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

AUG 09 2013

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

RE: Vermont 12-029

Dear Mr. Racine:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-029. This amendment revises the reimbursement methodology for inpatient hospital services. Specifically, it updates the diagnosis-related group (DRG) relative weights and changes the base year data used to calculate payments.

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 12-029 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 -- 029

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 2013 $3,181
b. FFY 2014 $3,128

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATT. 4.19-A, PG 1C-3, 1C-4, 1C-5, 1C-6, 1C-7, 1C-8, 1C-10, 1C-11, 1C-12

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
ATT. 4.19-A, PG 1C-3, 1C-4 1C-5, 1C-6, 1C-7, 1C-8, 1C-10, 1C-11, 1C-12

10. SUBJECT OF AMENDMENT: DRG REBASE

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: 12/27/13

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: AUG 09 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:

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

V. Ongoing Maintenance

As a part of ongoing maintenance of the payment system, the DVHA will change the following rate setting components either separately or in combination:

A. Annually
   1. The DRG Grouper used to group claims. If a new DRG grouper includes a new DRG for which the OVHA does not have a relative weight assigned, the DVHA will use the Medicare relative weight to assign the DRG to a Vermont tier weight until such time as all DRG relative weights are updated.
   2. The factors representing length of stay in payments for psychiatric cases made to eligible hospitals.
   3. The Cost to Charge Ratio assigned to each hospital for use in establishing claim outlier status

B. At least once every four years
   1. The base period of claims and Medicare Cost Report(s) used to establish DRG relative weight values
   2. The DRG Relative Weight Values
   3. The inflation factor used to best represent current costs
   4. The Fixed Outlier Value
   5. The Outlier Payment Percentage

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

IV. Special Payment Provisions (Continued)

3. The Cost to Charge Ratio (CCR) to be applied for calculating the outlier cost of the case will be assigned to each participating in-state hospital specifically on an annual basis based on a recently filed MCR. Each out-of-state hospital will be assigned a CCR based upon its peer group.

    a. Border Teaching Hospitals: The CCR to apply will be assigned to each participating hospital specifically on an annual basis based on a recently filed MCR for each hospital in the peer group.
    b. Non-Border Teaching Hospitals: The CCR that will be assigned will be the average CCR of all in-state hospitals.
    c. Other Out-of-State Hospitals: The CCR that will be assigned will be the average CCR of all in-state hospitals.

I. Extraordinary Access Issues

In order to ensure access to non-Vermont hospitals providing unusual and highly complex services, the DVHA has the authority to establish rates on a case by case basis or by hospital.

J. New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. If the new facility is an in-state hospital, it will receive the same base rate as other in-state hospitals and all other payment policies for in-state hospitals will apply. If it is an out-of-state hospital, it will receive a base rate based upon the out-of-state peer group it is assigned to. All other payment provisions will follow the policies for the out-of-state hospital peer group to which it is assigned or the authority as outlined in IV.G and IV.H above.

K. New Medicaid Providers

Prospective payment rates for established facilities which had not been an OVHA participating provider prior to October 1, 2012 will receive payments based on the same provisions that apply to new facilities as described in IV.J.

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

IV. Special Payment Provisions (Continued)

G. Out of State Facilities

Out-of-state facilities will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. However, the values of components of the formulas differ from those used to pay in-state hospitals.

1. A Base Rate will be assigned to each participating out-of-state hospital based upon its peer group.

   a. Border Teaching Hospitals: Defined as hospitals within 10 miles of the Vermont border that operate post-graduate training programs. For services rendered on or after October 1, 2012, the base rate will equal 4,976.00.
   b. Non-Border Teaching Hospitals: Defined as hospitals greater than 10 miles of the Vermont border that operate post-graduate training programs. For services rendered on or after 1, 2012, the base rate will equal $2,974.00.
   c. Other Out-of-State Hospitals: Defined as hospitals not meeting the criteria of G.1.a or G.1.b. For services rendered on or after October 1, 2012, the base rate will equal $2,745.00.

H. Outlier Payments

2. Using the formula for outlier payments described in III.A.2, a Fixed Outlier Value, an Outlier Payment Percentage, and a Cost to Charge Ratio will be assigned to each participating hospital based upon its peer group.

1. Fixed Outlier Value
   a. In-state Hospitals: $24,000
   b. Border Teaching Hospitals: $40,000
   c. Non-Border Teaching Hospitals: $50,000
   d. Other Out-of-State Hospitals: $50,000

2. Outlier Payment Percentage
   a. In-state Hospitals: 80%
   b. Border Teaching Hospitals: 50%
   c. Non-Border Teaching Hospitals: 50%
   d. Other Out-of-State Hospitals: 50%

Hospitals that are eligible for payment under the per diem methodology for psychiatric stays are not eligible to receive an outlier payment for cases in the psychiatric DRGs listed in IV.C.

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

IV. Special Payment Provisions (Continued)

C. Psychiatric DRG Cases Provided by In-State Hospitals

In-state hospitals will be paid for psychiatric cases under a DRG per diem methodology instead of a DRG per case methodology using the formula shown in III.A above.

The Psychiatric DRGs paid under this methodology are those Psychiatric DRGs as assigned by the Grouper being utilized by DVHA. Effective October 1, 2012, this included the following DRGs:

DRG 56: Degenerative Nervous System Disorders w MCC
DRG 57: Degenerative Nervous System Disorders w/o MCC
DRG 80: Nontraumatic Stupor and Coma w MCC
DRG 81: Nontraumatic Stupor and Coma w/o MCC
DRG 876: O.R. Procedure with Principal Diagnosis of Mental Illness
DRG 880: Acute Adjustment Reaction & Psychosocial Dysfunction
DRG 881: Depressive Neuroses
DRG 882: Neuroses Except Depressive
DRG 883: Disorders of Personality & Impulse Control
DRG 884: Organic Disturbances & Mental Retardation
DRG 885: Psychoses
DRG 886: Behavioral & Developmental Disorders
DRG 887: Other Mental Disorder Diagnoses
DRG 894: Alcohol/Drug Abuse or Dependence, Left AMA
DRG 895: Alcohol/Drug Abuse or Depend. with Rehabilitation Therapy
DRG 896: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w MCC
DRG 897: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w/o MCC

On an ongoing basis, the factors applied representing the length of stay will be the same as those utilized by Medicare in its Inpatient Psychiatric Prospective Payment System. The factors applied are additive by length of stay.

The psychiatric base per diem rate was set to ensure that there is sufficient access to services. Effective October 1, 2012, the Base Per Diem Rate for in-state hospitals is $1,052.00.

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

IV. Special Payment Provisions

A. Rehabilitation DRG

In-state hospitals with a claim that groups into the Rehabilitation DRGs (DRGs 945 and 946 in MS-DRG Grouper Version 30.0) will be paid an additional $300 per diem for the entire length of the patient's stay for the single episode of care. Border Teaching Hospitals will be paid an additional $200 per diem. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case.

The Rehabilitation DRGs paid under this methodology are those Rehabilitation DRGs as assigned by the Grouper being utilized by DVHA. Effective October 1, 2012, this included the following DRGs:
DRG 945: Rehabilitation W CC/MCC
DRG 946: Rehabilitation W/O CC/MCC

B. Neonate DRGs

In-state hospitals that do not serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional $300 per diem for the entire length of the patient's stay for the single episode of care. Border Teaching Hospitals will be paid an additional $200 per diem. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case.

In-state hospitals that do serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional $400 per diem for the entire length of the patient's stay for the single episode of care. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case. A hospital with a disproportionate share of neonate cases is a hospital that had more than 50% of all of the neonate DRG cases in the rate setting claims period.

The Neonate DRGs paid under this methodology are those Neonate DRGs as assigned by the Grouper being utilized by DVHA. Effective October 13, 2012, this included the following DRGs:

DRG 789: Neonates, Died or Transferred to another Acute Care Facility
DRG 790: Extreme Immaturity or Respiratory Distress Syndrome, Neonate
DRG 791: Prematurity with Major Problems
DRG 792: Prematurity without Major Problems
DRG 793: Full Term Neonate with Major Problems
DRG 794: Neonate with Other Significant Problems

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

III. Payments Inpatient Hospital Services (Continued)

2. Relative Weights

Relative weights were assigned to each DRG in the CMS MS-DRG Grouper Version 29.0 based on Vermont hospital costs. The relative weight is the average cost of the claims grouped into the DRG divided by the average cost of all claims in the base period.

Before calculating the relative weight for a DRG, tests were conducted to ensure that there was sufficient volume and conformity among the cases in the DRG to set a stable relative weight. A DRG was found to have sufficient sample size to compute a relative weight if: (a) There was a minimum of 10 claims across the two years of data; and (b) There were sufficient claims to pass this statistical test: The standard error of the claims' costs is within 25% of the mean with a 90% level of confidence.

Before running the statistical test, low-cost and high-cost outliers were removed from each DRG, which are defined as any claim that was outside +/- two standard deviations from the geometric mean cost of the DRG.

This test yielded 228 stable DRGs, 403 unstable DRGs, and 119 empty DRGs (no Vermont claims volume in the base period utilized). The 522 unstable and empty DRGs were then collapsed into 12 tier groups based on the Medicare relative weight for each DRG. After the claims were collapsed into these categories, a new average cost was computed for the claims in each tier and a relative weight was set.

Effective with dates of admission on or after October 1, 2012, all DRGs that were collapsed into a tier will share the same relative weight.

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

III. Payments Inpatient Hospital Services (Continued)

B. Discussion of Payment Components

1. Base Rates

The in-state Base Rate effective October 1, 2012 is based on claims with dates of discharge from October 1, 2008 to September 30, 2011 from all in-state hospitals plus Dartmouth-Hitchcock Medical Center. The cost values were assigned to each hospital claim on a claim-by-claim basis using data from each hospital's Medicare Cost Report (MCR). The cost report used to assign the cost for each claim was based on the discharge date of the claim. Claims with dates of discharge from October 1, 2008 to September 30, 2009 were assigned costs using the hospital's 2009 fiscal year end MCR. Claims with dates of discharge from October 1, 2009 to September 30, 2011 were assigned costs using the hospital's 2010 fiscal year end MCR.

Allowed charges on each detail line of the inpatient claim were multiplied by a hospital-specific cost to charge ratio (CCR). The CCR assigned to each detail line is based on the revenue code billed for the detail line. The mapping of revenue codes to CCRs followed the principles that were described in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule for 2007 published in the Federal Register on August 18, 2006, with the following exceptions. The Medicare IPPS group for Routine Days was split into two groups—Adults & Peds and Nursery. The Medicare IPPS group for Intensive Days was split into three groups—ICU, Surgical ICU and NICU. The Medicare IPPS group for Other Services was split into four groups—Emergency Room, Clinic, Observation and Other Services.

The cost value of the claim is adjusted for inflation using Global Insight's Health Care Cost Review New CMS Hospital Prospective Reimbursement Market Basket moving average factors. Claim costs are inflated to the mid-point of the rate year.

The in-state base rate was derived by computing the average inflated cost per case across all claims in the base period. The in-state Base Rate effective October 1, 2012 for non-psychiatric DRGs is $7,249.

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

III. Payment for Inpatient Hospital Services

A. Payment Formulas

1. Non-Outlier DRG Payment Per Case = (Base Rate Assigned to Hospital x DRG Relative Weight)

2. Outlier DRG Payment Per Case = (Cost of Case – Outlier Threshold) x Outlier Payment Percentage

   where

   Cost of Case = Allowable Charges x Hospital-specific Cost to Charge Ratio and Outlier Threshold = (Base Rate x DRG Relative Weight) + Fixed Outlier Value

3. Psychiatric DRG Payment Per Case = (Base Per Diem Rate Assigned to Hospital x DRG Relative Weight x Factor Representing Length of Stay)

   where

   Factor Representing Length of Stay = The factors assigned by the Medicare Inpatient Psychiatric Facilities Prospective Payment System effective October 1, 2012

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

Effective with dates of admission on or after October 1, 2012, the Department of Vermont Health Access (DVHA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

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. Hospitals may be eligible for special payment provisions in addition to payments made under this methodology as discussed in Section IV below.

II. Data Sources and Preparation of Data for Computation of Prospective Rates

A. Introduction

The calculation of prospective rates requires the use of claims data and cost report data. The historical claims data is obtained from a chosen base period and the cost for these claims is derived from Medicare cost report data for the corresponding period. Claim costs are adjusted to the year in which the rates are in effect to account for inflation. Claims are grouped together into a diagnostic related group (DRG) based upon the diagnoses present on the claim.

B. Data Sources- Initial Period

For the rate setting period effective October 1, 2012, hospital cost report data from all in-state Medicaid providers plus Dartmouth-Hitchcock Medical Center for the fiscal years ending 2009 and 2010 were used to assign cost values to claims used in the rate development process. All hospitals included in the analysis have a fiscal year end of September 30 with the exception of one hospital (Retreat Health Care) which has a fiscal year end of December 31. The claims used to assign relative weight values and to develop base rates were from the same hospitals for which cost data was collected and were from the hospital fiscal years ending 2009, 2010 and 2011.

C. Data Sources- Subsequent Periods

More recent cost report and claims data will be used to develop new base rates and relative weights no less than once every four fiscal years.

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