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 and Ambulatory Surgical Center Services

2. Effective with dates of service on or after May 1, 2008, the Department of Vermont Health Access (DVHA) began reimbursing qualified providers for outpatient hospital services under a prospective fee schedule as set forth in this plan. Effective with dates of service on or after July 1, 2021, Ambulatory Surgical Centers were added to this group of qualified providers. The majority of services are paid using the Medicare Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) fee schedule as its basis. Effective July 1, 2021, dental services will no longer be paid using Medicare OPPS APC fee schedule but will be paid via a Vermont Medicaid specific payment methodology. 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 are paid using either a fee that has been set on DVHA's professional fee schedule or by using a cost-to-charge ratio multiplied by covered charges. 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 most recent OPPS fee schedule rates were set as of January 1, 2024 and are effective for services provided on or after that date. All rates are published on the DVHA website.

i. Participating Hospitals and Ambulatory Surgical Centers
All in-state and out-of-state hospitals and Ambulatory Surgical Centers 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 although may deviate in rare circumstances from this methodology for specific operational and/or policy reasons. Effective July 1, 2021, dental services covered by DVHA and payable under Medicare OPPS in APC 5871 will not be paid using the pricing logic for APC 5871. Instead, DVHA will pay for dental services in an outpatient hospital or ambulatory surgical center setting using the Vermont Medicaid specific methodology described in 2.a.iii.I. 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 July 1, 2018, the DVHA has defined peer groups to set rates for groups of hospitals in its OPPS. Effective July 1, 2021, Ambulatory Surgical Centers were added as a defined peer group. Effective January 1, 2024, the rate paid for each service payable in DVHA's OPPS using APC rates will be set as follows:

- For in-state hospitals that have a Medicare classification of critical access hospital (CAH): the peer group base rate is 106.5% of the Medicare 2024 OPPS national APC payment rate without local adjustment.
- For in-state hospitals that do not have a Medicare classification of CAH and who are not considered an academic medical center, the peer group base rate is 83.5% of the Medicare 2024 OPPS national APC payment rate without local adjustment.
- For two academic medical centers, the University of Vermont Medical Center (UVMMC) and Dartmouth-Hitchcock Medical Center, the peer group base rate is 82% of the Medicare 2024 OPPS national APC payment rate without local adjustment.
- For all other out-of-state hospitals, the peer group base rate is 79% of the Medicare 2024 OPPS national APC payment rate without local adjustment.
- For Ambulatory Surgical Centers, the peer group base rate is 79% of the Medicare 2024 OPPS national APC payment rate without local adjustment.

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

2. a. 2. Outpatient Hospital and Ambulatory Surgical Center Services (Continued)

The percentages listed above are considered the base rates for DVHA's OPPS. The DVHA maintains a global policy of reimbursing the lesser of total claim billed charges and total estimated APC payments.

Effective with dates of service on or after July 1, 2016, the DVHA will no longer pay separately for outpatient hospital services billed using revenue codes 510-519 (clinic services).

Since the DVHA uses peer groups that distinguish in-state critical access hospitals (CAHs) from other hospitals, 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 endeavors to update the APC rates, the packaging methodology, and the outlier payment methodology annually based upon the Medicare OPPS Final Rule set each year. The DVHA will also update the status indicators quarterly based upon the Medicare quarterly OPPS Addendum B updates.

B. Outlier Payments

The DVHA will follow a modified Medicare OPPS pricing methodology with respect to identifying claims eligible as high-cost outliers and for the outlier payment calculation for these claims; the modification relates to apportionment of packaged charges to a specific APC; for operational simplicity, DVHA uses all packaged charges and costs on a claim to determine whether the two-tiered test used by Medicare is met.

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 or Dartmouth Hitchcock, 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 or any in-state or out-of-state Ambulatory Surgical Center, 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.

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

2. a. 2. Outpatient Hospital and Ambulatory Surgical Center Services (Continued)

iii. Special Payment Provisions (Continued)

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 simplifies the Medicare OPPS payment methodology for observation services and pays the observation APC 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).

E. Medicare Crossover Claims

Effective with dates of service on or after May 1, 2008, the DVHA 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 DVHA.

G. New Facilities and New Medicaid Providers

New facilities under the APC system and 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 or Ambulatory Surgical Center, 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 and Ambulatory Surgical Center Services (Continued)

iii. Special Payment Provisions (Continued)

H. Emergency Department Per Diem for Extended Mental Health Stays

Extended Emergency Department stays in which a Medicaid beneficiary meets clinical criteria for inpatient psychiatric level of care and there are no beds available for placement are reimbursed at a per diem rate established by the Division of Rate Setting equal to the average statewide rate per patient day paid for services furnished in nursing facilities during the previous calendar year.

I. Other Rate Adjustments

There may be some situations where a fee has not been established by the Medicare OPPS or by the DVHA 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.

J. Outpatient Dental Services

Effective with dates of services on or after July 1, 2021, covered outpatient dental services will no longer be paid using Medicare's OPPS APC fee schedule. Instead, covered outpatient dental services for Hospitals and Ambulatory Surgical Centers will be paid via a Vermont Medicaid specific payment methodology. This payment methodology for outpatient dental services will work in conjunction with the existing Vermont Medicaid dental fee schedule. DVHA has created two Vermont Medicaid specific APC groups (APC 001 and APC 002) for covered outpatient dental services. All outpatient dental services delivered in an outpatient hospital or ambulatory surgical center setting will be reimbursed for the technical component of the service as follows:

Diagnostic Services (D0120-D0999) – Packaged Service ($0.00)
Preventative Services (D1110-D1999) – Packaged Service ($0.00)
Restorative Services (D2140-D2999) – APC 001
Endodontics (D3110-D3999) – APC 001
Periodontics (D4210-D4999) – APC 001
Prosthodontics (D5110-D5999) – APC 001
Implant Services (D6010-D6199) – APC 001
Prosthodontics, Fixed (D6205-D6999) – APC 001
Oral & Maxillofacial Surgery (D7111-D7999) – APC 002
Orthodontics (D8010-D8999) – VT Medicaid Dental Fee Schedule Rate
General Services (D9110-D9999) – VT Medicaid Dental Fee Schedule Rate

Covered outpatient dental services assigned to either APC 001 or 002 will be assigned a Medicare status indicator of T, which will indicate that the OPPS multiple procedure reduction will be applied. For packaged services, a Medicare status indicator of N will be applied. For dental services paid through DVHA's dental professional fee schedule, a Medicare status indicator of M will be applied. (Continued)

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

2. a. 2. Outpatient Hospital and Ambulatory Surgical Center Services (Continued)

iv. Ongoing Maintenance

As a part of ongoing maintenance of the payment system, the DVHA 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.

Alternative Payment Methodologies

In any fiscal year following FY 2002, an FQHC/RHC has the option to retain payment under the standard methodology defined in 1902(bb)(6) or to adopt an APM methodology different from the Medicaid BIPA PPS. To utilize the APM methodology, compliance with specific statutory requirements must be met. Firstly, the State and each individual FQHC/RHC must mutually agree to the APM's application. Additionally, the methodology must ensure that the center or clinic receives a payment at least equivalent to their entitlement under the Medicaid BIPA PPS rate.

1. Alternative Payment Methodology (APM #1 effective 01/01/2018 – 06/30/2023)

Effective January 1, 2018 FQHCs/RHCs electing the APM were paid under either (a) or (b) below for the period of January 1, 2018 through December 31, 2021. Effective January 1, 2022 through June 30, 2023 FQHCs/RHCs electing the APM were paid under (a) below.

a) APM #1 Baseline Rates

i. Rebasing the BIPA Base rate to the 2016 Medicare Cost Reports.
ii. Included the $5.00 Medicare AIR bump for FQHC providers that were in practice in 2010.
iii. Increased by the Medicare Economic Index (MEI) inflationary factor.

b) Differential APM

i. APM 25% of APM #1 Baseline Rates + 75% of the 2017 APM for dates of service January 1, 2019 through December 31, 2019.
ii. APM 50% of APM #1 Baseline Rates + 50% of the 2017 APM for dates of service January 1, 2020 through December 31, 2020.
iii. APM 75% of APM #1 Baseline Rates + 25% of the 2017 APM for dates of service January 1, 2021 through December 31, 2021.

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

2. b. Rural Health Clinic Services/Federally Qualified Health Centers (Continued)

2. Alternative Payment Methodology (APM #2 effective 07/01/2023 – 02/20/2024)

Effective July 1, 2023 FQHCs/RHCs electing the APM were paid with the following methodology for the period of July 1, 2023 through February 20, 2024:

a) APM #2 utilizes the FQHC/RHC costs associated with their 2016 Medicare Cost Report and includes the $5.00 Medicare AIR bump for FQHC providers that were in practice during CY 2010. The rate calculated under this Alternative Payment Methodology (APM #2) also includes a 3.8% increase based off CY 2023 MEI plus an additional 10% Legislative directed increase.

3. Alternative Payment Methodology (APM #3 effective 02/21/2024)

Effective February 21, 2024 FQHCs/RHCs electing the APM will be paid with the following methodology:

a) APM #3 utilizes APM #2 as the base while including a 4.6% increase based off CY 2024 MEI.

Payment to RHC's and FQHC's not electing the APM will be made at the federal Prospective Payment System (PPS) payment level consistent with BIPA and adjusted for changes in scope and reasonable costs. Rates for FQHCs and RHCs were last updated effective February 21, 2024.

FQHCs and RHCs are free to participate in the Medicaid Next Generation Accountable Care Organization (ACO) Program.

DVHA requests all facilities submit cost reports each year to DVHA by May of each calendar year. In addition, if the facility is requesting a change to its PPS rate based on scope of service or reasonable cost changes, it must include a copy of its most current cost report with the request for a PPS review. These reviews will be conducted throughout the year and PPS rates adjusted, if appropriate, per the results of the review.

As of January 1, 2018, DVHA will no longer conduct cost settlement activities related to FQHC and RHC encounter rate setting. The cost report submissions, therefore, will be used to support the scope of service and reasonable cost process and not for any additional cost settlement activities.

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

3. Other Laboratory and X-Ray Services

Payment is limited to laboratories and laboratory services certified by Medicare.
Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

Effective April 1, 2023 other Clinical Diagnostic Laboratory services, not covered under the Medicare OPPS payment methodology, will be paid at 99% of Medicare's Clinical Diagnostic Laboratory fee schedule. COVID-19 Codes will remain at 100% of Medicare's Clinical Laboratory fee schedule. These rates will be updated annually using the latest version of Medicare's Clinical Diagnostic Laboratory fee schedule. Medicaid reimbursement for Clinical Diagnostic Laboratory tests may not exceed the amount that Medicare recognizes for such tests. All rates are published on the DVHA website.

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.

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

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.

(Continued)

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. Rates were set as of 02/15/2023 utilizing the CMS 2023 Lower Utilization Payment Adjustment (LUPA) rate calculation process 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.

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

6. Licensed Behavior Analysts and Licensed Assistant Behavior Analysts

Payment is made at the lower of the actual charge or the Medicaid rate on file. Rates were set as of 6/1/19 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 providers.

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

6. d. Other Practitioners Services (continued)

6a. Applied Behavior Analysis Case Rate

DVHA uses a tiered case rate payment methodology for Applied Behavior Analysis services delivered to beneficiaries who have a diagnosis of Autism Spectrum Disorder, or early childhood developmental disorder, and Medicaid as their primary insurance. Providers will be reimbursed prospectively based on anticipated direct service treatment hours per beneficiary.

Vermont Medicaid pays for ABA using two separate funding methodologies, case rate payment methodology for individuals with Medicaid as their sole insurance, and fee-for-service for individuals who have additional insurance coverage, as outlined in Attachment 4.19-B item 6.d.6. Medicaid retains the right to require a provider to file claims using an alternative payment methodology as part of a Corrective Action Plan if a provider fails to follow billing requirements for either methodology.

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

6. d. Other Practitioners Services

7. Licensed Dental Hygienist Services
Payment is made at the lower of the actual charge or the Medicaid rate on file. Rates were set as of 2/1/2022 and are effective for services on or after that date. All rates are published on the DVHA website. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

8. Licensed Dental Therapist Services
Payment is made at the lower of the actual charge or the Medicaid rate on file. Rates were set as of 5/1/2023 and are effective for services on or after that date. All rates are published on the DVHA website. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

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 02/15/2023, at 90% of the CMS 2023 Lower Utilization Payment Adjustment (LUPA) rate 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 on the DVHA website. 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 on the DVHA website. 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 2/1/2022 and are effective for services on or after that date. All rates are published on the DVHA website. 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) Payment of brand and generic covered outpatient drugs, including select over-the-counter drugs compounded drug products, and select accessory-type medical devices dispensed by an enrolled pharmacy will include the reimbursement for the Actual Acquisition Cost (AAC) of the drug plus a professional dispensing fee (PDF). All covered outpatient drugs and select accessory-type medical devices can be found on the Vermont Department of Health Access website. These products will be reimbursed based on the lowest of:

a. The National Drug Average Acquisition Cost (NADAC) + PDF;
b. The Wholesale Acquisition Cost (WAC) + 0% + PDF;
c. The State Maximum Allowable Cost (SMAC) + PDF;
d. The Federal Upper Limit (FUL) + PDF
e. AWP-19% + PDF;
f. Submitted Ingredient Cost + Submitted dispensing fee;
g. The provider's Usual and Customary (U&C) charges; or
h. The Gross Amount Due (GAD).

(2) A Professional Dispensing Fee (PDF) will be paid for (a) through (e) above:

a. The Professional Dispensing Fee for a retail community, institutional or long-term care pharmacy is $11.13. The Professional Dispensing Fee for a retail community, institutional or long-term care pharmacy will be increased by $3.26 for the following dates of service: 6/03/2024 - 6/30/2024.
b. The Professional Dispensing Fee for specialty drugs including but not limited to biologics and limited distribution drugs is $17.03.

(3) Payment for Clotting Factors from specialty pharmacies will include the Actual Acquisition Cost (AAC) plus a professional dispensing fee as described in (2) above. Reimbursement shall be the lowest of:

a. The National Drug Average Acquisition Cost (NADAC) + PDF;
b. The Wholesale Acquisition Cost (WAC) + 0% + PDF;
c. The State Maximum Allowable Cost (SMAC) + PDF;
d. AWP-19% + PDF;
e. Submitted Ingredient Cost + Submitted dispensing fee;
f. The provider's Usual and Customary (U&C) charges; or
g. The Gross Amount Due (GAD).

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

12. a. Prescribed Drugs (continued)

(4) Payment for Clotting Factors through Hemophilia Treatment Center specialty pharmacies will be reimbursed at the lowest of:

a. The Wholesale Acquisition Cost (WAC) + 0% + PDF;
b. The State Maximum Allowable Cost (SMAC) + PDF;
c. AWP-19% + PDF;
d. Submitted Ingredient Cost + Submitted dispensing fee;
e. The provider's Usual and Customary (U&C) charges; or
f. The Gross Amount Due (GAD).

(5) Facilities purchasing drugs through the Federal Supply Schedule (FSS) or the drug pricing program under 38 U.S.C. 1826, 42 U.S.C. 256b, or 42 U.S.C. 1396-8, other than the 340B drug pricing program will be reimbursed no more than the actual acquisition cost for the drug plus a $11.13 professional dispensing fee.

(6) Facilities purchasing drugs at Nominal Price (outside of 340B or FSS), will be reimbursed no more than the Actual Acquisition Cost for the drug plus a $11.13 Professional Dispensing Fee. Nominal Price as defined in 447.502 of the Code of Federal Regulations, Part 42 means a price that is less than 10% of the average manufacturer price (AMP) in the same quarter for which the AMP is computed.

(7) Investigational drugs are not a covered service under the DVHA pharmacy program.

(8) High-Investment Carve-Out Drugs must be billed separately from the inpatient DRG claim and cannot be acquired through the 340B program. These inpatient drugs will be paid at the actual acquisition cost, and providers must submit an invoice documenting costs. The High-Investment Carve-Out Drug List is available on the DVHA website.

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

12 a. Prescribed Drugs

(9) Rates for Physician Administered Drugs will be paid at 98% of Medicare's rates. The exception to this methodology is that codes identified on the DVHA high-investment carve-out drugs list are reimbursed at actual acquisition cost. Rates for Physician Administered Drugs will be updated annually using the latest version of Medicare's average sales price (ASP) drug pricing file. Medicaid reimbursement for Physician Administered Drugs may not exceed the amount that Medicare recognizes for such services.

When no Medicare rate is available, rates are established by analyzing payment and utilization data, other state Medicaid rates, or rates for similar codes. If a fixed rate cannot be established reimbursement will equal 100% of the actual acquisition cost. All rates are published on DVHA's website.

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

12. a. Prescribed Drugs (continued)

(10) 340B Drug Rebate Program:

i. Payment for drugs, including specialty drugs, purchased through the federal 340B program by 340B covered entities will be at the 340B actual acquisition cost, not to exceed the 340B ceiling price, plus the 340B professional dispensing fee (PDF).

ii. Payment for physician administered drugs, including specialty physician administered drugs, purchased through the federal 340B program by 340B covered entities will be at the 340B actual acquisition cost, not to exceed the 340B ceiling price.

iii. Drugs acquired through the federal 340B drug price program and dispensed by 340B contract pharmacies are not covered.

iv. Payment for drugs purchased outside of the 340B program by 340B covered entities will be reimbursed using the logic in Section 12.a.(1) plus the PDF listed in Section 12.a.(2).

v. A 340B entity may carve out of the 340B drug pricing program (i.e. the 340B entity opts not to bill Medicaid for drugs purchased through the 340B program.) Payment for non-340B drugs purchased by a 340B entity that has drugs carved out of the 340B program will be reimbursed using the logic in 12.a.(1) plus the PDF listed in Section 12.a.(2).

vi. The 340B PDF is $11.13 for non-specialty drugs. The 340B PDF is $17.03 for specialty drugs.

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. The Medicaid rates are 75% of the 2023 regional commercial dental insurance rates. The agency's rates were set as of 7/1/2023 and are effective for services on or after that date. All rates are published on the DVHA website.

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 Nonmedical Institutions (PNMI) for Child Care Services: payment is made via capitation rates as described in the *Methods, Standards and Principles for Establishing Payment Rates for Private Nonmedical Institutions Providing Residential Child Care Services*. 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.

Adult Day Health Rehabilitation Services: Payment is made at the lower of the actual charge or the Medicaid reimbursement rate on file. Rates were set as of July 1, 2023 and are available on the DAIL Adult Services Division website.

Assistive Community Care Services: Payment is made at a uniform per diem rate, paid monthly. No reimbursement will be made for room and board. Rates were set as of July 1, 2023 and are available on the DVHA website.

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 on the DVHA website.

18. Hospice Services
Hospice services are reimbursed at the lower of the actual charge or the Medicaid rate on file. Rates were set as of 1/1/2024 with a Medicare-defined urban/rural differential. With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one of the following five predetermined rates for each day in which an individual receives the respective type, duration and intensity of the services furnished under the care of the hospice.

1. Routine Home Care (RHC) Hospice providers are paid one of two levels of RHC for dates of service on or after 1/1/2016. This two-rate payment methodology will result in a higher RHC rate based on payment for days one (1) through sixty (60) of hospice services care and a lower RHC rate for days sixty-one (61) or later. A minimum of a sixty (60) day gap in hospice services is required to reset the counter which determines which payment category a participant is qualified for.
2. Continuous Home Care
3. Inpatient Respite Care
4. General Inpatient Care
5. Service Intensity Add-On

The State does not apply the optional cap limitation on payments.

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)

19. Case Management Services (Continued)

The Parents as Teachers (PAT) Targeted Case Management service under the Strong Families Vermont Sustained Family Support Home Visiting Program is reimbursed on a per member per month basis at a rate of $595.30 or the lesser of billed charges.

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 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

Rates for ambulance services were set as of 07/01/2023 and will be paid at 100% of Medicare's 2023 urban base ambulance rates. When no Medicare rate is available rates are established by analyzing payment and utilization data, other state Medicaid rates, or rates for similar codes. If a fixed rate cannot be established reimbursement equals 60% of the billed charges. Payment for transportation other than ambulance services is made through a negotiated per member, per week (PMPW) payment methodology made to the existing network of NEMT brokers. The agency's rates were set as of 01/01/2022 and are effective for services on or after that date, except that the rate is changed from $34.75 to $68.20 PMPW for services effective April 1, 2023 through May 24, 2023. All rates are published on the DVHA website. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

b. Treatment no Transport
Ambulance service response and treatment when no transport is provided will be paid at 40% of the 2023 Medicare rate for Basic Life Support (BLS), non-emergency transport.

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.

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

25. Telehealth

Telehealth is defined as methods for health care service delivery using telecommunications technologies. Telehealth includes telemedicine and audio-only.

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 via two-way, real-time, audio and video interactive communications through a secure connection that complies with HIPAA.

Audio-only is defined as real-time health care delivery by a provider who is located at a distant site to a patient at an originating site for purposes of evaluation, diagnosis, consultation, or treatment using telephone or audio-only telecommunications technology.

Chart reviews, electronic mail messages, text communications, or facsimile transmissions are not considered telehealth.

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 on the VT Medicaid website. 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, 2024, the RVUs used are the Medicare RBRVS values published by the Centers for Medicare and Medicaid on its website for calendar year (CY) 2024 including any of those subject to a "lesser of" policy as published by CMS. The DVHA will recognize site of service differentials such that it 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. DVHA generally also follows Medicare's policy of discounting RVUs to reflect non-physician payments. While DVHA generally has adopted the same Medicare discount amounts, DVHA may deviate from Medicare, for policy reasons, as to the magnitude of discounting among different non-physician clinicians paid via the RBRVS system. When no Medicare rate is available, rates are established by analyzing payment and utilization data, other state Medicaid rates, or rates for similar codes. If a fixed rate cannot be established reimbursement equals to 60% of billed charges.

Effective with dates of service on or after August 1, 2017, the DVHA will use one conversion factor, referred to as the standard conversion factor, for DVHA covered services payable in the RBRVS methodology. As of July 1, 2023, the standard conversion factor will be $29.38. The DVHA will pay for these services using the standard conversion factor multiplied by the RVU value on file with DVHA as referenced in the first paragraph on this page. Each RVU will be multiplied by the appropriate geographic practice cost index (GPCI). The updated GPCIs are 1.000 for Physician Work, 0.993 for Practice Expense and 0.518 for Malpractice Insurance.

Effective with dates of service on or after October 1, 2016, the DVHA implemented a second conversion factor that is paid only to eligible enrolled Vermont Medicaid providers, for selected evaluation and management services, who attest to being a primary care provider. As of July 1, 2023, the primary care conversion factor was $37.28. The calculations with the RVUs and GPCIs will be identical to those described above, but a higher rate will be paid as a result of using a different conversion factor specific to these targeted services and providers.

Information on all rates, including those identified as being eligible for the primary care conversion factor, are published at http://dvha.vermont.gov/for-providers. Information for providers wishing to attest to being eligible for the primary care conversion factor are published at http://vtmedicaid.com/assets/provEnroll/EPCPAttestForm.pdf.

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.

$$PYSS\$_{TOTAL\ (ACOi+PAYER)} = (\text{Expected TCOC } \$_{ACOi} - \text{Actual TCOC } \$_{ACOi}) \textit{ risk adjusted, truncated}$$
subject to cap of 10% of the "Actual $\$_{ACOi}$"

$$\text{Payout of } PYSS\$_{ACOi+} = (\ MAXSR_{ACOi} * (\ PYSS\$_{TOTAL\ (ACOi+PAYER)}\ ))\ *\ QS$$
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.

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

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 three 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

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

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 three, calendar year 2016 (CY 2016), the three historic benchmark years are CY 2012, 2013 and 2014. 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 year one. In year two, ACO contracts were amended to allow for a program integrity audit to be conducted upon the completion of the third year of the shared savings program. Should an audit (and any subsequent appeals process) find that a portion of ACO shared savings for the 2015 performance year was earned as a result of up-coding or inaccurate quality performance reporting, an amount equal to that portion of savings paid to the ACO in the Performance Year 2 reconciliation would be recouped as part of the financial transaction for the Performance Year 3 reconciliation. For the 2016 performance year, the DVHA Program Integrity unit reserves the right to conduct an audit of ACO providers within its normal business practices and would recover any overpayments accordingly.

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:

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

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 three 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.

K. 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.

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

31. Durable Medical Equipment Prosthetics/Orthotics, and Supplies (DMEPOS)

Other Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule services not covered under the Medicare OPPS payment methodology will be paid at 98% of Medicare's Vermont Rural Rate (VR rate) or Vermont Non-Rural Rate (VNR rate) when no Rural Rate was available. Rates are updated annually using the most recent Medicare rates.

For manually priced codes for dates of service on or after 1/1/2021, DVHA will reimburse invoice cost plus 30% or MSRP minus 15%, up to the billed charge, whichever is lower. The Vermont Medicaid Fee Schedule lists codes that are manually priced.

Effective 8/15/2023, Vermont Medicaid provides reimbursement for select medically necessary incontinence supplies through a contracted vendor serving the entire state. Incontinence supply reimbursement for the contracted items is made as specified in the negotiated contract. With prior approval, payment may be made to other durable medical equipment providers following the manual priced reimbursement methodology.

All rates are published on the DVHA website.

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

32. 1905(a)(29) Medication-Assisted Treatment (MAT)

MAT is covered under the Medicaid State Plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.

a) Opioid Treatment Programs (OTP) receive per-member, per-month (PMPM) reimbursement for MAT services and provision of methadone. OTPs must provide at least one MAT encounter per month to receive a PMPM rate. Effective 7/1/2023 through 3/31/2025, the PMPM rate without health home services is $400.90. Effective 4/1/2025, the PMPM rate without health home services is $388.88. Effective 7/1/2023 through 3/31/2025, the PMPM rate with health home services is $572.72. Effective 4/1/2025, the PMPM rate with health home services is $555.53.

b) Payment for authorized providers of MAT services other than OTPs is made at the lower of the actual charge for the MAT 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 on the DVHA website. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

c) Unbundled prescribed MAT drugs that are delivered by OTPs or are physician administered, other than methadone, are reimbursed according to the Physician Administered Drugs fee schedule at Item 12(a)(9) of Attachment 4.19-B.

d) Unbundled MAT prescribed drugs and biologicals used to treat opioid use disorder (OUD) that are delivered by authorized providers other than OTPs are reimbursed in the same manner as the Prescribed Drug methodology as listed in Item 12(a) of Attachment 4.19-B.

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

33. Vaccines

Payment methodologies for vaccines vary by setting and other delivery factors. Payment methodologies include:

- Pediatric Immunization Program for vaccines for children under age 19: Page 9a Item 1.5.
- Outpatient Hospital Services: Attachment 4.19-B Item 2a.
- Physician Services: Attachment 4.19-B Item 5.
- Prescribed Drugs for vaccines provided by pharmacies: Attachment 4.19-B Item 12 a.
- Physician Administered Drugs: Attachment 4.19-B Item 12 a.
- The adult vaccine purchasing program is administered by the Vermont Department of Health. The reimbursement methodology for the adult vaccine purchasing program is a per member per month rate. The rate is set annually in April and effective July 1. The rate is calculated using a reconciliation of prior year program revenue and expenses, and estimated vaccine cost and utilization, program operating and administrative costs, and assessable covered lives for the state fiscal year starting July 1.

Payment methodology for vaccine administration is Resource-Based Relative Value (RBRVS). Attachment 4.19-B Item 26

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.