

STATE OF VERMONT  
AGENCY OF HUMAN SERVICES  
DIVISION OF RATE SETTING

**METHODS, STANDARDS AND PRINCIPLES FOR  
ESTABLISHING MEDICAID PAYMENT RATES  
FOR LONG-TERM CARE FACILITIES**

~~JULY 2013~~DECEMBER 2014

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12/31/2014  
SUPERSEDES  
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(e) Service of any document required to be served by this rule shall be made by delivering a copy of the document to the person or entity required to be served or to his or her representative or by sending a copy by prepaid first class mail to the official service address. Service by mail is complete upon mailing.

### 1.11 Representation in All Matters before the Division

(a) A facility may be represented in any matter under this rule by the owner (in the case of a corporation, partnership, trust, or other entity created by law, through a duly authorized agent), the nursing facility administrator, or by a licensed attorney or an independent public accountant.

(b) The provider shall file written notification of the name and address of its representative for each matter before the Division. Thereafter, on that matter, all correspondence from the Division will be addressed to that representative. The representative of a provider failing to so file shall not be entitled to notice or service of any document in connection with such matter, whether required to be made by the Division or any other person, but instead service shall be made directly on the provider.

### 1.12 Severability

If any part of these rules or their application is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end the provisions of these rules are severable.

### 1.13 Effective Date

(a) These rules are effective from January 29, 1992, (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, July 1, 1998, May 1, 1999, July 1, 1999, August 1, 1999, July 1, 2001, November 1, 2002, May 1, 2004, July 1, 2004, July 1, 2005, July 1, 2006, October 1,

2007, July 1, 2008, July 1, 2009, July 1, 2010, April 1, 2011, ~~and July 1, 2013, September 9, 2013, and December XX, 2014~~.

(b) Application of Rule: Amended provisions of this rule shall apply to:

(1) all cost reports draft findings issued on or after the effective date of the most recent amendment, and

(2) all rates set on or after the effective date of the most recent amendment.

(c) With respect to any administrative proceeding pending on the effective date of the most recent amendment the Director or the Secretary may apply any provision of such prior rules where the failure to do so would work an injustice or substantial inconvenience.

## 2 ACCOUNTING REQUIREMENTS

### 2.1 Accounting Principles

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules authorize specific variations in such principles.

(b) The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operational efficiency.

(c) The provider shall report on an accrual basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. In such a case, the provider's accounting process shall provide sufficient information to compile data to satisfy the accrued expenditure reporting requirements and to demonstrate the link between the accrual data

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**14 SPECIAL RATES FOR CERTAIN INDIVIDUAL RESIDENTS****14.1 Availability of Special Rates for Individuals with Unique Physical Conditions**

(a) In rare and exceptional circumstances, a special rate shall be available for the care of an individual eligible for the Vermont Medicaid program whose unique physical conditions makes it otherwise extremely difficult to obtain appropriate long-term care.

(b) A special rate under this subsection is available subject to the conditions set out below.

(c) Required Findings. Before a rate is payable under this section:

(1) the Commissioner of the Department of Vermont Health Access, in consultation with the Department's Medical Director, and the Director of ~~Licensing and Protection~~ Adult Services Division, must make a written finding that the individual's care needs meet the requirements of this section and that the proposed placement is appropriate for that individual's needs; and

(2) the Division of Rate Setting, in consultation with the Commissioner of the Department of Vermont Health Access and the Commissioner of the Department of Disabilities, Aging and Independent Living, must determine that the special rate, calculated pursuant to paragraph (e) of this subsection, is reasonable for the services provided.

(d) Plan of Care:

(1) Before an individual can be placed with any facility and a rate established, pursuant to this subsection, a plan of care for that person must be approved by the Director of ~~Adult Services Division Licensing and Protection~~ Adult Services Division and the Medical Director of the Department of Vermont Health Access.

(2) The facility shall submit the resident's assessment and plan of care for review by the Director of ~~Adult Services Division Licensing and Protection~~ Adult Services Division and the Medical Director of the Department of Vermont Health Access whenever there is a significant change in the resident's condition, but in no case less frequently than every six months. This review shall form the basis for a determination that the payment of the special rate should be continued or revised pursuant to 14.1(e)(2).

(e) Calculation of the Special Rate:

(1) A per diem rate shall be set by the Division based on the budgeted allowable costs for the individual's plan of care. The rate shall be exempt from the limits in section 7 of these rules.

(2) From time to time the special rate may be revised to reflect significant changes in the resident's assessment, care plan, and costs of providing care. The Division may adjust the special rate retroactively based on the actual allowable costs of providing care to the resident.

(3) Special rates set under this section shall not affect the facility's normal per diem rate. The case-mix weight of any resident on whose behalf a special rate is paid shall not be included in the calculation of the facility's average case-mix score pursuant to subsection 7.2(b), but the days of care shall be included in the facility's Medicaid days and total resident days. The provider shall track the total costs of providing care to the resident and shall self-disallow the incremental cost of such care on cost reports covering the period during which the facility receives Medicaid payments for services to the resident.

**14.2 Special Rates for Certain Former Patients of the Vermont State Hospital**

(a) A special rate is available for nursing home services to patients transferred directly from the Vermont State Hospital or to such

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**Certificate of Need (CON):** certificate of approval for a new institutional health service, issued pursuant to 18 V.S.A. §2403.

**Certified Rate:** the rate certified by the Division of Rate Setting to the Department of Vermont Health Access.

**Common Control:** where an individual or organization has the power to influence or direct the actions or policies of both a provider and an organization or institution serving the provider, or to influence or direct the transactions between a provider and an organization serving the provider. The term includes direct or indirect control, whether or not it is legally enforceable.

**Common Ownership:** where an individual or organization owns or has equity in both a facility and an institution or organization providing services to the facility.

**Companion Aide: a Licensed Nurse Aide (LNA) with specialized training in person-centered dementia care.**

**Cost Finding:** the process of segregating direct costs by cost centers and allocating indirect costs to determine the cost of services provided.

**Cost Report:** a report prepared by a provider on forms prescribed by the Division.

**Direct Costs:** costs which are directly identifiable with a specific activity, service or product of the program.

**Director:** the Director of Rate Setting.

**Division:** the Division of Rate Setting, Agency of Human Services.

**Donated Asset:** an asset acquired without making any payment in the form of cash, property or services.

**Facility or nursing facility:** a nursing home facility licensed and certified for

participation in the Medicaid Program by the State of Vermont.

**Fair Market Value:** the price an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

**FASB:** Financial Accounting Standards Board.

**Final Order of the Division:** an action of the Division which is not subject to change by the Division, for which no review or appeal is available from the Division, or for which the review or appeal period has passed.

**Free standing facility:** a facility that is not hospital-affiliated.

**Funded Depreciation:** funds that are restricted by a facility's governing body for purposes of acquiring assets to be used in rendering resident care or servicing long term debt.

**Fringe Benefits:** shall include payroll taxes, workers' compensation, pension, group health, dental and life insurances, profit sharing, cafeteria plans and flexible spending plans, child care for employees, employee parties, and gifts shared by all staff. Fringe benefits may include tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED.

**Generally Accepted Accounting Principles (GAAP):** those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins,

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and other pronouncements of the AICPA or FASB.

**Generally Accepted Auditing Standards (GAAS):** the auditing standards that are most widely recognized in the public accounting profession.

**Health Care Cost Service:** publication, by Global Insight, Inc., of national forecasts of hospital, nursing home (NHMB), and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

**Hold Day:** a day for which the provider is paid to hold a bed open is counted as a resident day.

**Hospital-affiliated facility:** a facility that is a distinct part of a hospital provider, located either at the hospital site or within a reasonable proximity to the hospital.

**Incremental Cost:** the added cost incurred in alternative choices.

**Independent Public Accountant:** a Certified Public Accountant or Registered Public Accountant not employed by the provider.

**Indirect Costs:** costs which cannot be directly identified with a particular activity, service or product of the program. Indirect costs are apportioned among the program's services using a rational statistical basis.

**Inflation Factor:** a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

**Interim Rate:** a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

**Look-back:** a review of a facility's actual costs for a previous period prescribed by the Division.

**Medicaid Resident:** a nursing home resident for whom the primary payor for room and board is the Medicaid program.

**New England Consumer Price Index (NECPI-U):** the New England consumer price index for all urban consumers as published by the Health Care Cost Service.

**New Health Care Project:** A project requiring a certificate of need (CON) pursuant to 18 V.S.A. §9434(a) or projects which would require a CON except that their costs are lower than those required for CON jurisdiction pursuant 18 V.S.A. § 9434(a).

**OBRA 1987:** the Omnibus Budget Reconciliation Act of 1987.

**Occupancy Level:** the number of paid days, including hold days, as a percentage of the licensed bed capacity.

**Paid feeding/dining assistants:** persons (other than the facility's administrator, registered nurses, licensed practical nurses, certified or licensed nurse aides) who are qualified under state law pursuant to 42 C.F.R. §§483.35(h)(2), 483.160 and 488.301 and who are paid to assist in the feeding of residents.

**Per Diem Cost:** the cost for one day of resident care.

**Prescription Drugs:** drugs for which a physician's prescription is required by state or federal law.

**Person-Centered Dementia Care:** care that includes the following elements: an individualized approach to care planning that uses the perspective of the person with dementia as the primary frame of reference; values the personhood of the individual with dementia; and provides a social environment that supports psychological needs.

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**Prospective Case-Mix Reimbursement System:** a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

**Provider Reimbursement Manual, CMS-15:** a manual published by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, used by the Medicare Program to determine allowable costs.

**Rate year:** the State's fiscal year ending June 30.

**Related organization or related party:** an individual or entity that is directly or indirectly under common ownership or control or is related by family or other business association with the provider. Related organizations include but are not restricted to entities in which an individual who directly or indirectly receives or expects to receive compensation in any form is also an owner, partner, officer, director, key employee, or lender, with respect to the provider, or is related by family to such persons.

**Resident Assessment Form:** Vermont version of a federal form, which captures data on a resident's condition and which is used to predict the resource use level needed to care for the resident.

**Resident Day:** any day of services for which the facility is paid. For example, a paid hold day is counted as a resident day.

**Restricted Funds and Revenue:** funds and investment income earned from funds restricted for specific purposes by donors, excluding funds restricted or designated by an organization's governing body.

**RUG IV:** A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

**Secretary:** the Secretary of the Agency of Human Services.

**Special hospital-based nursing facility:** a facility that meets the following criteria: (a) is physically integrated as part of a hospital building with at least one common wall and a direct internal access between the hospital and the nursing home; (b) is part of a single corporation that governs both the hospital and the nursing facility; and (c) files one Medicare cost report for both the hospital and the nursing home.

**Standardized Resident Days:** Base Year resident days multiplied by the facility's average Case-Mix score for the base year.

**State nursing facilities:** facilities owned and/or operated by the State of Vermont.

**Swing-Bed:** a hospital bed used to provide nursing facility services.

## 17 TRANSITIONAL PROVISIONS

~~[Repealed]~~ Notwithstanding any other provisions of these rules, the amendments to these rules effective December XX, 2014 and shall be applied to payments for services rendered on or after January 1, 2015.

### 17.1 Companion Aide Pilot Project

The Companion Aide Pilot Project will provide a per diem rate adjustment to selected facilities to develop additional knowledge and experience in the area of person-centered dementia care through the use of Companion Aides. Companion Aides will be Licensed Nurse Aides with specialized training in person-centered dementia care to provide an individualized approach that uses the perspective of the person with dementia as the primary frame of reference.

The work of the Companion Aides funded by this pilot program must comply with the job description detailed in the Companion Aide

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application. The selected nursing facilities may have the Companion Aide work any shift.

The pilot project will be for 2.5 years beginning January 1, 2015 and ending on June 30, 2017.

(a) Selection Process

(1) All Vermont nursing facilities participating in the Medicaid program are eligible to apply.

(2) Five facilities will be selected from the pool of completed applications by the Commissioner of the Department of Disabilities Aging and Independent Living. One facility will be selected from each of five geographical areas of the State based on the county groupings in the Council on Aging service areas. These geographical areas will be Northwest Vermont (Addison, Chittenden, Franklin and Grand Isle counties); Northeast Vermont (Caledonia, Essex, and Orleans counties); Central Vermont (Lamoille, Orange, and Washington counties); Southwest Vermont (Rutland and Bennington counties); and Southeast Vermont (Windham and Windsor counties).

(3) Within each geographical area, the applicants will be ranked by the proportion of their residents with a diagnosis of Alzheimer's or dementia compared to the number of total residents, and the facility with the highest proportion will be selected. This data will be reported on the Companion Aide application and must be from the Minimum Data Set (MDS) information used for the June 15, 2014 picture date in the second quarter of 2014.

(4) If no nursing facility applies from a given region, an additional nursing facility from the geographical area with the highest number of applicants will be selected. If there are two regions with no applicants, an additional facility then will be selected

from the geographical area with the second highest number of applicants.

(5) If there is a tie in the selection process, the facility with the highest percentage of Medicaid residents to total residents for State fiscal year 2014, based on census information reported to the Division of Rate Setting, will be selected.

(b) Rate Adjustment Calculations and Procedures

(1) The rate adjustment will include the salary and fringe benefit costs for the approved number of Companion Aides at the selected facilities. The hourly salaries and fringe benefit rates will be reported on the Companion Aide application and reviewed by the Division of Rate Setting.

(2) The selected facilities will be funded at a ratio of five Companion Aides per 100 filled beds. The calculated number shall be rounded up or down to determine the number of Companion Aide Full Time Equivalents (2,080 hours/year). The resulting number of aides to be funded will vary with the number of filled beds at the selected facilities.

(3) The number of total beds filled shall equal the total number of residents reported on the June 15, 2014 MDS picture date (Q2 2014) summary report supplied to the Division of Licensing and Protection.

(c) Inflation of Rate Adjustments

The original per diem adjustment for Companion Aides will be inflated on July 1, 2015 and July 1, 2016 using the same methodology as detailed in Subsection 5.8 of these rules.

(d) End of Adjustment and Special Nursing Rebase Provisions

(1) The adjustments in this Section will be terminated as of July 1, 2017 when Nursing Care costs are rebased to base year 2015.

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This will be the first year when the costs of the Companion Aides will be in the facility's base year costs.

(2) For facilities with years ending earlier than December 31, the Division will annualize the cost of the Companion Aides so that a full year of these costs will be included in the selected facilities' 2015 base year costs.

(3) The Companion Aide costs at the five selected facilities will be exempt from the cap on nursing costs in the July 1, 2017 rebase. In rebases after that time, the extant cap on Nursing Care Costs will apply.

(e) Ongoing Reporting Requirements

The selected facilities shall complete an annual Companion Aide Pilot Project Outcome Report. This report will be sent to the providers with the Companion Aide application so nursing facility staff will understand the data reporting requirement when they apply for the pilot. These reports will be due by November 10, 2015 and November 10, 2016. The Division may end the Companion Aide rate adjustment for a facility that does not comply with the ongoing reporting requirements.

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