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

JUL 19 2013

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

RE: Vermont 12-025

Dear Mr. Racine:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-025. This amendment updates the DSH reimbursement for state plan year (SPY) 2013. Specifically it changes the base year used to calculate the DSH payments from fiscal year (FY) 2009 to FY 2010.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. The Medicaid State plan amendment 12-025 is approved effective October 1, 2012. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,
/s/

Cindy Mann
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 12 -- 025

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)
OCTOBER 1, 2012

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

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

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

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

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $ 0
b. FFY 2013 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT. 4.19-A PG 1F, 1G AND 1I

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

10. SUBJECT OF AMENDMENT: DISPROPORTIONATE SHARE PAYMENTS (DSH)

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
/ s /

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/ s /

13. TYPED NAME:
DOUGLAS A. RACINE

14. TITLE:
SECRETARY, AGENCY FOR HUMAN SERVICES

15. DATE SUBMITTED: 12-20-12

16. RETURN TO:

STEPHANIE BECK

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUL 19 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT. 01 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
/ s /

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy & Financial Mgt., CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

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 2013 (effective October 1, 2012), the Base Year used is the fiscal year ending September 30, 2010. 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, Report 5, Net Patient Care Revenue by Payer
   1. Net Medicaid 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

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

VIII. Disproportionate Share Payments (DSH)

Each year of the program, DVHA 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 the DSH Eligibility Group that maximizes the hospital's DSH payment.

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 2013 is $37,448,781. At the time that DSH payments are disbursed, DVHA 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 of the Total DSH Funding for the DSH SPY or 50% of 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 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)

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).

When all cost reports are available, the State will recalculate each hospital's specific payment limit starting with Medicaid State Plan Year (SPY) FY 2011 using audited Medicare Cost Reports. The State will then compare the hospital specific limit against DSH payments made for the SPY to determine if any hospital was paid in excess of its specific limit. The same procedure will occur in subsequent SPYs.

If the recalculated hospital specific limits show that the State made a payment to a hospital in excess of its hospital specific limit, the State will recoup any excess payment and redistribute the funds to other hospitals using the payment formula set forth in VIII.A using the applicable DSH State Plan for the year of the overpayment.

Furthermore, if the State's DSH auditor has findings demonstrating that DSH payments made for SPY 2011 or subsequent years exceed the documented hospital specific limits, the State will recoup and redistribute to other hospitals using the payment formula set forth in VIII.A that was in place for the applicable DSH state plan year under audit.