
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -INPATIENT HOSPITAL CARE

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions (PPCs).

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26(c), the DVHA assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
 - a. The identified PPC would otherwise result in an increase in payment.
 - b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19 (B) of this State plan, the DVHA will utilize modifiers that are self-reported by providers on claims that indicate if an OPPC occurred. When one of the OPPC modifiers is present on the claim, the DVHA will calculate a non-payment amount to ensure that the services rendered which the OPPC pertains to are not paid for by DVHA.

This provision applies to all providers contracted with the DVHA.

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Supersedes

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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) 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 DVHA will follow the Medicare OPPS pricing methodology with respect to how each CPT/HCPCS will be treated in the Medicare OPPS, with the exception that the DVHA will not utilize Medicare OPPS composite pricing logic. 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, 2011, two rates will be in place for each APC. The standard rates will be set at 83.8% of the Medicare OPPS median APC rate without local wage adjustments. The standard rates will be paid to all out-of-state hospitals. The enhanced rates will be set at 103.0% of the Medicare OPPS median APC rate without local wage adjustments. The enhanced rates will be paid to all in-state hospitals.

Hospitals in the state of Vermont classified by Medicare as a sole community hospital (SCH), or a critical access hospital (CAH) will receive 107.1% of the rate in place (either the standard or enhanced rate). Dartmouth-Hitchcock Medical Center will also receive 107.1% of the rate in place.

The DVHA will update the APC rates, the status indicators, the packaging methodology, and the outlier payment methodology annually based upon the Medicare OPPS Final Rule set each year.

B. Outlier Payments

The DVHA 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)

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)

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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)

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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 Commissioner 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 DVHA 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 DVHA 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 DVHA 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. The Agency's rates were set as of July 1, 2009 and are effective for services on for after that date. All rates are published on <http://dvha.vermont.gov/for-providers>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

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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 07/01/09 and are effective for services on or after that date. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

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

6. d. Other Practitioners Services

1. Behavioral Health Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.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 07/01/09 and are effective for services on or after that date. All rates are published at www.dvha.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 07/01/09 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

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.dvha.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.dvha.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.dvha.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.dvha.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.dvha.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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

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

12 a. Prescribed Drugs

- (1) "Multiple Source" drugs are paid, as of 7/15/09, at the lowest of:
 - (a) AWP-14.2% + dispensing fee;
 - (b) CMS Federal Upper Limit (FUL) + dispensing fee;
 - (c) State Maximum Allowable Cost (MAC) + dispensing fee; or
 - (d) the Usual and Customary (U&C) (includes dispensing fee).
- (2) "Single-source" drugs are paid, as of 07/15/09, at the lower of:
 - (a) AWP-14.2% + dispensing fee; or
 - (b) Usual and Customary (U&C) (includes dispensing fee).
- (3) "Physician Certified as Brand Necessary" are paid, as of 07/15/09, at the lower of:
 - (a) AWP-14.2% + dispensing fee; or
 - (b) the Usual and Customary (U&C) (includes dispensing fee).
- (4) All compounded prescriptions must contain more than one ingredient, and:
 - (a) As of 07/15/09, ingredients will be priced at the lesser of AWP – 14.2%, the MAC, or the FUL (plus a dispensing fee).
 - (b) The ingredients' costs will be totaled and priced at the lesser of the calculated cost in (a) or the claim's U&C cost.

Effective July 1, 2009, the dispensing fee for all fills and refills will be:

- a. \$ 4.75 for Vermont pharmacies,
- b. \$19.75 for compounded prescriptions at Vermont pharmacies,
- c. \$2.50 for out-of-state pharmacies, and
- d. \$17.50 for compounded prescriptions at out-of-state pharmacies.

'MAC' is a commonly utilized acronym in prescription drug management, translating to 'maximum allowable cost'. MAC represents the highest price a pharmacy will be reimbursed for the dispensing of a specific dose and formulation of a generic medication when that medication is available from multiple manufacturers. The goal of MAC pricing is to establish a fair and equitable level of reimbursement for all pharmacies, while simultaneously assuring that our clients are paying the lowest possible cost for such drug products. For a MAC price to be established on any given product, there needs to be a minimum of three suppliers. This generally consists of the originator brand and at least two generic sources. MAC pricing is established through an in-depth review of the prices paid by a typical pharmacy for the generic sources of the product. From there, a MAC price is established using a formula that ensures an adequate balance of low cost to our clients, yet a reasonable profit for the dispensing pharmacy.

Our MAC list is fully updated on a quarterly basis, with mid-quarter changes routinely taking place when significant pricing changes arise or when new generics enter the market from multiple generic manufacturers. We also commit to a more expeditious and aggressive updating of our MAC list when the generic exclusivity period expires on key products. This helps to avoid any substantial lost savings opportunity that may result from delays in MAC list updating.

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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 Devices

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.

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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.

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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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at www.dvha.vermont.gov/for-providers.

18. Hospice Care

Payment for hospice services is at a per diem rate, based on Medicare rates which are adjusted for Medicaid and published annually and established in accordance with Medicare regulations at 42 CFR 418, subpart G. Fee schedule will be updated concurrently with Medicare updates. Hospice payments for inpatient care are limited and paid in accordance with 42 CFR 418.302(g). Acquired Immunodeficiency Syndrome cases are included in the limitation calculation. The State does not apply the optional cap limitation on payments. The agency's rates were set as of 10/01/10 and are effective for services on or after that date. All rates are published at <http://dvha.vermont.gov/for-providers>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

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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.

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

Payment rates for Targeted Case Management services for persons with developmental disabilities who are unable to access needed medical, social, educational and other services because of adaptive deficits due to their level of disability, provided by the Department of Disabilities, Aging, and Independent Living, are developed from direct staff salaries, benefits and operating expenses (including indirect costs) which will be rebased periodically. The State established payment rates based on an analysis of the provider cost structure and has periodically updated the rates 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. Rates are based on a unit of service equal to 15 minutes.

Payment rates for Targeted Case Management services for individuals who lack assistance of a family member or other interested person to assist them in accessing needed services are based on program costs. The State allocates costs to the program in accordance with its approved allocation plan. Costs include salaries, fringe benefits and indirect costs. Payment rates are based on the skill level of the provider. Separate rates have been established for each of two skill levels. Separate rates enable the agency to recognize differences in salary costs. The rate is based on a unit of service equal to one week.

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

The rates were set as of June 28, 2008 and are effective for services on or after that date. All rates are published at <http://dvha.vermont.gov/for-providers>.

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.

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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 .

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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. The agency's rates were set as of 10/01/10 and are effective for services on or after that date. All rates are published at <http://dvha.vermont.gov/for-providers/claims-processing-1>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at <http://dvha.vermont.gov/for-providers/claims-processing-1>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

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. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2011. All rates are published at <http://dvha.vermont.gov/for-providers/claims-processing-1>.

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. The agency's rates were set as of 07/01/08 and are effective for services on or after that date. All rates are published at <http://dvha.vermont.gov/for-providers/claims-processing-1>. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

Non-Emergency: Payment for transportation other than that covered in the Ambulance paragraph above is made at negotiated rates under the terms of a provider agreement. The agency's rates were set as of 01/11/11 and are effective for services on or after that date. All rates are published at <http://dvha.vermont.gov/for-providers/claims-processing-1>. Except as otherwise noted in the Plan, State-developed fee schedule rates are the same for both governmental and private providers.

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.

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

25. Telemedicine

Telemedicine is defined as the practice of health care delivery by a provider who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. Telephone conversations, chart reviews, electronic mail messages, and facsimile transmissions are not considered telemedicine.

The distant site provider uses telemedicine to provide a service to the patient at the patient site.

The applicable provider types are as follows:

1. Community Mental Health Clinics
2. Designated Agencies
3. Federally Qualified Health Centers
4. Rural Health Clinics
5. Physicians
6. Naturopathic Physicians

Qualifying distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology.

Qualifying patient sites are reimbursed a facility fee. The fee is set at 80% of Medicare and is effective for services on or after 7/01/10; all rates are published at <http://dvha.vermont.gov/for-providers>. Payment is made at the lower of the actual 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.

26. Resource Based Relative Value Scale (RBRVS)

Effective for dates of service on or after January 1, 2011, the DVHA will reimburse qualified providers who deliver services that are covered by the DVHA and have a Relative Value Unit (RVU) listed on Medicare's RBRVS schedule by using the RVU listed on Medicare's RBRVS schedule in developing the DVHA's rate. There may be situations where the DVHA covers a service that is not payable in Medicare's RBRVS but a RVU is available. The DVHA will utilize the available RVU in this instance. There may be other situations where the DVHA covers a service that is not payable in Medicare's RBRVS and a RVU is not available. The DVHA will utilize the rate on file for this service as defined in Sections 5 through 25 above.

The components used to develop rates in the DVHA RBRVS payment methodology include the RVUs published by Medicare, the Geographic Practice Cost Indices (GPCIs) published by Medicare, and Conversion Factors which are specific to the DVHA fee schedule.

(Continued)

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

Effective for dates of service on or after January 1, 2011, the RVUs used are the Medicare RBRVS values published by the Centers for Medicare and Medicaid on its website in the file RVU11A.zip. The DVHA will always use the Non-Facility values for the Practice Expense component of the RVU. The DVHA will follow Medicare's payment logic of using the lesser of the RBRVS or OPPS RVU values.

The GPCIs used are 1.000 for Work, 1.002 for Practice Expense and 0.523 for Malpractice Insurance.

The DVHA will use two conversion factors for DVHA covered services payable in the RBRVS methodology. A conversion factor of \$28.6797 is used for services in the following series: CPT 59000-59871, 70010-79999, 90471-90474, 90801-90899, 96101-96155, 98940-98943, and 99201-99480. For all other covered services payable in the RBRVS methodology, a conversion factor of \$21.3420 is used.

Where the Vermont legislature has mandated a two percent reduction on rates paid to providers, the rate on file does not reflect this two percent rate reduction. Depending upon the provider billing the service, DVHA modifier pricing logic may also apply.

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

1. The RVU values
2. The GPCI values
3. The conversion factors

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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.

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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)

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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

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