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State/Territory Name: VT

State Plan Amendment (SPA) #:16-0011 This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

November 23, 2016

Hal Cohen, Secretary
Vermont Agency of Human Services
280 State Drive
Waterbury, Vermont 05671

Dear Secretary Cohen:

We are pleased to enclose an approved copy of Vermont's approved State plan amendment (SPA) No. 16-0011 with an effective date of July 1, 2016, as requested by your Agency.

This SPA amended your Title XIX State plan to update the reimbursement methodology for outpatient hospital services to remove separate billing for revenue codes 510-519 (clinic services), and to make a corresponding adjustment upward in the percentage of the OPPS rates that VT will pay to participating hospitals.

Enclosed are the following pages to be incorporated within your State plan:

- Attachment 4.19-B, pages 2a(1a), 2a(1b), and 2a(1c)

If there are questions, please contact Tom Schenck at (617) 565-1325, or tom.schenck@cms.hhs.gov .

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc: Steven M. Costantino, Commissioner
Dylan Frazer, Health Programs Administrator, Policy Unit
Ashley Berliner, Director of Healthcare Policy and Planning

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: [redacted] 16-0011

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, 2016

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)(1)(ii)

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $ (1,099,625)
b. ~~FFY 2017~~ $ (4,444,198)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT 4.19-B PAGES 2A(1A), 2A(1B), AND 2A(1C)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
ATT 4.19-B PAGES 2A(1A), 2A(1B), AND 2A(1C)

10. SUBJECT OF AMENDMENT:
Outpatient Prospective Payment System 2016

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: [redacted]

13. TYPED NAME:
HAL COHEN

14. TITLE:
SECRETARY, AGENCY OF HUMAN SERVICES

15. DATE SUBMITTED: 9/23/16

16. RETURN TO:
DYLAN FRAZER

AGENCY OF HUMAN SERVICES
280 STATE DRIVE, CENTER BUILDING
WATERBURY, VT 05671-1000

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/23/2016

18. DATE APPROVED: 11/21/2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/2016

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Richard R. McGreal

22. TITLE Associate Regional Administrator

23. REMARKS

Pen and Ink change, Box 1

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE

2. a. Outpatient Hospital Services

OFFICIAL

2. Effective with dates of service on or after May 1, 2008, the Department of Vermont Health Access (DVHA) began reimbursing qualified providers for outpatient hospital services under a prospective fee schedule as set forth in this plan. The majority of services are paid using the Medicare Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) fee schedule as its basis. Covered services that are delivered in an outpatient setting that are not payable in Medicare's OPPS or are not packaged in the price for another service in Medicare's OPPS are paid using either a fee that has been set on DVHA's professional fee schedule or by using a cost-to-charge ratio multiplied by covered charges. The majority of the services on DVHA's professional fee schedule are derived from Medicare's Resource Based Relative Value Scale (RBRVS) relative value units (RVUs). Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 1, 2016 and are effective for services provided on or after that date. All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1.

i. Participating Hospitals
All in-state and out-of-state hospitals will be included in this payment methodology, regardless of any designation provided by Medicare.

ii. Discussion of Pricing Methodology

A. APC Rates
The DVHA will follow the Medicare OPPS pricing methodology with respect to how each CPT/HCPCS will be treated in the Medicare OPPS. Effective January 1, 2015, DVHA adopted some, but not all, of the Medicare OPPS composite and comprehensive 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, 2016, the DVHA has defined peer groups to set rates for groups of hospitals in its OPPS. The rate paid for each service payable in DVHA's OPPS using APC rates will be set as follows:

- For in-state hospitals that have a Medicare classification of critical access hospital (CAH): the peer group base rate is 115.00% of the Medicare 2016 OPPS national median APC rate without local adjustment.
- For in-state hospitals that do not have a Medicare classification of CAH: the peer group base rate is 100.00% of the Medicare 2016 OPPS national median APC rate without local adjustment.
- For Dartmouth-Hitchcock Medical Center: the peer group base rate is 90.00% of the Medicare 2016 OPPS national median APC rate without local adjustment.
- For out-of-state hospitals other than Dartmouth-Hitchcock Medical Center: the peer group base rate is 85.00% of the Medicare 2016 OPPS national APC median rate without local adjustment.

The percentages listed above are considered the base rates for DVHA's OPPS.

Effective with dates of service on or after July 1, 2016, the DVHA will no longer pay separately for outpatient hospital services billed using revenue codes 510-519 (clinic services). The base rates listed above have been increased to account for this policy change. However, due to the fact that some individual in-state hospitals were disproportionately impacted, positively or negatively, by this policy change, the DVHA is implementing a risk corridor for dates of service effective July 1, 2016 to June 30, 2017 as follows:

(Continued)

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

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

OFFICIAL

ii. Discussion of Pricing Methodology (Continued)

- If it was determined that an individual hospital's payments under the new peer group base rates would yield an amount that was greater than payments under the payment policies prior to July 1, 2016, then the individual hospital's base rate was lowered below their peer group base rate to the level that the hospital's net impact was equal to current payments.
- If it was determined that an individual hospital's payments under the new peer group base rates would yield an amount that was no greater than payments under the payment policies prior to July 1, 2016 but not less than 7.7% below payments under the payment policies prior to July 1, 2016, then the hospital receives its peer group base rate.
- If it was determined that an individual hospital's payments under the new peer group base rate would yield an amount that was more than 7.7% less than payments under the payment policies prior to July 1, 2016, then the individual hospital's base rate was raised above their peer group base rate to the level that the hospital's net impact was equal to 7.7% less than current payments.

The hospital-specific percentages based on the above risk corridor methodology are available here: http://dvha.vermont.gov/global-commitment-to-health/fy2017-opps-hospital-specific-percentages.pdf.

The DVHA will not pay any transitional outpatient payments (TOPs) made by Medicare to SCHs or to rural hospitals with 100 or fewer beds that are not SCHs as defined by Section 1886(d)(5)(D)(iii) of the Social Security Act.

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

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.

iii. Special Payment Provisions

A. Clinical Diagnostic Laboratory Services

When not packaged into another service payment in DVHA's OPPS, 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. Outpatient Hospital Services Paid at Cost

If the participating hospital is an in-state hospital, the Cost to Charge Ratio is applied to determine the payment, which is derived from the hospital's most recent filed Medicare Cost Report. If the participating hospital is an out-of-state hospital, the Cost to Charge Ratio is applied to determine the payment, which is the average in-state hospital Cost to Charge Ratio. The Cost to Charge Ratio is the total hospital cost to charge ratio, which includes inpatient and outpatient. The Cost to Charge Ratio is applied only to detailed lines on a claim in which: (1) the service is a covered service by DVHA and (2) it is not a packaged service in Medicare's OPPS and (3) it does not have a rate on the Medicare OPPS, the Medicare Lab Fee Schedule, or DVHA's professional fee schedule.

(Continued)

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

OFFICIAL

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

iii. Special Payment Provisions (Continued)

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

In addition to clinical diagnostic laboratory services, other services that DVHA 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; some rehabilitative therapies; and non-implantable durable medical equipment. The full list of covered outpatient services paid outside of DVHA's OPPS payment methodology can be found at http://dvha.vermont.gov/for-providers/claims-processing-1. 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 DVHA but fees for specific services will not exceed the fee established by Medicare.

D. Observation Services

The DVHA 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 DVHA will pay for units of observation service (1 hr = 1 unit) at a rate of $35.00/hour up to a maximum of 24 units ($840.00).

E. Medicare Crossover Claims

Effective with dates of service on or after May 1, 2008, the DVHA 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 DVHA.

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)