DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification (CMCS)

Robert Hoffman, Secretary
Agency of Human Services
State of Vermont
103 South Main Street
Waterbury, VT 05676-1201

MAY 2 6 2010

RE: TN Vermont 09-017

Dear Mr. Hoffman:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-017. Effective October 1, 2009, this amendment proposes to modify the Disproportionate Share Hospital (DSH) reimbursement methodology. Specifically, it adjusts the DSH Eligibility Groups and establishes payment formulas for the groups.

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(g) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-017 is approved effective October 1, 2009. 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,

Cindy Mann
Director (CMCS)

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 09 -- 017

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)
10/01/09

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

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $ 0
b. FFY 2011 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-A PAGE 1D, 1E, 1F, 1G, AND 1H

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
ATTACHMENT 4.19-A PAGE 1D, 1E, 1F, 1G, 1H, AND 1I

10. SUBJECT OF AMENDMENT: DISPROPORTIONATE SHARE HOSPITALS

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
ROBERT HOFMANN

14. TITLE:
SECRETARY, AGENCY FOR HUMAN SERVICES

15. DATE SUBMITTED: 12/15/09

16. RETURN TO:

KERI ANDERSEN

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 26 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: CINDY MANN

22. TITLE: DIRECTOR, CMCS

23. REMARKS

FORM CMS-179 (07-92)

Instructions on Back

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

Methods and Standards for Payment Adjustments to Hospitals Qualifying as Disproportionate Share Hospitals

Effective October 1, 2009, the Office of Vermont Health Access (OVHA) will make disproportionate share payments to hospitals as set forth in this plan.

VI. Eligible Hospitals

A. Minimum Requirements

In order to be eligible for disproportionate share payment, a hospital must:

1. Have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the Medicaid state plan. For hospitals outside of the Burlington-South Burlington Core Based Statistical Area (CBSA), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

   The above obstetric-related criteria do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age, or to hospitals which did not offer non-emergency obstetric services as of December 21, 1987.

2. Have a Medicaid inpatient utilization rate of at least one percent. The Medicaid inpatient utilization rate is defined as a hospital's total Medicaid inpatient days (including managed care days) divided by the total number of inpatient days.

(Continued)

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

VI. Eligible Hospitals (Continued)

B. Federally Deemed Hospitals

Additionally, the OVHA recognizes those hospitals deemed by federal law to be disproportionate share hospitals. The OVHA deems a hospital to be a disproportionate share hospital if:

1. The hospital has a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state (herein named DSH Eligibility Group #1); or

2. The hospital has a low income utilization rate exceeding 25 percent (herein named DSH Eligibility Group #2).

C. State-Defined Criteria

Hospitals that meet the minimum requirements in VI.A. but do not meet the criteria for VI.B will still qualify for disproportionate share payments based on:

1. The hospital's status as an in-state post-graduate teaching facility (herein named DSH Eligibility Group #3); or

2. The hospital's proportion of statewide Medicaid inpatient days (herein named DSH Eligibility Group #4)

(Continued)

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 2010 (effective October 1, 2009), the Base Year used is the fiscal year ending September 20, 2007. 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. Hospital inpatient and outpatient claims data, including sub providers
   1. Hospital Medicaid charges
   2. Medicaid inpatient days- Excluded from this figure are Medicare crossover claims, Title XXI days and days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease. Days for OVHA members eligible under Medicaid expansion programs are included.
   3. Title XIX payments

B. Hospital Medicare Cost Reports
   1. Hospital cost-to-charge ratios
   2. Total hospital inpatient days and total Medicaid days
   3. Total inpatient charges from all payers

C. A state-designed survey
   1. Attestation of federal obstetrical requirement
   2. Medicaid patient services revenue
   3. Total revenue for hospital patient services, including inpatient and outpatient services and services by sub provider
   4. Total state and local cash subsidies for inpatient services
   5. Total state and local cash subsidies for outpatient services
   6. Total inpatient charges attributable to charity care. This excludes contractual allowances and bad debt.
   7. Total outpatient charges attributable to charity care. This excludes contractual allowances and bad debt.

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

VIII. Disproportionate Share Payments

Each year of the program, OVHA will determine the DSH Eligibility Group that each hospital is eligible for before calculating payments. If a hospital is eligible for more than one DSH Eligibility Group, for the purposes of computing the funding for each DSH group, the hospital will be placed in only one DSH Eligibility Group in the following sequence:

DSH Eligibility Group #3
DSH Eligibility Group #1
DSH Eligibility Group #2
DSH Eligibility Group #4

Within a DSH Eligibility Group, funds will be assigned to each hospital using the formulas described in VIII.A. Hospitals may only receive funds from one DSH Eligibility Group each year.

The Total DSH Funding for the DSH State Plan Year 2010 is $36,548,781 (FFY dollar amount): an amount not to exceed the annual DSH allotment specified by CMS. At the time that DSH payments are disbursed, OVHA will publish the funding for each DSH Eligibility Group and a schedule showing the DSH payment made to each eligible hospital.

A. Payment Formulas

Before the calculation of funding by DSH Eligibility Group occurs, the calculation of each Hospital Specific Limit is completed as described in VIII.B. Funding for each Group is then completed as follows.

1. Funding for DSH Group #3 is done first. The amount funded for Group #3 is the lesser of 50% of the Total DSH Funding for the DSH SPY or 50% of the the combined Hospital Specific Limit for all hospitals in the Group.

2. Subtract the amount funded for DSH Group #3 from the Total DSH Funding for the DSH SPY to derive the remaining amount to be allocated between DSH Groups #1, #2 and #4.

3. Calculate for each hospital its percentage of the total Title XIX statewide days in the Base Year.

(Continued)

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

VIII. Disproportionate Share Payments (Continued)

a. The total statewide days value used in the calculation excludes the Title XIX days for any hospitals in DSH Group #3.
b. The total statewide days does include days from any in-state hospitals that were paid for Title XIX days in the Base Year even if they are not eligible for a DSH payment.

4. Sum the percentage of statewide days in the DSH Group.
   a. If a hospital was paid for Title XIX days in the Base Year but was not eligible for DSH because it did not meet the minimum requirements specified in VI.A.1 or VI.A.2, the percentage of its statewide days is included in DSH Group #4.
   b. If a hospital was paid for Title XIX days in the Base Year but was not eligible for DSH because its Hospital Specific Limit was less than $0, the percentage of its statewide days is included in DSH Group #4.

5. Calculate the DSH Allotment by DSH Eligibility Group using the following formula:

   *Total Remaining DSH Funding Available (computed in Step 2) **
   Total Percentage of Statewide Days in the DSH Group (computed in Step 4)

6. The DSH payments to each hospital in DSH Groups #1, #2 and #4 are made using the following methodology:

   a. For each DSH Group, compute an Aggregate Hospital Limit that is the sum of the individual Hospital Specific Limits within the DSH Group. The Hospital Specific Limits for hospitals meeting the criteria in VIII.A.4.a or VIII.A.4.b are not included in the calculation.
   b. Determine each hospital's limit as a percentage of the Aggregate Hospital Limit.
   c. Multiply the percentage computed in (b) by the DSH Group Allotment in VIII.A.5.

(Continued)

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

VIII. Disproportionate Share Payments (Continued)

B. Payment Limitations

The Omnibus Budget Reconciliation Act of 1993 established rules limiting the total disproportionate share payment that a hospital can receive. Disproportionate share payments are limited to no more than the cost of providing hospital services to patients who are either eligible for medical assistance under a state plan or have no health insurance for the services provided, less payments received under Title XIX (other than DSH payment adjustments).

The OVHA will test the calculated disproportionate share payments allocated to each hospital in each year to ensure that payments do not exceed federal limits established under the Omnibus Budget Reconciliation Act of 1993 or Section 1923 of the Social Security Act using protocols established in the DSH Audit procedures developed by CMS. The source data used to compute this limit is the data from the Base Year that was used to set payments in the DSH SPY as set forth in VII. A-C.

In the event that the initial calculation determines that a hospital's calculated disproportionate share payment exceeds the Hospital Specific Limit, the amount of funds above the limit will be redistributed to the other eligible hospitals in its DSH Eligibility Group.

The OVHA will ensure that the disproportionate share payments will not exceed the limits.

OS Notification

State/Title/Plan Number:	**Vermont 09-017**
Type of Action:	**SPA Approval**
Required Date for State Notification:	**June 6, 2010**
Fiscal Impact:	**FY 2009 $0 FFP** **FY 2010 $0 FFP**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes and No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: **Effective October 1, 2009, this amendment proposes to modify the Disproportionate Share Hospital (DSH) reimbursement methodology. Specifically, the State adjusts its DSH Eligibility Groups to more accurately reflect the State's goal in providing increased DSH payments to a particular provider identified by the State as an in state privately owned teaching facility. Additionally, the State establishes revised payment formulas for its DSH Eligibility Groups that result in increasing payments for some providers and decreasing for others. This provision is cost neutral because the total amount of DSH funds expended remains unchanged by the revision.**

Other Considerations: **There is a pending court case. The Plaintiff (Springfield Hospital) and their attorneys have notified CMS of their objections to this SPA primarily because it will result in a decrease in payment for them. We have responded to their concerns. CMS is satisfied that the State has met all the Federal requirements. We do not recommend the Secretary contact the governor. This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.**

CMS Contact: **Novena James-Hailey, (617) 565-1291**