

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

VII. Data Sources for Computation of Disproportionate Share Payments

A Base Year is established each year for collecting the data used to set disproportionate share payments in each State Plan Year (SPY). For payments in SPY ~~2014-2015~~ (effective October 1, 201~~34~~), the Base Year used is the fiscal year ending September 30, ~~2014~~2012. The Base Year will advance one year for each subsequent SPY. Data sources, and the data that will be used from them, include the following:

- A. From the State's Medicaid Management Information System (MMIS)
 - 1. Vermont Medicaid inpatient and outpatient hospital charges
 - 2. Vermont Medicaid inpatient days - Excluded from this figure are Title XXI days and days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMD).
 - 3. Vermont Medicaid payments
- B. Hospital Medicare Cost Reports
 - 1. Hospital cost-to-charge ratios
 - 2. Total hospital inpatient days and total Medicaid inpatient days
 - 3. Medicaid inpatient accommodation per diem costs
- C. Hospital Attestation. Federal statute, specifically 42 CFR 447 and 455 requires that hospitals provider certain information for the DSH calculation. The Department of Vermont Health Access (DVHA) collects this federally required information in the form of an attestation from hospitals. Hospitals are required to complete this attestation each year to allow the DVHA the ability to collect data that is not available from any other sources. The DVHA will establish the due date for hospitals to complete this attestation each year and will provide hospitals at least 60 calendar days to complete the attestation. The due date will be on or before May 1. Hospitals who do not submit a completed attestation by the due date waives its right to be eligible for a DSH payment for that DSH plan year.
 - 1. Attestation of federal obstetrical requirement.
 - 2. Total state and local cash subsidies for inpatient and outpatient services
 - 3. Disproportionate share payments from other states and Section 1011 payments
 - 4. Inpatient days for Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage
 - 5. Inpatient and outpatient hospital charges for Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage
 - 6. Payments for claims from Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage
- D. ~~Department of Banking, Insurance, Securities and Health Care Administration, Green Mountain Care Board's Payer Revenue by Hospital (former Report 5), Net Patient Care Revenue by Payer~~
 - 1. Net Medicaid and Net All Payer patient services revenue
 - 2. Gross Inpatient Charges
- E. Audited hospital financial statements and hospital accounting records.
 - 1. Total revenue for hospital patient services, including inpatient and outpatient services and services by sub provider

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