DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

MAY 29 2013

Douglas A. Racine, Secretary
Vermont Agency of Human Services
208 Hurricane Lane, Suite 103
Williston, Vermont 05495

RE: Vermont 12-015

Dear Mr. Racine:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-015. This amendment implements a 3.725% increase to the base rates paid for inpatient services to all hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. The Medicaid State plan amendment 12-015 is approved effective July 1, 2012. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,
/s/

Cindy Mann
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 12 -- 015

2. STATE: VERMONT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
JULY 1, 2012

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §430.12(c)(ii)

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $ 533,997
b. FFY 2013 $ 2,078,862

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT. 4.19-A PG 1C-5, 1C-8 AND 1C-10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
ATT. 4.19-A PG 1C-5, 1C-8 AND 1C-10

10. SUBJECT OF AMENDMENT: BUDGET BILL - INPATIENT

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
SIGNATURE OF SECRETARY OF ADMINISTRATION
[redacted]

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/ s /

13. TYPED NAME:
DOUGLAS A. RACINE

14. TITLE:
SECRETARY, AGENCY FOR HUMAN SERVICES

15. DATE SUBMITTED:

DAVID MILLIKEN

DEPARTMENT OF VERMONT HEALTH ACCESS
312 HURRICANE LANE, SUITE 201
WILLISTON, VT 05495

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 29 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
/ s /

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

III. Payments Inpatient Hospital Services (Continued)

B. Discussion of Payment Components

1. Base Rates

The in-state Base Rate effective October 3, 2008 is based on claims with dates of service from October 3, 2003 to September 30, 2007 from all in-state hospitals plus Dartmouth-Hitchcock Medical Center. The cost values were assigned to each hospital claim on a claim-by-claim basis using data from each hospital's Medicare Cost Report. The cost report used to assign the cost for each claim was based on the ending date of service of the claim.

Allowed charges on each detail line of the inpatient claim were multiplied by a hospital-specific cost to charge ratio (CCR). The CCR assigned to each detail line is based on the revenue code billed for the detail line. The mapping of revenue codes to CCRs followed the principles that were described in the Medicare Inpatient Prospective Payment System Final Rule for 2007 published in the Federal Register on August 18, 2006.

The cost value of the claim is adjusted for inflation using Global Insight's Health Care Cost Review New CMS Hospital Prospective Reimbursement Market Basket moving average factors. Claim costs are inflated to the mid-point of the rate year.

The in-state base rate was derived by computing the average inflated cost per case across all claims in the base period. The in-state Base Rate effective July 1, 2012 is $6,975.51.

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

C. Psychiatric DRG Cases for High-Volume Psychiatric Case Hospitals

In-state hospitals that had more than 10% of the Psychiatric DRG cases paid by DVHA in 2006 or who had a distinct part psychiatric unit in place prior to October 3, 2008 will be paid for psychiatric cases under a DRG per diem methodology instead of a DRG per case methodology using the formula shown in III.A above.

The Psychiatric DRGs paid under this methodology are those Psychiatric DRGs as assigned by the Grouper being utilized by DVHA. Effective October 3, 2008, this included the following DRGs:

DRG 56: Degenerative Nervous System Disorders w MCC
DRG 57: Degenerative Nervous System Disorders w/o MCC
DRG 80: Nontraumatic Stupor and Coma w MCC
DRG 81: Nontraumatic Stupor and Coma w/o MCC
DRG 876: O.R. Procedure with Principal Diagnosis of Mental Illness
DRG 877: Acute Adjustment Reaction & Psychosocial Dysfunction
DRG 881: Depressive Neuroses
DRG 882: Neuroses Except Depressive
DRG 883: Disorders of Personality & Impulse Control
DRG 884: Organic Disturbances & Mental Retardation
DRG 885: Psychoses
DRG 886: Behavioral & Developmental Disorders
DRG 887: Other Mental Disorder Diagnoses
DRG 894: Alcohol/Drug Abuse or Dependence, Left AMA
DRG 895: Alcohol/Drug Abuse or Depend. with Rehabilitation Therapy
DRG 896: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w MCC
DRG 897: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w/o MCC

On an ongoing basis, the factors applied representing the length of stay will be the same as those utilized by Medicare in its Inpatient Psychiatric Prospective Payment System. The factors applied are additive by length of stay.

Psychiatric base per diem rates were set to ensure that the payments for psychiatric cases in the new payment system were comparable to the previous payment system. Effective July 1, 2012, the Base Per Diem Rates are as follows:

For Institutions of Mental Disease (IMD):	$1,132.68 per diem
For all other eligible hospitals:	$1,132.68 per diem

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

E. Out of State Facilities

Out-of-state facilities will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. However, the values of components of the formulas may differ from those used to pay in-state hospitals.

1. A Base Rate will be assigned to each participating out-of-state hospital based upon its peer group.

   a. Border Teaching Hospitals: Defined as hospitals within 10 miles of the Vermont border that operate post-graduate training programs. For services rendered on or after July 1, 2012, the base rate will equal $4,754.75.
   b. Non-Border Teaching Hospitals: Defined as hospitals greater than 10 miles of the Vermont border that operate post-graduate training programs. For services rendered on or after July 1, 2012, the base rate will equal $2,917.27.
   c. Other Out-of-State Hospitals: Defined as hospitals not meeting the criteria of G.1.a or G.1.b. For services rendered on or after July 1, 2012, the base rate will equal $2,722.78.

2. A Fixed Outlier Value will be assigned to each participating out-of-state hospital based upon its peer group.

3. An Outlier Percentage will be assigned to each participating out-of-state hospital based upon its peer group.