludes recipients of MR clinic services, long term mental health services and assistive community care services
 - Individuals age 55 and older
 - Statewide data

- Identify individuals eligible for Medicaid only and individuals eligible for both Medicaid and Medicare (Duals)

- Calculate member months

- Aggregate paid Medicaid claims

- Calculate historical PMPM values

- Develop adjustments to historical data
 - Claims lag factors
 - Increased utilization due to enhanced access
 - Drug Rebates

- Calculate UPL
 - Define blend of NF and HCBS
 - PACE conventional approach is: $60\% \text{ NF} / 40\% \text{ HCBS} - \text{UPL} = \text{NF PMPM} \times \text{NF}\% + \text{HCBS PMPM} \times \text{HCBS}\%$

- Calculate PACE rate
 - Program savings assumption of ten percent

TN# 03-17

Supersedes

TN# None

Effective Date: 12/01/04

Approval Date: 02/10/04