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.

_X__ 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.

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 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 will be paid using a fee that has been set on DVHA's professional fee schedule. 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 rate was set as of January 1, 2015 and is 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, with the exception that the DVHA will utilize select Medicare OPPS composite pricing logic as of January 1, 2015. Prior to this date, the DVHA did not utilize any of 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 January 1, 2015, the rate paid for each service payable in DVHA's OPPS will be set as follows:

- For in-state hospitals that have a Medicare classification of either sole community hospital (SCH) or critical access hospital (CAH): 92.79% of the Medicare 2015 OPPS national median rate without local adjustment.
- For in-state hospitals that do not have a Medicare classification of either SCH or CAH: 86.64% of the Medicare 2015 OPPS national median rate without local adjustment.
- For Dartmouth-Hitchcock Medical Center: 74.76% of the Medicare 2015 OPPS national median rate without local adjustment.
- For out-of-state hospitals other than Dartmouth-Hitchcock Medical Center: 69.80% of the Medicare 2015 OPPS national median rate without local adjustment.

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 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.

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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

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.

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).

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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.

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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 OPPS 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 OPPS 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 interim payment shall be calculated at 110% of the Medicare amount for services provided on or after November 1, 2013. For services provided by FQHC's on or after November 1, 2013, the interim payment shall be calculated at 130% of the Medicare upper limit for that year. For RHC's not subject to Medicare upper limit, the Medicaid upper limit shall be 125% of the non-urban FQHC Medicare upper limit from each calendar year. Effective on and after October 1, 2014, for RHC's not subject to the Medicare upper limit, the Medicaid upper limit shall be 130% of the non-urban FQHC Medicare upper limit for that year. 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.

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.

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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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.

a. Supplemental Payments for Qualified Teaching Professionals

a. Notwithstanding other provisions of this Attachment 4.19-B, effective 7/1/2011, supplemental payment will be paid according to this subsection for professional services performed by Qualified Teaching Physicians (QTPs). The purpose of the supplemental payment is to ensure access to essential professional services for Medicaid beneficiaries through the care provided by teaching physicians on the faculty of the University of Vermont (UVM) College of Medicine.

QTPs include those physicians who are:
1. Licensed by the State of Vermont, where applicable;
2. Enrolled as a State of Vermont Medicaid provider; and
3. Hold salaried appointments on the faculty of the UVM College of Medicine and are employed by UVM Medical Group.

b. A supplemental payment will be made for services provided by QTPs in an amount equal to the difference between the Medicaid payments otherwise made for the services and payments at the Average Commercial Rate. Only the professional component of a procedure is eligible for a supplemental payment. Payment will be made quarterly and will not be made prior to the delivery of services.

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

c. The Average Commercial Rate to be paid to QTPs is determined as follows:

1. Compute the Average Commercial Fee Schedule: For the most recently completed calendar year, compute the average commercial payment rate per procedure code, including patient share amounts, paid by the top five commercial third party payers as determined by total billed charges reported for all QTPs. The average rate for each procedure code will be a straight average among all QTPs for which a rate is available.

2. Calculate the Average Commercial Payment Ceiling: For the most recently completed calendar year, multiply the Average Commercial Fee Schedule rate for each procedure code as determined above by the number of times each procedure code was paid to QTPs on behalf of Medicaid beneficiaries as reported from the Medicaid Management Information System (MMIS). The sum of the product for all procedure codes subject to enhanced payment represents the Average Commercial Payment Ceiling.

3. Calculate the Medicaid Payment Amount. Using the same data as in 11A.(c)(2), multiply the units for each procedure code by the most recent Medicaid rate on file for the procedure code.

d. The Medicaid Supplemental Payment to QTPs is equal to 95% of the difference between the Average Commercial Payment Ceiling for the year and the total Medicaid Payment Amount for the year.

e. The calculated supplemental payment amount is equal to 95% of the ACR as calculated and made available by the State for the calendar year.

6. a. Podiatrist's Services
Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment.4.19-B. 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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B . 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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B . 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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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 or the Medicaid rate. The agency's rates were set as of 07/01/09 and are effective for services on or after that date. For services delivered through the home telemonitoring delivery system, the rates are based on a fee-for-service methodology and rates were set and are effective as of 8/1/2014. Routine small cost items (e.g. cotton balls, tongue depressors, etc.) are covered in the visit or hourly rate paid to the agency. All rates are published at www.dvha.vermont.gov/for-providers. Set-up and maintenance fees for the home telemonitoring delivery system are paid once every 30 days on the fee schedule identified above. 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 or 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 or 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 or 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 or 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 or the Medicaid rate. The agency's rates were set as of 1/1/14 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 or the Medicaid rate. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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)

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.

(5) Drugs dispensed by limited distribution pharmacies are paid, at the lower of
- (a) "Multiple Source" drugs are paid, at the lowest of:
  - AWP-16.5% + dispensing fee;
  - CMS Federal Upper Limit (FUL) + dispensing fee;
  - State Maximum Allowable Cost (MAC) + dispensing fee; or
  - the Usual and Customary (U&C) (includes dispensing fee).
- (b) "Single-source" drugs are paid, at the lower of:
  - AWP-16.5% + dispensing fee; or
  - Usual and Customary (U&C) (includes dispensing fee)

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.

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

'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.

Limited Distribution Pharmacies dispense medications that may have special requirements for dosing or close lab monitoring. Because of these special requirements, drug manufacturers sometimes choose to limit the distribution of their drugs to only one or a few select pharmacies or, as part of the drug approval process, the Food and Drug Administration (FDA) may recommend this type of distribution. This type of restricted distribution allows the manufacturer to properly control the inventory of the drug; educating dispensing pharmacists about appropriate patient education and monitoring required; and ensure that any risks associated with the medication are minimized.

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.

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.

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. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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.

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.

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 .

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 .

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 Eligibi1ity Period
Not provided.

22. Respiratory Care
Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. This methodology was updated for dates of service effective on or after the date specified in the RBRVS section (26) of this attachment.. 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
Payment is made at the lower of the actual charge or the Medicaid rate on file for a physician providing the same service. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B . 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.

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.

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 by permitting two-way, real-time interactive communications between the patient at the originating site and the physician or practitioner at the distant site. Telephone conversations, chart reviews, electronic mail messages, and facsimile transmissions are not considered telemedicine.

With the application of the GT modifier, the distant site provider uses telemedicine to provide a service to the patient at the originating site.

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, 2015, 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)

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

Effective for dates of service on or after January 1, 2015, the RVUs used are the Medicare RBRVS values published by the Centers for Medicare and Medicaid on its website. The DVHA will utilize the Non-Facility values for services provided in the physician office and facility RVUs to providers when place of service is an inpatient hospital, outpatient hospital, emergency room, ambulatory surgical center, inpatient psychiatric facility, nursing facility or skilled nursing center. The DVHA will follow Medicare's payment logic of using the lesser of the RBRVS or OPPS RVU values for those select procedures subject to the policy.

The GPCIs used are 1.000 for Work, 1.004 for Practice Expense and 0.682 for Malpractice Insurance.

Effective with dates of service on or after January 1, 2015, the DVHA will use one conversion factor for DVHA covered services payable in the RBRVS methodology. The DVHA will pay for these services using a conversion factor of $28.71 multiplied by the RVU value on file with DVHA as referenced in the first paragraph on this page.

Effective with dates of service on or after July 1, 2015, the DVHA will implement a second conversion factor of $29.92 that will be paid only to eligible enrolled Vermont Medicaid providers who must attest to being a primary care physician by one of the following:

1. Board certification as a primary care physician by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA) or;
2. Have furnished evaluation & management (E&M) and vaccine administration services that equal at least 60% of the Medicaid codes billed during the most recently completed fiscal year.

If the provider meets these conditions, then the services paid using the conversion factor of $29.92 are those covered and separately payable by Vermont Medicaid and are within the range of E&M Codes from 99201 through 99499 or vaccine administration codes from 90460 through 90474.

When the $29.92 rate is used, there is no site of service adjustment. Reimbursement is always made using the RVUs associated with the office setting.

Depending upon the provider billing the service, the DVHA modifier pricing logic may also apply.

All rates are published at http://dvha.vermont.gov/for-providers .

27. Anesthesia

Payment is made at the lower of the actual charge or the Medicaid rate on file. Effective for dates of service on or after January 1, 2012, the DVHA will reimburse qualified providers who administer anesthesia services covered by the DVHA using the Medicare payment formula of (time units of service + base unit) multiplied by a conversion factor. The units of service billed are based on Medicare billing requirements. The base unit values used by DVHA are those put in place by Medicare effective January 1, 2012. The DVHA will follow Medicare's changes to the base unit values by updating the base units each January.

1. The DVHA will not use Medicare's conversion factor for Vermont, but rather a conversion factor of $18.15.

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)

28. Tobacco Cessation Counseling for Pregnant Women

Tobacco Cessation Counseling for Pregnant Women is defined as diagnostic, therapy, counseling services, and pharmacotherapy for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use; by or under supervision of a physician; or by any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services.

Payment is made at the lower of the actual charge or the Medicaid rate on file. Rates were set using the Medicare Resource Based Relative Value Scale (RBRVS). For services payable in Medicare's RBRVS payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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.

29. Tobacco Cessation Counseling for Non-pregnant Individuals

Tobacco Cessation Counseling for non-pregnant individuals is face-to-face counseling services with a qualified provider for cessation of tobacco use by individuals who use tobacco products or who are being treated for tobacco use; by or under supervision of a physician; or by any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services.

Payment is made at the lower of the actual charge or the Medicaid rate on file. Rates were set using the Medicare Resource Based Relative Value Scale (RBRVS). For services payable in Medicare's RBRVS payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. 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)

30. Integrated Care Models
Vermont Medicaid Shared Savings Program (VMSSP)

A. Overview

Payments under the VMSSP are made following the end of a performance year to qualifying ACOs that have agreed to participate for the purpose of improving clinical quality and patient experience, and achieving efficiencies across the total cost of care. Once data is collected and analyzed at the end of a performance year, a lump sum shared savings payment will be made to qualifying ACOs no later than the last day of August following the end of that performance year. The ACO distributes payments to member providers according to their participation agreements. The program will only pay shared savings (up-side risk) if eligible, and will not require recoupment (down-side risk) in the event there is an increase in actual expenditures in any of the first three performance years.
As represented by the formulas below, the total amount of shared savings in a given performance year is equal to the difference between the truncated, risk-adjusted, expected total cost of care (TCOC) and the truncated, risk-adjusted actual total cost of care for the attributed population of each ACO. The ACO portion of shared savings payment is equal to the product of the maximum savings rate and the total amount of shared savings for that ACO, adjusted by the ACO-specific quality score.

$$\text{PYSS\$}_{\text{TOTAL (ACO}i\text{+PAYER)}} = (\text{Expected TCOC \$}_{\text{ACO}i} - \text{Actual TCOC \$}_{\text{ACO}i}) \textit{ risk adjusted, truncated}$$

subject to cap of 10% of the "Actual $\$_{ACOi}$"

$$\text{Payout of PYSS\$}_{\text{ACO}i+} = (\text{MAXSR}_{\text{ACO}i} * (\text{PYSS\$}_{\text{TOTAL (ACO}i\text{+PAYER)}})) * \text{QS}$$

subject to MSR, savings rate tiers, and adequate population size

Where:

PAYER=DVHA (State Share and FMAP)

PYSS$ = Performance Year Shared Savings Dollars

TCOC = Total Cost of Care

MAXSR= Maximum Savings Rate (50%)

QS= Quality Score

MSR=Minimum Savings Rate

ACOi = a specific ACO contracted with the VMSSP

The calculations are done retrospectively for each ACO using the claims data for services identified in the TCOC rendered in a performance year with allowance for six months run-out. To be eligible for savings, a minimum population size of 5,000 and minimum savings rate of at least 2% must be demonstrated. Once the minimum savings rate is reached, the state will calculate a tiered savings rate based on total savings. If program savings are between 2-5% (Tier 1), the ACO will qualify for 25% of total shared savings. If program savings is above 5% (Tier 2), the ACO will qualify for 50% of total shared savings up to a cap. The cap is set at 10% of actual total cost of care in a given performance year for that ACO.

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

A. Attributed Populations

For the purposes of calculating shared savings, beneficiaries will be considered attributed lives if they are enrolled in Medicaid for at least ten non-consecutive months in a performance year, except for the following excluded populations:

1. Individuals who are dually eligible for Medicare and Medicaid;
2. Individuals who have third party liability coverage;
3. Individuals who are eligible for enrollment in Vermont Medicaid but have obtained coverage through commercial insurers; and
4. Individuals who are enrolled in Vermont Medicaid but receive a limited benefit package.

This exclusion is for the purpose of shared savings calculation only, and will not impact the receipt of services in any way.

A. Attribution Methodology
Beneficiaries will be attributed to ACOs in the VMSSP through the following process:

1. Retrospective claims attribution using a methodology in which claims for eligible beneficiaries are identified for the presence of qualifying Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes billed in the previous twelve months by primary care providers enrolled with Medicaid.

2. For eligible beneficiaries not attributed by retrospective claims attribution, assign the beneficiary to his/her primary care provider that he/she selected or was auto-assigned upon enrollment.

Attribution is done at the rendering provider and billing provider TIN level that is affiliated with an ACO participant. Any ACO participant that includes at least one ACO rendering provider with attributed lives to him/her must have an exclusive participant relationship with only one ACO in the VMSSP. Those ACO participants who do not attribute lives can participate in multiple ACOs in the VMSSP.

D. Patient Freedom of Choice
Beneficiaries will have freedom of choice with regard to their providers consistent with their benefit as described in 42 CFR 431.51.

E. Risk Score
Risk adjustment is done using the most recently released CMS community version of the Hierarchical Condition Classification software.

F. Total Cost of Care
Participants in the VMSSP are responsible for the Total Cost of Care (TCOC) of their attributed population of beneficiaries in each performance year. The TCOC is comprised of a defined set of core services. Core services included in the TCOC for year two include: inpatient hospital, outpatient hospital, physician (primary care and specialty), nurse practitioner, physical and occupational therapy, mental health facility and clinic, ambulatory surgery center, federally qualified health center, rural health center, chiropractor, podiatrist, psychologist, optometrist, optician, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility. The TCOC is the sum of payments made for core services rendered in the given performance year. Expenditures for attributed beneficiaries are capped at the value of the 99th percentile of expenditures for the attributed lives within enrollment categories.

Core services are determined by the State annually. DVHA determines the core service applicable in each performance year prior to the start of the program year. Services not in the TCOC calculations are called

non-core services. DVHA maintains the list of core and non-core services applicable to each performance year, which can be found at: http://dvha.vermont.gov/administration/totalcostofcare.pdf

G. Expected Total Cost of Care (TCOC)

The expected total cost of care calculation uses three historic benchmark years of claims data. In performance year two, calendar year 2015 (CY 2015), the three historic benchmark years are CY 2011, 2012 and 2013. The benchmark years will be updated on a rolling basis annually—that is, the oldest year of data used in the calculations of the benchmark in the previous performance year will be dropped and a more current year will be added to the benchmark reflecting data closer to the performance year.

The risk adjustment process described in section E and the truncation calculation described in section F are performed and a total ACO eligible population compound annual growth rate (CAGR) is calculated from re-priced data in the three benchmark years.

The expected TCOC is computed for each enrollment category separately.

The formula applied is:

(Truncated, risk adjusted PMPM from last year in the benchmark period) * (1+CAGR) * (1+CAGR)

In some years, an additional adjustment may be made to the expected TCOC to account for rate changes made by DVHA between the benchmark years and the performance year that would not be reflected in the CAGR.

H. Actual Total Cost of Care

The actual TCOC calculation will be derived from claims for actual attributed population of each ACO during a performance year. Risk-adjustment and truncation are also performed as described in sections E and F.

I. Gain and Loss-Sharing

The maximum savings rate in the VMSSP is fifty percent. There are no loss-sharing and/or recoupment requirements under the program for the first three years.

J. Quality and Patient Experience Measures Requirements for Reporting Measures

The VMSSP uses the Gate and Ladder methodology to calculate a Quality Score (QS) that is then used in the calculation of the payment of shared savings as described in section A. The Gate and Ladder are defined as follows:

Gate -- The ACO must earn a minimum number of the eligible points as stated in its contract in order to receive a share of any generated savings. If the ACO is not able to meet the overall quality gate, then it will not be eligible for any shared savings.

Ladder -- In order to retain a greater portion of the savings for which the ACO is eligible, the ACO must achieve higher performance levels for the measures. There are six steps on the ladder, which reflect increased levels of performance.

For year two of the VMSSP pilot, the ACO's performance on the payment measures will be compared to performance targets. The targets are based either on national Medicaid HEDIS benchmarks or ACO-specific prior year performance. When the targets are based on national Medicaid HEDIS benchmarks, 1, 2 or 3 points will be assigned based on whether the ACO performed at the national 25th, 50th or 75th percentile for the measure. When no national benchmarks are available, the ACO will receive 0 points for a statistically significant decline over prior year performance, 2 points for no statistically significant change over prior year performance, and 3 points for a statistically significant improvement over prior year performance.

In addition to earning points for attainment of quality relative to national benchmarks, ACOs can earn 1 additional point for every payment measure that is compared to a national benchmark for which they achieved statistically significant improvement relative to the prior program year. Improvement points will not be available for measures that already use ACO-specific improvement targets instead of national benchmarks.

The core measure set and Gate and Ladder threshold and scores are subject to change prior to the beginning of each performance year. Current measure sets, thresholds and scores can be found at the following web address: http://dvha.vermont.gov/administration/performance-measures-and-shared-savings.pdf.

I. Monitoring and Reporting

The VMSSP includes a series of internal monitoring and reporting measures that are scheduled to be calculated and analyzed quarterly or at minimum, semi-annually.

As a condition of continuance beyond December 31, 2016, Vermont will evaluate the program to demonstrate improvement against past performance using cost and quality data to determine whether the payment methodology has achieved or needs revisions to achieve the goals of improving health, increasing quality and lowering the growth of health care costs. With regard to methodological changes and moving towards a more robust metric framework that is tied to payment, Vermont will reflect in its annual updates any changes to the measures being used to assess program performance and/or determine payment eligibility and distribution.

Vermont will:

1. Provide CMS, at least annually, with data and reports evaluating the success of the program against the goals of improving health, increasing quality and lowering the growth of health care costs;

2. Provide CMS, at least annually, with updates, as conducted, to the state's metrics;

3. Review and renew the payment methodology as part of the evaluation; and,

4. Make all necessary modifications to the methodology, including those determined based on the evaluation and program success, through State Plan Amendment updates.

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.

INCREASED PRIMARY CARE SERVICE PAYMENT 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: There is a single GPCI for VT so no calculation is necessary.

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405, 447.410, and 447.415.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐semi-annually ☐annually

Primary Care Services Affected by this Payment Methodology

☒ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99288, 99297, 99351 – 99353, 99358 - 99360, 99363, 99364, 99366 - 99368, 99374 – 99380, 99411, 99412, 99429, 99441 – 99444, 99455, 99456, 99499

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added). 99406 (10/01/10), 99407 (10/01/10), 99408 (01/01/12), 99409 (01/01/12)

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $6.87.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at http://dvha.vermont.gov/.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at http://dvha.vermont.gov/.

Fee Schedule Development
The fee schedule was developed by the State and uses the January 2013 release in conjunction with the 2009 conversion factor to set the rates. The State will not adjust the fee schedule to account for Medicare rate changes throughout the year. Rather, the State will make an annual adjustment effective with services beginning January 1 of each year.